Texas Children's	Inpatient Rehabilitation Services Guideline	
Guideline # 6200	***Categories*** Clinical →Care Coordination, Care Coordination – Utilization management , TCHP Guidelines	***This Guideline Applies To:*** Texas Children's Health Plan ***Document Owner*** Lisa Fuller

GUIDELINE STATEMENT:

Texas Children's Health Plan (TCHP) performs authorization of all Inpatient Rehabilitation Services performed in a freestanding rehabilitation facility

DEFINITIONS:

Rehabilitation: A set of interventions designed to optimize functioning and reduce disability in individuals with health conditions in interaction with their environment.

Inpatient Rehabilitation Facility: Freestanding rehabilitation hospitals that provide medically necessary items and services under the direction of a physician for the care and treatment of inpatient members with the goal of optimizing function.

Inpatient Rehabilitation Services: Services furnished in an inpatient rehabilitation facility under physician orders that are provided by qualified technical or professional health personnel such as registered nurses, physical therapists, occupational therapists and speech pathologists or audiologists.

PRIOR AUTHORIZATION GUIDELINES

1. Inpatient Rehabilitation Services are a benefit of Texas Medicaid when provided as part of a general acute care inpatient admission, or with prior authorization for members who are 20 years of age and younger in a freestanding rehabilitation facility. Inpatient rehabilitation services in an acute care setting are included in the hospital DRG payment.

2. All requests for prior authorization for Inpatient Rehabilitation Services are received via fax, phone or electronically by the Utilization Management Department and processed during normal business hours.

3. TCHP requires clinical documentation to be provided to support the medical necessity of Inpatient Rehabilitation Services that may include:
   - A preadmission evaluation of the patient's condition
   - Baseline level of function and summary of medical history

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- Medical treatment needs (e.g., skilled therapies and/or specialized nursing care), including expected frequency and duration of treatment, and other information relevant to the member's care needs
- Prognosis including expected level of improvement and anticipated length of stay required to achieve that level of improvement
- Signed physician order for Inpatient Rehabilitation Services

4. Inpatient Rehabilitation Services are medically necessary when **ALL** of the following criteria are met:
   - The member has an acute problem or an acute exacerbation of a chronic problem resulting in a significant decrease in functional ability that will benefit from inpatient rehabilitation services.
   - A condition is considered to be acute or an acute exacerbation of a chronic condition only during the six months from the onset date of the acute condition or the acute exacerbation of the chronic condition.
   - The intensity of necessary rehabilitative service cannot be provided in the outpatient setting.
   - The member requires and will receive multidisciplinary team care defined as at least **two** therapies (occupational therapy (OT), physical therapy (PT), and/or speech therapy (ST)).
   - This therapy will be provided for a **minimum** of three hours per day, five days per week.

5. Inpatient rehabilitation may be prior authorized for up to two months when the attending physician submits documentation of medical necessity.

6. The treatment plan must indicate that the member is expected to improve within a 60-day period and be restored to a more functional lifestyle for an acute condition or the previous level of function for an acute exacerbation of a chronic condition.

7. Requests for subsequent services for increments up to 60 days may be prior authorized based on medical necessity.

8. Requests for prior authorization of subsequent services must be received before the end-date of the preceding prior authorization.

9. An **initial** request for prior authorization must include documentation from the provider to support the medical necessity of the service and includes the following:
   - The request for inpatient rehabilitation and an updated written comprehensive treatment plan signed and dated by the physician no more than 60 days prior to the requested start date
   - A Comprehensive Care Program (CCP) Prior Authorization Request form signed and dated by the physician
   - A current therapy evaluation with the documented age of the member at the time of evaluation
   - Therapy goals related to the member's needs including goals for improving, maintaining, or slowing deterioration of function

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- A description of the specific therapy being prescribed, diagnosis, treatment goals related to the member's individual needs, and duration and frequency of therapy
- The date of onset of the illness or injury
- The requested dates of service
- Consists of at least two appropriate physical modalities (OT, PT, and/or ST) designed to resolve or improve the member's condition.
- Includes a minimum of three hours of team interaction with the member every day, five days per week.

10. A prior authorization request for an **additional** 60 days of therapy will be considered with documentation supporting medical necessity including:
    - Documentation required for an initial request
    - A brief synopsis of the outcomes of the previous treatment relative to the debilitating condition.
    - The expected results to be achieved by an extension of the active treatment plan and the time interval at which this extension outcome should be achieved.
    - Discussion why the initial two months of inpatient rehabilitation has not met the member's needs and why the member cannot be treated in an outpatient setting.
11. Requests that do not meet the criteria established by this procedure will be referred to a TCHP Medical Director for review.

12. Preauthorization is based on medical necessity and not a guarantee of benefits or eligibility. Even if preauthorization is approved for treatment or a particular service, that authorization applies only to the medical necessity of treatment or service. All services are subject to benefit limitations and exclusions. Providers are subject to State and Federal Regulatory compliance and failure to comply may result in retrospective audit and potential financial recoupment.

REFERENCES:

Government Agency, Medical Society, and Other Publications:

Texas Medicaid Provider Procedures Manual Children's Services Handbook, Accessed February 2024 ~~https://www.tmhp.com/sites/default/files/file-library/resources/provider-manuals/tmppm/pdf-chapters/2023/2023-02-feb/2_Childrens_Services.pdf~~

https://www.tmhp.com/sites/default/files/file-library/resources/provider-manuals/tmppm/pdf-chapters/2024/2024-02-february/2_04_childrens_services.pdf

Status	Date	Action
Approved	03/14/2024	Clinical & Administrative Advisory Committee Reviewed and Approved for Implementation

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Original Document Creation Date: 10/21/2016	This Version Creation Date: 03/12/2023	Effective/Publication Date: 03/27/2023

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