

Inpatient Rehabilitation (IRFs) and Long-Term Acute Care (LTACs)

Policy

Mass General Brigham Health Plan reimburses medically necessary Inpatient Rehabilitation (IRFs) and Long-Term Acute Care (LTACs) are licensed by the state and provide inpatient acute rehabilitation, traumatic brain injury, spinal cord injury, and/or ventilator services.

Reimbursement

Providers are reimbursed according to the plan's network provider reimbursement or contracted rates. Claims are subject to payment edits that are updated at regular intervals.

Mass General Brigham Health Plan's reimbursement is based on the line of business, unless otherwise specified within the medical policies; please follow the guidelines based on membership type. Covered services are defined by the member's benefit plan. The manner in which covered services are reimbursed is determined by the Mass General Brigham Health Plan payment policy and by the provider's agreement with Mass General Brigham Health Plan. Member liability amounts may include but are not limited to: copayments; deductible(s); and/or co-insurance; and will be applied dependent upon the member's benefit plan.

Various services and procedures require referral and/or prior authorization. Referral and prior authorization requirements can be located [here](#).

Please reference procedure codes from the current CPT, HCPCS Level II, and ICD-10-CM manuals, as recommended by the American Medical Association (AMA), the Centers for Medicare & Medicaid Services (CMS), and the American Hospital Association. CMS and the AMA revise HIPAA medical codes on a pre-determined basis, including changes to CPT, HCPCS, Revenue and ICD-10 codes and definitions.

Please refer to the CMS or CPT guidelines for requisite modifier usage when reporting services. The absence or presence of a modifier may result in differential claim payment or denial.

Mass General Brigham Health Plan reviews claims to determine eligibility for payment. Services considered incidental, mutually exclusive, integral to the primary service rendered, or part of a global

Provider Payment Guidelines

allowance, are not eligible for separate reimbursement. Please refer to [Coding Provider Payment Guidelines](#) for more information.

All claims are subject to audit services and medical records may be requested from the provider.

Note: Each time there is a change in the member's LOC, a new inpatient authorization number will be assigned as if it were a new admission. Therefore, each LOC will have a distinct inpatient authorization number.

Definitions:

Acute Rehabilitation Hospital/Acute Rehabilitation Unit: is a facility or unit within a facility licensed by the state to provide care devoted to the provision of comprehensive services to patients whose disability are primarily physical, coordinated with efforts to minimize the patient's mental, social, and vocational disadvantages. The patient has the ability to participate in 3 hours of rehabilitation at least 5 days a week and requires the oversight of a medical practitioner 3 times a week. The course of treatment is limited to the period in which the patient continues to make progress toward his or her treatment goal.

Inpatient Rehabilitation Facility (IRFs): Freestanding rehabilitation hospitals and rehabilitation units in acute care hospitals that provide intensive rehabilitation programs. Patients who are admitted must be able to tolerate three hours of intense rehabilitation services per day. Inpatient Rehabilitation Hospitalization is preceded by a new acute condition or an acute exacerbation of a chronic condition that results in significant decrease in functional status in comparison to baseline.

Long-Term Acute Care (LTACs): LTACs is certified as acute care hospitals, but LTACs focus on patients who, on average, stay more than 25 days. Many of the patients in LTCHs are transferred there from an intensive or critical care unit. LTACs specialize in treating patients who may have more than one serious condition; but who may improve with time and care and return home. Services provided in LTACs typically include comprehensive rehabilitation, respiratory therapy, head trauma treatment, and pain management. Patients typically have multiple complex medical conditions that require daily physician evaluations, skilled nursing of at least 6.5 hours a day, and equipment found in a hospital setting.

Daily: For services rendered by a physical therapist, occupational therapist or speech language pathologist, daily means 5 days a week. For nursing services, daily means 7 days a week.

Provider Payment Guidelines

Acute Rehabilitation Hospital Level of Care:

- An acute rehabilitation hospitalization is preceded by a new acute condition or an acute exacerbation of a chronic condition that results in significant decrease in functional status in comparison to baseline.
- Generally, a member is considered appropriate for rehabilitation hospital placement only when a medical need exists for an intensive rehabilitation program that includes a multi-disciplinary approach to improve the member's ability to function to his or her maximum potential. Factors must be present in the member's condition that indicates the potential for functional improvement. A member who requires therapy solely to maintain function is not considered an appropriate rehabilitation hospital patient. The nature of the member's condition must also require all the following:
 - Members must require 24-hour availability of a physician with special training or experience in rehabilitation as reflected by frequent (every 2-3 days), medically necessary physician involvement in the patient's care.
 - Members must require 24-hour availability of a registered nurse with specialized training or experience in rehabilitation.
 - Members must be able to actively participate in, and be expected to benefit from, at least 3 hours a day (minimally 5 days/week) of therapy, including at least 2 different disciplines consisting of physical therapy, occupational therapy, and speech therapy.
 - Members should be capable of actively participating in a rehabilitation program, as demonstrated by purposeful responsiveness to verbal, visual, and/or tactile stimuli and the ability to follow simple commands.
 - Significant practical improvement towards achieving a maximum level of functioning or pain management must be expected to occur within a reasonable time period.
 - Significant practical improvement towards achieving a maximum level of functioning or pain management must be expected to occur within a reasonable time period commensurate with the member's diagnosis. As a benchmark, progress meeting short-term goals is expected on a weekly basis.

Long-Term Acute Care (LTACs) Level of Care:

- That include at least daily physician intervention or the 24-hour availability of medical services and equipment available only in a hospital setting; or

Provider Payment Guidelines

- The member has a medical condition and treatment needs such that no effective, less costly alternative placement is available to the member such as subacute or SNF level of care.

Please reference coverage guidelines for level of care criteria and definitions within the [Extended Care Facility Medical Policy](#).

Mass General Brigham Health Plan Reimburses:

- Rehabilitation Nursing
- Physical Therapy
- Occupational Therapy
- Speech-Language Pathology
- Social Services
- Prosthetic and Orthotic Services

Mass General Brigham Health Plan Does *Not* Reimburse:

- Private Duty Nursing
- Custodial Care Services
- Personal Services (e.g., telephones, television, guest trays, etc.)

Providers should bill the Level of Care with the corresponding revenue code(s) as outlined in their provider agreements and in the applicable policy.

Revenue Codes

Level of Care	Code	Description
Level C1-	0120	Long Term Acute Care (LTAC)
Level R1-	0128	Rehabilitation
Level R2-	0129	Acute Complex Rehabilitation

Related Policies

[Definition of Skilled Care](#)

[Extended Care Facility](#)

[General Coding and Billing](#)

[Inpatient Authorization User Guide](#)

[Prior Authorization, Notification and Referral Guidelines](#)

Provider Payment Guidelines

References

American Medical Association, *CPT current year, Professional Edition*
 American Medical Association, *HCPCS Level II, current year, Professional Edition*
[CMS Inpatient Rehabilitation](#)
[CMS Long-Term Care Hospital PPS](#)
[MassHealth Long-Term-Care-Services](#)
[MassHealth Chronic-Disease-and-Rehabilitation-Inpatient-Hospital-Services](#)

Publication History

Topic: Inpatient Rehabilitation/Long-Term Acute Care	Owner: Network Management
<i>June 12, 2020</i>	<i>Original documentation</i>
<i>December 1, 2020</i>	<i>Removed Per Diem Exclusion</i>
<i>December 23, 2020</i>	<i>Removed Per Diem Inclusion</i>
<i>January 1, 2023</i>	<i>Document rebrand</i>

This document is designed for informational purposes only. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization/notification and utilization management guidelines when applicable, adherence to plan policies and procedures, claims editing logic, and provider contractual agreement. In the event of a conflict between this payment guideline and the provider's agreement, the terms and conditions of the provider's agreement shall prevail. Payment policies are intended to assist providers in obtaining Mass General Brigham Health Plan 's payment information. Payment policy determines the rationale by which a submitted claim for service is processed and paid. Payment policy formulation takes into consideration a variety of factors including: the terms of the participating providers 'contract(s); scope of benefits included in a given member's benefit plan; clinical rationale, industry-standard procedure code edits, and industry-standard coding conventions.

Mass General Brigham Health Plan includes Mass General Brigham Health Plan, Inc., and Mass General Brigham Health Plan Insurance Company.