

MEDICA®

UTILIZATION MANAGEMENT POLICY

TITLE: INPATIENT REHABILITATION FACILITY (ACUTE REHABILITATION)

EFFECTIVE DATE: August 20, 2018

IMPORTANT INFORMATION – PLEASE READ BEFORE USING THIS POLICY

These services may or may not be covered by all Medica plans. Please refer to the member’s plan document for specific coverage information. If there is a difference between this general information and the member’s plan document, the member’s plan document will be used to determine coverage.

With respect to Medicare and Minnesota Health Care Programs, this policy will apply unless those programs require different coverage.

Medica may use tools developed by third parties, such as MCG Care Guidelines®, to assist in administering health benefits. Medica utilization management (UM) policies and MCG Care Guidelines are not intended to be used without the independent clinical judgment of a qualified health care provider taking into account the individual circumstances of each member’s case. Medica UM policies and MCG Care Guidelines do not constitute the practice of medicine or medical advice. The treating health care providers are solely responsible for diagnosis, treatment, and medical advice.

Members may contact Medica Customer Service at the phone number listed on their member identification card to discuss their benefits more specifically. Providers with questions about this Medica UM policy may call the Medica Provider Service Center toll-free at 1-800-458-5512.

PURPOSE

To promote consistency between reviewers in utilization management decision-making by providing the criteria that generally determine the medical necessity of inpatient rehabilitation facility (acute rehabilitation) services. The Benefit Considerations box below outlines the process for addressing the needs of individuals who do not meet these criteria.

MEDICAL NECESSITY CRITERIA

For medical necessity criteria, Medica uses MCG™ Care Guidelines, 21st edition, 2017, Recovery Facility Care General Recovery Guidelines.

BENEFIT CONSIDERATIONS

1. Prior authorization **is required** for admission and continued stay for inpatient rehabilitation (acute rehabilitation) services. Review of these services will occur prior to admission, concurrently or retrospectively to determine if medical necessity criteria were met. Denial may result if criteria were not met. Please see the prior authorization list for product specific prior authorization requirements.
2. Clinical records, when requested by Medica, must be submitted by facilities to Medica within 24 hours or one business day.
3. Coverage may vary according to the terms of the member’s plan document.
4. For patients not meeting criteria for inpatient rehabilitation facility (acute rehabilitation) services, alternative levels of care may be appropriate such as a skilled nursing facility, hospice, transitional care, observational status, or short-term home health.
5. If the Medical Necessity and Coverage Criteria are met, Medica will authorize benefits within the limits in the member’s plan document.
6. If it appears that the Medical Necessity and Coverage Criteria are not met, the individual’s case will be reviewed by the medical director or an external reviewer. Practitioners are advised of the appeal process in their Medica Provider Administrative Manual.

CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS)

- For Medicare members, refer to the following, as applicable at: <http://www.cms.hhs.gov/mcd/search.asp?>

DOCUMENT HISTORY

Original Effective Date	January 1, 2016
Began use of MCG™ Care Guidelines	01/01/2016 (19th edition)
MCG Care Guidelines Edition Updates (<i>Medica Effective Date</i>)	20 th edition: 10/10/2016, 21 st edition: 08/31/2017, 21 st edition reaffirmed: 08/20/2018
Administrative Update(s)	04/01/2017, 05/01/2017