

CHAPTER 21-000 REHABILITATION CARE IN HOSPITALS

21-001 Definitions

Activities of Daily Living: Activities performed by the client relating to self-care, such as bathing, continence, eating, dressing, grooming, mobility, toileting, and transferring.

Distinct Part Unit: A Medicare-certified hospital-based substance abuse, psychiatric, or physical rehabilitation unit that is certified as a distinct part unit for Medicare.

Initial Evaluation: See 471 NAC 21-003.02A

Rehabilitation Hospitals and Distinct Part Units in Acute Care Hospitals: Hospitals that are licensed as rehabilitation hospitals by the licensing agency of the state in which they are located, and distinct parts as defined in these regulations.

Rehabilitation Services: Any medical or remedial services recommended by and within the scope of practice under state law of a physician, for maximum reduction of physical or mental disability and restoration of a client to the client's best possible functional level.

Rehabilitation Team: A multidisciplinary coordinated team, comprised of individuals described in 471 NAC 21-003.02(i)-(vii), which is responsible for performing the initial evaluation, determining the extent to which rehabilitation is possible, identifying rehabilitation goals, and developing the rehabilitation program.

21-002 Provider Requirements

21-002.01 General Provider Requirements: To participate in the Nebraska Medical Assistance Program (Medicaid), providers of rehabilitation services shall comply with all applicable participation requirements codified in 471 NAC Chapters 2 and 3. In the event that provider participation requirements in 471 NAC Chapters 2 or 3 conflict with requirements outlined in 471 NAC Chapter 21, the individual provider participation requirements in 471 NAC Chapter 21 shall govern.

21-002.02 Specific Provider Requirements: Rehabilitation services must be provided in a hospital or a distinct part of a hospital that:

- i. Provides rehabilitation services;
- ii. Is licensed or formally approved as a hospital by the Nebraska Department of Health and Human Services, Division of Public Health or, if the hospital is located in another state, the authority responsible for licensing or formal approval in that state;
- iii. Has licensed and certified rehabilitation beds;
- iv. Meets the requirements for participation in Medicare for rehabilitation hospitals; and
- v. Has in effect a utilization review plan which applies to all Medicaid clients.

21-002.02A Provider Agreement: A hospital which provides rehabilitation services shall complete and sign Form MC-20, "Medical Assistance Hospital Provider Agreement" (see 471-000-91) and submit the completed form to the Department for approval and enrollment as a provider. Each hospital shall have a separate provider agreement (and a separate provider number) for rehabilitation services. The hospital shall submit a description of the rehabilitation program with the provider agreement.

21-002.02A1 Out-of-State Hospital Provider Agreement: In addition to a completed and signed Form MC-20, an out-of-state hospital shall also submit documentation of its certification/accreditation status from the state survey agency in the state where the hospital is located. The Department will not process claims received from an out-of-state hospital until all information required under this section has been received.

Also see 471 NAC 10-010.03J, Out-of-State Hospital Rates, and 10-010.06G, Payment to an Out-of-State Hospital for Outpatient Hospital and Emergency Room Services.

21-002.02B Hospital Level of Rehabilitation Care: The Rehabilitation hospital must provide a hospital level of rehabilitative care. Hospitals with a significant number of rehabilitation team members working on a part time basis must provide evidence to establish that the hospital did, in fact, provide a hospital level of rehabilitative care. Evidence documenting the hospital level of rehabilitative care includes, but is not limited to:

1. Verification that team conferences were held at least once every two weeks;
2. Verification that there was a need for, and involvement of, various allied health professionals; and,
3. Verification of the intensity of the rehabilitative program.

21-003 Service Requirements

21-003.01 General Requirements

21.003.01A Medical Necessity: Rehabilitation services must be provided in accordance with the medical necessity guidelines outlined in 471 NAC 1-002.02A.

21-003.01B Prior Authorization of Medical Rehabilitation Care: Medicaid requires prior authorization of all medical inpatient rehabilitation services to determine the medical necessity, appropriateness of setting, and length of stay. Prior authorization functions, admission reviews, concurrent reviews, and retrospective prepayment reviews are conducted by the peer review organization (PRO), an entity contracted with Medicaid to perform these services. The PRO also performs reconsideration reviews of inpatient hospital denials when requested by the provider.

21-003.01C Services Provided for Clients Enrolled in the Nebraska Medicaid Managed Care Program: See 471 NAC 1-002.01.

21-003.01C1 Delayed Enrollment: When a client is in an acute care medical or rehabilitation facility prior to the client's enrollment in Managed Care, the effective date of

enrollment is delayed until the client is discharged from the facility or transferred to a lower level of care. See 482 NAC 2-002.05D.

21-003.01D HEALTH CHECK (EPSDT) Treatment Services: See 471 NAC Chapter 33.

21-003.02 Covered Services: Medicaid covers rehabilitation services for patients requiring a hospital level of care, and a rehabilitation program which incorporates a multidisciplinary coordinated team approach to upgrade his/her ability to function as independently as possible. A program of this scope usually includes:

- i. Intensive skilled rehabilitation nursing care;
- ii. Physical therapy;
- iii. Occupational therapy; and
- iv. If needed, speech therapy;
- v. Nursing staff to provide general nursing services, and support the other disciplines by monitoring the patient's activities on the nursing floor to ensure that s/he participates in carrying out the activities of daily living utilizing the training received in therapy;
- vi. Ongoing general and, as needed, direct supervision of a physician with special training or experience in the field of rehabilitation (For coverage limitations, billing, and payment of physicians services, see 471 NAC 18-000.); and,
- vii. If needed, a psychologist and/or social worker to help resolve any psychological and social problems which are impeding rehabilitation. (For coverage limitations, billing, and payment of psychological services, see 471 NAC 20-000 and/or 32-000.)

21-003.02A Rehabilitation Evaluation: When a client is admitted to the hospital for rehabilitation care, an assessment must be made of his/her:

- i. Medical condition;
- ii. Functional limitations;
- iii. Prognosis;
- iv. Possible need for corrective surgery;
- v. Attitude toward rehabilitation; and
- vi. The existence of any social problems affecting rehabilitation.

After these assessments are made, the physician, in consultation with the rehabilitation team, decides whether rehabilitation is possible; what the reasonable rehabilitation goals are; and what type of rehabilitation program is required to achieve these goals.

21-003.02A1 Limitations to Coverage of the Initial Evaluation:

21-003.02A1a Duration of Evaluation: When more than 10 days are required to complete the initial evaluation, the Department will carefully review the case to ensure that the additional time was necessary. The Department may request, and the hospital shall submit, documentation showing the necessity of the additional time. Inpatient hospital care is required for this period, and covered under Medicaid if the client's condition warrants a multidisciplinary team evaluation.

21.003.02A1b Identical or Similar Admission Conditions: If, during a previous hospital stay, the client completed a program for essentially the same condition for

which inpatient hospital care is now being provided, the Department covers the initial evaluation period only if:

- i. A change in circumstances has occurred which makes an evaluation reasonable and necessary; or,
- ii. The subsequent admission is to an institution utilizing advanced techniques or technology not available in the first institution.

21-003.02A1c Dementia or Senility: In view of the client's limited rehabilitation potential, a multidisciplinary team evaluation is not considered reasonable and necessary for a client who is demented or severely senile.

21-003.02A2 Mental Confusion: Medicaid does not cover hospitalization for rehabilitation following an evaluation if mental confusion with an inability to learn is the only existing disability. Alternatively, the fact that an individual is "confused" is not a basis for concluding that a multidisciplinary team evaluation is not warranted.

21-003.02B Rehabilitation Program: Medicaid covers hospitalization in cases where the rehabilitation team determines, after the initial evaluation, that a significant practical improvement can be expected in a reasonable period of time. Rehabilitation goals must be realistic and reasonable. Vocational rehabilitation is generally not considered a realistic goal for most clients receiving rehabilitation services under Medicaid. For the majority of clients, the most realistic rehabilitation goal is self-sufficiency in:

1. Bathing;
2. Ambulation;
3. Toileting;
4. Eating;
5. Dressing;
6. Homemaking; or
7. Sufficient improvement in the areas of self-sufficiency to allow the client to live in the community with assistance rather than in an institution.

In assessing the reasonableness of the established goal or the likelihood that the rehabilitation goal can be achieved in a reasonable period of time, considerable weight must be given to the rehabilitation team's judgment, except where experience indicates that in a significant number of cases the team's judgment has proven to be unreliable. An expectation of the attainment of complete independence in the activities of daily living is not necessary, but there must be an expectation of an improvement that would be of a practical benefit to the client.

21-003.02C Team Conferences: Rehabilitation team conferences must be held at least every 2 weeks to:

1. Assess the individual's progress or the problems impeding progress;
2. Consider possible resolutions to the problems;
3. Reassess the continuing validity of the rehabilitation goals established at the time of the initial evaluation;
4. Reassess the need for any adjustment in these goals or in the prescribed treatment program; and
5. Develop discharge plans.

Team conferences may be a formal or informal, but must involve interactive discussion regarding the patient. The decisions made during conferences must be recorded in the patient's clinical record. The Department may request, and the hospital shall provide, documentation of team conferences.

21-003.02D Discharge: Medicaid covers a maximum of 3 days to discharge the client. If more than 3 days is needed to safely discharge the client, payment for additional days will be made only when adequate justification for the delayed discharge is submitted to the Department.

21-003.03 Non-Covered Services

21-003.03A Poor Candidate for Rehabilitation: When the initial evaluation results in a conclusion that the client is a poor candidate for rehabilitation care, Medicaid limits coverage of inpatient hospital care to a reasonable number of days needed to permit appropriate placement of the client. An intensive rehabilitation program under these circumstances is not considered reasonable and necessary to the treatment of the client's illness or injury.

21-003.03B Further Progress is Unlikely: Rehabilitation services are covered until further progress toward the established rehabilitation goal is unlikely, or further progress may be achieved in a less intensive setting. In making decisions as to whether further progress may be carried out in a less intensive setting, the Department considers:

1. The degree of improvement which has occurred; and
2. The type of program required to achieve further improvement.

When further progress is unlikely, coverage is provided through the time it is reasonable for the physician, in consultation with the rehabilitation team, to have concluded that further improvement would not occur, and effected the client's discharge. Because planning is an integral part of any rehabilitation program and must begin upon the client's admittance to the facility, an extended period of time for discharge action is not reasonable after:

1. Established goals have been reached;
2. A determination has been made that further progress is unlikely; or
3. Care in less intensive setting is appropriate.

21-004 Billing and Payment for Chiropractic Services

21-004.01 Billing

21-004.01A General Billing Requirements: Providers shall comply with all applicable billing requirements codified in 471 NAC Chapter 3. In the event that billing requirements in 471 NAC Chapter 3 conflict with billing requirements outlined in this 471 NAC Chapter 21, the billing requirements in 471 NAC Chapter 21 shall govern.

21-004.01B Specific Billing Requirements

21-004.01B1 Billing Instructions: The provider shall bill Medicaid in accordance with the billing instructions included in this Chapter.

21-004.02 Payment

21-004.02A General Payment Requirements: Medicaid will reimburse the provider for services rendered in accordance with the applicable payment regulations codified in 471 NAC Chapter 3. In the event that payment regulations in 471 NAC Chapter 3 conflict with payment regulations outlined in this 471 NAC Chapter 21, the payment regulations in 471 NAC Chapter 21 shall govern.

21-004.02B Specific Payment Requirements

21-004.02B1 Payment for Inpatient Care: All rehabilitation services, regardless of the type of hospital providing the service, will be reimbursed on a per diem basis. This includes services provided at a facility enrolled as a provider for rehabilitation services which is not a licensed rehabilitation hospital or a Medicare-certified distinct part unit. The per diem rate will be the sum of the following:

1. The hospital-specific base payment per diem rate (See Appendix 471-000-82, Inpatient Hospital Services, Section III.A.1);
2. The hospital-specific capital per diem rate (See Appendix 471-000-82, Inpatient Hospital Services, Section III.A.2); and
3. If applicable, the hospital's direct medical education per diem rate (See Appendix 471-000-82, Inpatient Hospital Services, Section III.A.3).

Payment for each discharge equals the per diem rate times the number of approved patient days. Payment is made for the day of admission but not for the day of discharge.

21-004.02B2 Payment for Outpatient Hospital and Emergency Room Services: See 471 NAC 10-010.06, Payment for Outpatient Hospital and Emergency Room Services.

21-005 Evaluation Report and Plan of Care: The hospital shall submit an evaluation report to the Medical Director of the Division of Medicaid and Long-Term Care, or the Medicaid designated contractor, by the end of the second week following admission. The evaluation report must outline a detailed plan of care, and identify time frames applicable to each goal included in the rehabilitation program. The plan of care must contain a detailed staff report describing the client's:

1. Progress;
2. Problems; and
3. Discharge planning, involving possible relocation of the client to the most appropriate setting.