Subject: Acute Inpatient Rehabilitation

Policy Number: NMP10

Effective Date*: August 2003

Updated: October 2015

This National Medical Policy is subject to the terms in the IMPORTANT NOTICE at the end of this document

For Medicaid Plans: Please refer to the appropriate State’s Medicaid Manual(s), publication(s), citation(s), and documented guidance for coverage criteria and benefit guidelines prior to applying Health Net Medical Policies

The Centers for Medicare & Medicaid Services (CMS)
For Medicare Advantage members please refer to the following for coverage guidelines first:

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Inpatient Hospital Pain Rehabilitation Programs: http://www.cms.gov/manuals/Downloads/bp102c01.pdf

None Use Health Net Policy

Instructions

- Medicare NCDs and National Coverage Manuals apply to ALL Medicare members in ALL regions.
- Medicare LCDs and Articles apply to members in specific regions. To access your specific region, select the link provided under “Reference/Website” and follow the search instructions. Enter the topic and your specific state to find the coverage determinations for your region. *Note: Health Net must follow local coverage determinations (LCDs) of Medicare Administration Contractors (MACs) located outside their service area when those MACs have exclusive coverage of an item or service. (CMS Manual Chapter 4 Section 90.2)
- If more than one source is checked, you need to access all sources as, on occasion, an LCD or article contains additional coverage information than contained in the NCD or National Coverage Manual.
- If there is no NCD, National Coverage Manual or region specific LCD/Article, follow the Health Net Hierarchy of Medical Resources for guidance.

Note: As of January 10, 2010, Inpatient Rehabilitation Facility (IRF) care is only considered by Medicare to be reasonable and necessary under 1862(a)(1)(A) of the Social Security Act if the patient meets all of the requirements outlined in 42 CFR §§412.622(a)(3), (4), and (5), as interpreted in this section. This is true regardless of whether the patient is treated in
the IRF for 1 or more of the 13 medical conditions listed in 42 CFR §412.23(b)(2)(ii) or not. Medicare requires determinations of whether IRF stays are reasonable and necessary to be based on an assessment of each beneficiary’s individual care needs.

**Current Policy Statement**
Health Net, Inc. considers admission to an acute inpatient rehabilitation facility (IRF) medically necessary when the documentation in the patient’s IRF medical record (which must include the preadmission screening, the overall plan of care, the admission orders and the post-admission physician evaluation if requested) must demonstrate a reasonable expectation that the following criteria were met at the time of admission to the IRF:

**Medicare Medical Necessity Criteria is contained in the attached document to assist in your review**

1. The patient must require the active and ongoing therapeutic intervention of multiple therapy disciplines (physical therapy, occupational therapy, speech-language pathology, or prosthetics/orthotics therapy), one of which must be physical or occupational therapy.

2. The patient must generally require an intensive rehabilitation therapy program. Under current industry standards, this intensive rehabilitation therapy program generally consists of at least 3 hours of therapy per day at least 5 days per week. In certain well-documented cases, this intensive rehabilitation therapy program might instead consist of at least 15 hours of intensive rehabilitation therapy within a 7 consecutive day period, beginning with the date of admission to the IRF. (see *Brief Exception Policy*)

3. The patient must reasonably be expected to actively participate in, and benefit significantly from, the intensive rehabilitation therapy program at the time of admission to the IRF. The patient can only be expected to benefit significantly from the intensive rehabilitation therapy program if the patient’s condition and functional status are such that the patient can reasonably be expected to make measurable improvement (that will be of practical value to improve the patient’s functional capacity or adaptation to impairments) as a result of the rehabilitation treatment and if such improvement can be expected to be made within a prescribed period of time.

**Definition of Measurable Improvement**
A patient can only be expected to benefit significantly from an intensive rehabilitation therapy program provided in an IRF, if the patient’s IRF medical record indicates a reasonable expectation that a measurable, practical improvement in the patient’s functional condition can be accomplished within a predetermined and reasonable period of time. In general, the goal of IRF treatment is to enable the patient’s safe return to the home or community-based environment upon discharge from the IRF. The patient’s IRF medical record is expected to indicate both the nature and degree of expected improvement and the expected length of time to achieve the improvement.

Since discharge planning is an integral part of any rehabilitation program and must begin upon the patient’s admission to the IRF, an extended period of time for
discharge from the IRF would not be reasonable and necessary after established
goals have been reached or the determination has been made that further progress
is unlikely.

For an IRF stay to be considered reasonable and necessary, the patient does not
have to be expected to achieve complete independence in the domain of self-care.
However, to justify the need for a continued IRF stay, the documentation in the IRF
medical record must demonstrate the patient’s ongoing requirement for an intensive
level of rehabilitation services and an inter-disciplinary team approach to care.
Further, the IRF medical record must also demonstrate that the patient is making
functional improvements that are ongoing and sustainable, as well as of practical
value, measured against his/her condition at the start of treatment.

4. The patient must require physician supervision by a rehabilitation physician, defined
as a licensed physician with specialized training and experience in inpatient
rehabilitation. The requirement for medical supervision means that the rehabilitation
physician must conduct face-to-face visits with the patient at least 3 days per week
throughout the patient’s stay in the IRF to assess the patient both medically and
functionally, as well as to modify the course of treatment as needed to maximize the
patient’s capacity to benefit from the rehabilitation process.

5. The patient must require an intensive and coordinated interdisciplinary approach to
providing rehabilitation. At a minimum, the interdisciplinary team must document
participation by professionals from each of the following disciplines (each of whom
must have current knowledge of the patient as documented in the medical record at
the IRF):
- A rehabilitation physician with specialized training and experience in rehabilitation
  services;
- A registered nurse with specialized training or experience in rehabilitation;
- A social worker or a case manager (or both); and
- A licensed or certified therapist from each therapy discipline involved in treating
  the patient.

The interdisciplinary team must be led by a rehabilitation physician who is
responsible for making the final decisions regarding the patient’s treatment in the
IRF. This physician must document concurrence with all decisions made by the
interdisciplinary team at each meeting. The periodic team conferences—held a
minimum of once per week—must focus on:
- Assessing the individual's progress towards the rehabilitation goals;
- Considering possible resolutions to any problems that could impede progress
towards the goals;
- Reassessing the validity of the rehabilitation goals previously established; and
- Monitoring and revising the treatment plan, as needed.

*Brief Exception Policy:
While patients requiring an IRF stay are expected to need and receive an intensive
rehabilitation therapy program, as described above, this may not be true for a limited
number of days during a patient’s IRF stay because patients’ needs vary over time. For
example, if an unexpected clinical event occurs during the course of a patient’s IRF stay that
limits the patient’s ability to participate in the intensive therapy program for a brief period
not to exceed 3 consecutive days (e.g., extensive diagnostic tests off premises, prolonged
intravenous infusion of chemotherapy or blood products, bed rest due to signs of deep vein
thrombosis, exhaustion due to recent ambulance transportation, surgical procedure, etc.),
the specific reasons for the break in the provision of therapy services must be documented
in the patient’s IRF medical record. If these reasons are appropriately documented in the patient’s IRF medical record, such a break in service (of limited duration) will not affect the determination of the medical necessity of the IRF admission.

**Specific Criteria**

**Standard Indications**

Health Net, Inc. considers admission to an acute inpatient rehabilitation facility medically necessary for any of the following categories of patients due to the seriousness and extent of the impairments and disabilities described in the medical record when specific criteria are met:

1. **Major stroke** whenever the stroke (or series of strokes) leads to a significant functional deficit (typically paralysis, contracture, incapacitating paresis or incapacitating ataxia) of at least two extremities or one extremity with significant involvement of higher CNS functions. The patient must be able to tolerate 3 hrs of therapy per day. For recurrent strokes, the need for inpatient intervention is determined by the degree of new impairment since the previous stroke, including the patient’s prior level of function.

2. **Major trauma** typically resulting in musculoskeletal injuries of more than one extremity or at least functional impairment of one extremity together with higher CNS neurological impairment requiring physical therapy to restore strength and range of motion (ROM), occupational therapy to re-educate motor control and function, and nursing to manage associated wounds and injuries.

3. **Traumatic brain injury** (TBI), whether it be focal (traumatic or post-surgical) or global (anoxic, post infectious, etc.), whenever the TBI leads to a significant functional deficit (typically paralysis, contracture, incapacitating paresis or incapacitating ataxia) of at least two extremities or one extremity with significant involvement of higher functions.

4. **Significant spinal cord injury** resulting in a significant functional deficit (paralysis, contracture or incapacitating paresis) of at least two extremities.

5. **Nerve root injury** when there is a persistent (typically >14 days) functional deficit (paralysis, contracture or incapacitating paresis) in at least two extremities and the deficit is not expected to be self-limited following surgical intervention (e.g. decompression).

6. **Major burn** associated with multiple disabilities as a result of significant scarring on multiple extremities or on the face (eyes/mouth) and at least one extremity (Note: acute phase of burn care may be provided as long as the primary reason for admission is rehabilitative; burn care without an intensive rehabilitation need may be appropriate for a long-term care stay or a SNF stay where less intensive rehabilitation is available).

**Variable Indications**

Health Net, Inc. considers admission to an acute inpatient rehabilitation facility medically necessary for any of the following variable impairments when supported by a moderate level of explicit or implicit evidence apparent from the simple descriptive narrative in the medical record, and when the criteria are met:

**Note**: As a rule of thumb, widespread impairments with multiple disabilities require inpatient rehabilitation, while focal deficits tend to be amenable to outpatient therapy. Conversely, global impairments typically create widespread disabilities but may have a low expectation of improvement or may spontaneously improve with general strengthening. They may not
allow the level of effort or rate of progress expected in acute inpatient rehabilitation; a Skilled Nursing Facility (SNF) venue with gradual reconditioning is often appropriate here when the impairment is particularly diffuse or cyclical in nature.

1. **Major focal trauma** with massive, catastrophic injuries to multiple extremities only when 3 or more hours of therapy are **required** on a daily basis.

2. **Focal peripheral nerve injury** or pathology only when there are multiple injuries that create a significant functional deficit (paralysis, contracture or incapacitating paresis) in at least two extremities.

3. **Diffuse peripheral motor nerves** or neuromuscular junctions pathology (e.g. myasthenia gravis, Guillain-Barre and chronic immune demyelinating polyneuropathy) if at least two extremities have significant functional deficits (paralysis, contracture or incapacitating paresis) and the weakness is not simply a qualitative difference since a prior inpatient admission.

4. **Chronic or relapsing disease** (e.g., multiple sclerosis) when self care/home management training, i.e., activities of daily living, compensatory training, meal preparation, safety procedures, and instruction in the use of adaptive equipment is **required** in addition to physical therapy and **all** of the following are met:
   - There has been a fundamental (and usually sudden) deterioration in the functional status which is expected to be sustained; and
   - The specific functional deficit has not been previously addressed by rehabilitation; and
   - New compensatory strategies are required.

**Bilateral knee replacement** to restore strength and ROM using complex rehabilitative management and the use of specialized equipment at a frequency that would be impractical in an outpatient or SNF setting

**Single hip fracture that are not surgically treated** associated with extensive soft tissue injury, functional impairment and consequent disability requiring coordinated multidisciplinary intervention that cannot be provided at a lower level of care, including SNF and/or outpatient setting

**Amputation** (only unilateral above-the-knee and bilateral above- or below-the-knee amputations) that requires prosthetic fitting and motor re-education with functional adaptation.

**Polyarthritis** when there is joint pathology (arthritis) that has progressed to the point of significant functional deficit (markedly restricted ROM in the joint and/or associated contractures) in at least two extremities.

**Arthritis of the spine** with significant limitation of motion only when it is associated with crippling arthritis in a single extremity with documented expectation for improvement.

**Osteoarthritis** only if it results in a significant functional deficit of multiple extremities that precludes treatment in a less intensive environment.
Not Medically Necessary
Health Net, Inc. does not consider admission to an acute inpatient rehabilitation facility medically necessary for any of the following because appropriate care can be provided in a less intensive setting (e.g., SNF or outpatient setting)

1. **Transient ischemic attacks** (TIAs)

2. **Nerve root injury** with mild to moderate paresis and/or weakness due to nerve root compression because it requires physical therapy for strengthening but does not require coordinated multi-disciplinary care.

3. **Single nerve injury** needs can be typically met in the outpatient or SNF environment.

4. **Cyclical exacerbations of disease** when simple strengthening is expected to return the patient to the baseline level of function.

5. Patients who are on IVIG or apheresis who are neurologically unstable because they typically cannot tolerate the level of intensive therapy expected of inpatient rehabilitation and are therefore appropriately managed in a hospital or, when neurologically stable, in a SNF.

6. Patients with diffuse peripheral motor pathology who present with a poorly defined constellation of symptoms, centering around generalized weakness do not require the skilled services of multiple disciplines on a repetitive basis but benefit primarily from PT reconditioning and time to convalesce, services which are available in a SNF

7. **Non-catastrophic single extremity injuries** can usually be rehabilitated in an outpatient or SNF rehabilitation environment and seldom require 3 or more hours of therapy on a daily basis

8. **Hip fractures** that are surgically corrected can usually be rehabilitated in an outpatient or SNF environment and seldom require 3 or more hours of therapy on a daily basis

9. **Single total hip replacement** can usually be rehabilitated in an outpatient or SNF environment and seldom require 3 or more hours of therapy on a daily basis

10. **Chronic pain rehabilitation**

11. **Acute pain management** following an acute event because it is part of the recovery phase of the acute hospital stay; in addition, pain management that does not require 3 hours per day of skilled intervention on a daily basis.

12. **Amputation** of one leg below-the-knee, one or more toes, the loss of fingers, or the loss of a single hand or arm does not require daily skilled intervention and needs can typically be performed in the outpatient or SNF environment

13. **Amputation of non-extremity parts** (e.g. ears, breast, jaw, panniculi) does not require inpatient rehabilitation.

14. The needs of a patient with **mild to moderate arthritis** can be typically met in the outpatient or SNF environment
15. **Minor trauma**, such as falls from a standing position, are primarily orthopedic in nature and do not generally require coordinated multidisciplinary intervention. Therapy, following casting or surgical intervention, is primarily physical and does not require the additional services (e.g., for neuromotor re-education) of another discipline.

16. **Spinal fracture** (compression fractures) recovery requires bed rest with subsequent remobilization and strengthening; there is no necessity for neuromuscular reeducation or compensatory training unless cord compression or nerve root compression has created a significant motor deficit.

17. **Recovery after major orthopedic or neurosurgery** because from a rehabilitation perspective recovery involves remobilization and general strengthening, and rarely involves skilled therapy services or rarely requires the coordination of multiple disciplines. Routine post-operative recovery, when it does not require targeted rehabilitation, additionally is included as part of the hospital stay for inpatient surgery; protracted recoveries that do not require continued acute inpatient care are more typically managed in a SNF, swing bed or long-term care facility.

18. **Post-procedure CNS catastrophic event** (e.g., anoxic brain injury) after which the patient experiences acute deconditioning (rather than chronic). This would be accompanied by an acute hospital course, which is longer than the expected course for that procedure (at least 10-14 days). Such patients may suffer from cachexia and inanition with loss of both upper and lower body strength and inability to independently perform simple Activities of Daily Living (ADLs). In most instances these patients have only a PT (strengthening) requirement, which can be appropriately met by a SNF. However, if there is a need for high level of involvement by the rehabilitation physician, then the multi-disciplinary requirement is met by the combination of medicine plus PT, and inpatient rehabilitative care is medically necessary. A patient is only appropriate for transfer to an acute inpatient rehabilitation facility after all acute problems have been resolved and diagnostic workups completed. Inpatient rehabilitation is not a substitute for Long Term Acute Care (LTAC).

19. **Post-operative recovery from orthopedic surgery** involving a single extremity because weakness without contractures requires physical therapy to restore strength and additional therapies are rarely required when neuromuscular re-education is not necessary; single extremity involvement can typically be rehabilitated in a less intensive setting (outpatient or occasionally SNF).

20. **Post recovery operative neurosurgery** in the absence of a significant motor deficit (e.g. multiple extremity loss of function) caused by cord or nerve root injury. Preoperative weakness caused by compression that is alleviated by surgery also does not necessitate inpatient rehabilitation as strengthening is the primary required intervention.

21. **Recovery from surgery on the spine** in the absence of a significant post-operative motor deficit.

22. **Deconditioning** (generalized debilitation) that is associated with an acute exacerbation of a chronic illness, a chronic disease or aging will frequently benefit from rehabilitation, but do not require inpatient rehabilitation. It is a medical condition, not a rehabilitation issue, and intervention is limited to medical management rather than remediation.
23. **Coma stimulation therapy** because the scientific literature does not demonstrate that coma therapy is medically efficacious. Coma therapy is therefore appropriately considered investigational. In addition, the typical services provided do not require the round-the-clock presence of an RN or the frequent assessment and intervention of a physician. Finally, the probability of practical improvement is below the threshold required to support intensive inpatient intervention.

24. **Cognitive therapy** consisting of those interventions directed at improving memory, problem solving and the like are considered investigational, and therefore not medically necessary, because the individual services themselves are predominantly of unproven efficacy; in addition, typical cognitive therapy programs do not require the round-the-clock presence of an RN or the frequent assessment and intervention of a physician and can be provided in a less intensive outpatient or SNF environment.

25. **Cardiac Rehabilitation** services do not require admission to an acute inpatient rehabilitation facility. Phase I is provided as part of an acute care hospital admission; an inpatient medical need (e.g. recovery after cardiovascular surgery) is an indication for a continued hospital stay, not inpatient rehabilitation. Phase II cardiac rehabilitation does not require daily intervention with the typical prescribed amount of monitored exercise being one hour three times per week in most programs. Admission to an acute inpatient rehabilitation facility must be based on a need for rehabilitation services, not the need for ongoing acute care services. The other component of cardiac rehabilitation, education and lifestyle modification, is not appropriately considered therapy, does not require an inpatient environment, is not “time-sensitive” (no benefit of immediate post-acute education over delayed post-convalescent education), and is not required on a daily basis. Since the educational component of cardiac rehabilitation does not contribute to a determination of a need for intensive inpatient rehabilitation (the “3 hour” requirement), if a patient is admitted to inpatient rehabilitation for other reasons and is receiving for those other indications the services necessary to justify inpatient status, cardiac rehabilitation may be provided in addition to those other therapies and 1 hour per day of monitored exercise can contribute to the “3 hour” requirement.

26. **Pulmonary rehabilitation** services do not require admission to an acute inpatient rehabilitation facility. They may be provided on an outpatient basis. Pulmonary rehabilitation does not require daily intervention and, additionally, it can typically be provided in a less intensive setting (outpatient or occasionally SNF). A need for ongoing inpatient care of the pulmonary disease is a medical justification for acute or long-term hospitalization, not inpatient rehabilitation. The prescribed amount of monitored exercise is typically one hour three times per week in most programs. The other component of pulmonary rehabilitation, education and lifestyle modification, is not appropriately considered therapy, does not require an inpatient environment, is not “time-sensitive” (no benefit of immediate post-acute education over delayed post-convalescent education), and is not required on a daily basis. Since the educational component of pulmonary rehabilitation does not contribute to a determination of a need for intensive inpatient rehabilitation (the “3 hour” requirement), if a patient is admitted to an acute inpatient rehabilitation facility for other reasons and is receiving for those other indications the services necessary to justify inpatient status, pulmonary rehabilitation may be provided in addition to those other therapies and 1 hour per day of monitored exercise can contribute to the “3 hour” requirement.

**Codes Related To This Policy**

**NOTE:**
The codes listed in this policy are for reference purposes only. Listing of a code in this policy does not imply that the service described by this code is a covered or non-covered health service. Coverage is determined by the benefit documents and medical necessity criteria. This list of codes may not be all inclusive.

On October 1, 2015, the ICD-9 code sets used to report medical diagnoses and inpatient procedures will be replaced by ICD-10 code sets. Health Net National Medical Policies will now include the preliminary ICD-10 codes in preparation for this transition. Please note that these may not be the final versions of the codes and that will not be accepted for billing or payment purposes until the October 1, 2015 implementation date.

ICD-9 Codes
Too numerous to list

CPT Codes
Too numerous to list

HCPCS Codes
Too numerous to list

Scientific Rationale
An acute rehabilitation facility provides short-term comprehensive rehabilitation and/or medically intensive services for a targeted patient population who have had an acute event as the result of an illness, injury, or exacerbation of a disease process. The level of care is more intensive than the traditional skilled nursing facility and less intensive than acute inpatient hospital care. It requires frequent, recurrent patient assessment and review of the clinical course and treatment plan for a limited time period until the condition is stabilized or a predetermined treatment course is completed. Acute rehabilitation care requires the coordinated services of an interdisciplinary team including physicians, nurses, and other relevant professional disciplines who are trained and knowledgeable to assess and manage these specific conditions and perform the necessary procedures. The goal of acute rehabilitation care is to discharge residents to their homes or to a lower level of care as their recovery progresses.

Pulmonary rehabilitation programs are used to treat patients with severe COPD and asthma. They educate patients about living with their disease, strengthen their accessory muscles of respiration, design a home therapy program, and determine equipment needs.

In the acute rehab setting, professional disciplines frequently include most of the following:

- Unit Director
- Physician that specializes in physical medicine and rehabilitation
- Registered and Licensed Practical Nurses that specialize in physical medicine and rehabilitation
- Physical Therapists and Assistants
- Occupational Therapists and Assistants
- Speech Language Pathologist
- Psychologist
- Pulmonologist
- Respiratory Therapist
- Case Manager
- Pastoral Care
- Vocational Rehab Counselor
Traumatic brain injury (TBI) occurs when a sudden physical assault on the head causes damage to the brain. The damage can be focal, confined to one area of the brain, or diffuse, involving more than one area of the brain. The severity of a TBI can range from a mild concussion to the extremes of coma or even death. Immediate treatment for TBI involves surgery to control bleeding in and around the brain, monitoring and controlling intracranial pressure, insuring adequate blood flow to the brain, and treating the body for other injuries and infection. The outcomes ranging from good recovery to death depends on the cause of the injury and on the location, severity, and extent of neurological damage. These patients are frequently sent to the acute rehab setting for cognitive rehabilitation.

The process of rehabilitation after traumatic brain injury has two main goals. The first is prevention of and minimization of disability from complications. The second is maximization of recovery and useful function in the face of the limitations imposed by residual impairment. Specialized, interdisciplinary, and comprehensive treatment programs are necessary to address the particular medical, rehabilitation, social, family, and educational needs of patients with TBI. Rehabilitation services, matched to the needs of persons with TBI, and community-based non-medical services are required to optimize outcomes over the course of recovery. Post-acute approaches to TBI rehabilitation include home-based rehabilitation, outpatient rehabilitation programs, community re-entry programs, comprehensive day treatment programs, residential community reintegration programs, and neurobehavioral programs.

An extensive literature has examined the effectiveness of comprehensive rehabilitation programs for persons with TBI. Unfortunately, most studies are not rigorous from a methodological standpoint, so conclusions regarding effectiveness must be approached with caution. Indeed, critical analysis of the literature on TBI rehabilitation yields only a few studies that suggest effectiveness under limited conditions.

**Review History**

- August 5, 2003: Medical Advisory Council Review
- July 26, 2005: Updated
- August 2007: Update – no revisions
- December 2007: Existing criteria replaced with a new set of criteria
- October 2008: Update. Revised policy statement to adhere to most current Medicare language.
- September 2010: Revised Commercial criteria
- November 2011: Update. Added revised Medicare Table. No Revisions.
- October 2014: Update - no revisions
- October 2015: Update – no revisions.

**References – Update October 2015**


References – Update October 2014

References – Update October 2013

References – Update October 2012


References – Update November 2011

References – Update August 2010

References – Update October 2008
1. Medicare Benefit Policy Manual. Chapter 1 - Inpatient Hospital Services Covered Under Part A. 2/10/06. 110 - Inpatient Hospital Stays for Rehabilitation Care. (Rev. 1, 10-01-03) A3-3101.11, HO-211.

References - Initial

**Important Notice**

**General Purpose.**
Health Net's National Medical Policies (the "Policies") are developed to assist Health Net in administering plan benefits and determining whether a particular procedure, drug, service or supply is medically necessary. The Policies are based upon a review of the available clinical information including clinical outcome studies in the peer-reviewed published medical literature, regulatory status of the drug or device, evidence-based guidelines of governmental bodies, and evidence-based guidelines and positions of select national health professional organizations. Coverage determinations are made on a case-by-case basis and are subject to all of the terms, conditions, limitations, and exclusions of the member's contract, including medical necessity requirements. Health Net may use the Policies to determine whether under the facts and circumstances of a particular case, the proposed procedure, drug, service or supply is medically necessary. The conclusion that a procedure, drug, service or supply is medically necessary does not constitute coverage. The member's contract defines which procedure, drug, service or supply is covered, excluded, limited, or subject to dollar caps. The policy provides for clearly written, reasonable and current criteria that have been approved by Health Net's National Medical Advisory Council (MAC). The clinical criteria and medical policies provide guidelines for determining the medical necessity criteria for specific procedures, equipment, and services. In order to be eligible, all services must be medically necessary and otherwise defined in the member's benefits contract as described this "Important Notice" disclaimer. In all cases, final benefit determinations are based on the applicable contract language. To the extent there are any conflicts between medical policy guidelines and applicable contract language, the contract language prevails. Medical policy is not intended to override the policy that defines the member's benefits, nor is it intended to dictate to providers how to practice medicine.

**Policy Effective Date and Defined Terms.**
The date of posting is not the effective date of the Policy. The Policy is effective as of the date determined by Health Net. All policies are subject to applicable legal and regulatory mandates and requirements for prior notification. If there is a discrepancy between the policy effective date and legal mandates and regulatory
requirements, the requirements of law and regulation shall govern. * In some states, prior notice or posting on the website is required before a policy is deemed effective. For information regarding the effective dates of Policies, contact your provider representative. The Policies do not include definitions. All terms are defined by Health Net. For information regarding the definitions of terms used in the Policies, contact your provider representative.

**Policy Amendment without Notice.**
Health Net reserves the right to amend the Policies without notice to providers or Members. In some states, prior notice or website posting is required before an amendment is deemed effective.

**No Medical Advice.**
The Policies do not constitute medical advice. Health Net does not provide or recommend treatment to members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

**No Authorization or Guarantee of Coverage.**
The Policies do not constitute authorization or guarantee of coverage of particular procedure, drug, service or supply. Members and providers should refer to the Member contract to determine if exclusions, limitations, and dollar caps apply to a particular procedure, drug, service or supply.

**Policy Limitation: Member’s Contract Controls Coverage Determinations.**
Statutory Notice to Members: The materials provided to you are guidelines used by this plan to authorize, modify, or deny care for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under your contract. The determination of coverage for a particular procedure, drug, service or supply is not based upon the Policies, but rather is subject to the facts of the individual clinical case, terms and conditions of the member's contract, and requirements of applicable laws and regulations. The contract language contains specific terms and conditions, including pre-existing conditions, limitations, exclusions, benefit maximums, eligibility, and other relevant terms and conditions of coverage. In the event the Member’s contract (also known as the benefit contract, coverage document, or evidence of coverage) conflicts with the Policies, the Member’s contract shall govern. The Policies do not replace or amend the Member’s contract.

**Policy Limitation: Legal and Regulatory Mandates and Requirements**
The determinations of coverage for a particular procedure, drug, service or supply is subject to applicable legal and regulatory mandates and requirements. If there is a discrepancy between the Policies and legal mandates and regulatory requirements, the requirements of law and regulation shall govern.

**Reconstructive Surgery**
CA Health and Safety Code 1367.63 requires health care service plans to cover reconstructive surgery.
"Reconstructive surgery" means surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do either of the following:

1. To improve function or
2. To create a normal appearance, to the extent possible.

Reconstructive surgery does not mean "cosmetic surgery," which is surgery performed to alter or reshape normal structures of the body in order to improve appearance.

Requests for reconstructive surgery may be denied, if the proposed procedure offers only a minimal improvement in the appearance of the enrollee, in accordance with the standard of care as practiced by physicians specializing in reconstructive surgery.

**Reconstructive Surgery after Mastectomy**
California Health and Safety Code 1367.6 requires treatment for breast cancer to cover prosthetic devices or reconstructive surgery to restore and achieve symmetry for the patient incident to a mastectomy. Coverage for prosthetic devices and reconstructive surgery shall be subject to the co-payment, or deductible and coinsurance conditions, that are applicable to the mastectomy and all other terms and conditions applicable to other benefits. "Mastectomy" means the removal of all or part of the breast for medically necessary reasons, as determined by a licensed physician and surgeon.

**Policy Limitations: Medicare and Medicaid**
Policies specifically developed to assist Health Net in administering Medicare or Medicaid plan benefits and determining coverage for a particular procedure, drug, service or supply for Medicare or Medicaid members shall not be construed to apply to any other Health Net plans and members. The Policies shall not be interpreted to limit the benefits afforded Medicare and Medicaid members by law and regulation.