

**PARTNERSHIP HEALTHPLAN OF CALIFORNIA
POLICY / PROCEDURE**

Policy/Procedure Number: MCUP3003 (previously UP100303)		Lead Department: Health Services Business Unit: Utilization Management	
Policy/Procedure Title: Rehabilitation Guidelines for Acute and Skilled Nursing Inpatient Services		<input checked="" type="checkbox"/> External Policy <input type="checkbox"/> Internal Policy	
Original Date: 04/25/1994		Next Review Date: 01/14/2027 Last Review Date: 01/14/2026	
Applies to:	<input checked="" type="checkbox"/> Medi-Cal		<input type="checkbox"/> Employees
Reviewing Entities:	<input checked="" type="checkbox"/> IQI	<input type="checkbox"/> P & T	<input checked="" type="checkbox"/> QUAC
	<input type="checkbox"/> OPERATIONS	<input type="checkbox"/> EXECUTIVE	<input type="checkbox"/> COMPLIANCE <input type="checkbox"/> DEPARTMENT
Approving Entities:	<input type="checkbox"/> BOARD		<input type="checkbox"/> COMPLIANCE <input type="checkbox"/> FINANCE <input checked="" type="checkbox"/> PAC
	<input type="checkbox"/> CEO	<input type="checkbox"/> COO	<input type="checkbox"/> CREDENTIALS <input type="checkbox"/> DEPT. DIRECTOR/OFFICER
Approval Signature: Robert Moore, MD, MPH, MBA			Approval Date: 01/14/2026

I. RELATED POLICIES:

- A. MCUP3041 - Treatment Authorization Request (TAR) Review Process
- B. MCUG3038 - Review Guidelines for Member Placement in Extended Care (Custodial/Long Term Care, Skilled or Subacute) Facilities
- C. MCUG3024 - Inpatient Utilization Management
- D. MPUG3011 - Criteria for Home Health Services
- E. MCUP3114 - Physical, Occupational and Speech Therapies

II. IMPACTED DEPTS:

- A. Health Services
- B. Claims
- C. Member Services

III. DEFINITIONS:

- A. Medical Necessity - Medical necessity means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness or injury.
- B. UM Nurse Coordinator – This is the Partnership HealthPlan of California nurse in the Utilization Management department who is assigned to a case and who performs reviews for medical necessity and coordinates services covered by Partnership within the health plan and with the staff at the treating facility.

IV. ATTACHMENTS:

- A. N/A

V. PURPOSE:

To provide guidelines for review of rehabilitation facility admissions and define the criteria for authorization of rehabilitation services at either a skilled nursing facility or an acute care facility to ensure that services that are delivered are medically appropriate and consistent with diagnosis and level of care required for each individual.

VI. POLICY / PROCEDURE:

- A. Overview

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1. Acute rehabilitation is an interdisciplinary process under the direction of a physician skilled in rehabilitation medicine. It is intended to help the physically or cognitively impaired Member achieve or regain maximum functional potential for mobility, self-care, and independent living. Certification for inpatient acute rehabilitation services is contingent upon the presence of one or more major physical impairments which significantly interfere with function and which require complex therapeutic interventions to restore function.
2. Rehabilitative services for the physically and/or cognitively impaired Member are covered in the following circumstances:
 - a. Immediately post hospitalization for acute trauma or other disease resulting in impairment
 - b. Maintenance therapy for chronically impaired Members is expected to be provided in long-term care facilities or subacute hospitals and is included in the facility's per diem rate
 - c. In-home care for homebound Members
3. The Member must demonstrate a need for an interdisciplinary therapeutic program to reach the goals established by the initial evaluation. A severe functional deficiency must be present in one or more of the following areas:
 - a. Self-care skills - including drinking, feeding, dressing, hygiene, grooming, bathing, perineal care, and/or use of upper or lower extremity prosthesis or orthosis. (Activities of Daily Living or ADLs)
 - b. Mobility skills - including dependence upon an assistant or supervision in transferring to and from chair, toilet, tub or shower, upright ambulation and/or use of wheelchair
 - c. Bladder control and management - needing assistance in urination and in developing and/or maintaining a bladder program due to lack of bladder control
 - d. Bowel control and management - needing assistance in excretion and in developing and/or maintaining a bowel program due to lack of bowel control
 - e. Pain management - pain so severe as to markedly limit functional performance
 - f. Safety - needing instruction because of impaired judgment, impulsive behavior, or physical deficits in the proper and safe management of self-care and/or avoidance of complications such as contractures, decubiti or urinary tract infections
 - g. Cognitive functioning - needing speech and /or language therapy in association with another primary problem listed above
 - h. Communication - needing speech and/or language therapy in association with another primary problem listed above
4. Members are not eligible for rehabilitative services unless the Member's other medical problems are stable and will not interfere substantially with the rehabilitation program. The Member must also demonstrate a cognitive ability to understand the program and the motivation to participate in all aspects of the program. The Member must have adequate endurance to actively participate in the program. The degree of endurance required will vary depending on the therapeutic setting.
5. The attending physician must refer the Member to the rehabilitation program for an initial evaluation. For Members not currently inpatient, either the Member's primary care provider (PCP) must make the referral or concur with the physician who made the referral. After the rehabilitation program has completed the initial evaluation, a treatment plan must be developed in consultation with the referring physician as indicated.
6. A Treatment Authorization Request (TAR) must be submitted by the rehabilitation program indicating the services requested, a description of medical need, level of rehabilitation services, and a copy of the treatment plan. The referring physician must sign the treatment plan. In order to expedite care, Partnership will accept the TAR with an unsigned treatment plan, however; the rehabilitation program must obtain the physical signature as soon as possible.

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7. The written treatment plan must include the following:
 - a. Date of onset of the illness
 - b. Medical diagnosis necessitating the service, with severity and duration of condition
 - c. Related medical conditions
 - d. Impairments necessitating an inpatient or skilled nursing admission for rehabilitation services
 - e. Functional limitations including cognitive abilities, mobility and self-care limitations, emotional problems, and communication difficulties
 - f. History and results of previous rehabilitation services and outcomes of treatment
 - g. Prognosis
 - h. Therapeutic goals to be achieved by each discipline and anticipated time to achieve goals
 - i. Types of services to be rendered by each discipline related to the problem
 - j. Description of plan to instruct household members or other caregivers to provide needed care after discharge from the rehabilitation program.
 - k. Documentation that the Member has sufficient strength and endurance to actively participate in the proposed treatment.
 8. The UM Nurse Coordinator reviews the TAR for medical necessity and consults with the referring physician or rehabilitation staff as indicated. Definition of "medical necessity" states that necessary health care services are those needed to protect life and to prevent significant illness or significant disability, or to alleviate pain. The Chief Medical Officer or physician designee is the only individual who can deny TARs for inpatient or skilled nursing rehabilitation services.
 9. If additional days are needed beyond the initial TAR, a progress report must be submitted to Partnership documenting that significant improvement has occurred with the initial therapy and that continued therapy will further improve the Member's function, although not necessarily restoration of full capacity. The progress report must indicate plans for discharge and measured progress in each problem area being treated. In addition, the report must detail the Member's active participation in therapy and that the Member still requires close supervision in an inpatient or skilled setting.
 10. Requests for extension of inpatient rehabilitation services are denied for medical necessity for the following reasons:
 - a. Therapeutic goals have been attained or the prospect of further incremental improvement is so small that an additional expense is not justified
 - b. Lack of progress toward attaining goals, with further progress unlikely
 - c. Inability or unwillingness of Member or family to cooperate with the Member's program
 - d. Goals can be achieved at a lower level of care
- B. Admission Criteria
- All statements in Section VI.B.1. Patient Selection and Section VI.B.2. Admission below must apply to the patient (Partnership Member).
1. Patient Selection
 - a. The patient must have a physical disability of which the medical condition and functional performance can be realistically improved through intensive, accepted rehabilitation measures.
 - b. The patient must have the potential to be medically and emotionally stable for management on a rehabilitation nursing service and be capable of active participation in a rehabilitation program.
 - c. The patient must be in need of close daily medical supervision by a physician with specialized training or experience in rehabilitation and must require 24-hour rehabilitation nursing or other rehabilitation services.
 - d. Primary admitting diagnosis must include one of the following:
 - 1) Stroke

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- 2) Spinal cord injury
 - 3) Amputation
 - 4) Major multiple trauma
 - 5) Fracture of femur (hip)
 - 6) Brain injury
 - 7) Polyarthritis - including rheumatoid arthritis
 - 8) Neurological disorder, including multiple sclerosis, motor neuron diseases, polyneuropathy, muscular dystrophy, and Parkinson's Syndrome
 - 9) Burns
 - 10) Other conditions requiring intensive rehabilitative care
2. Admission
- a. Skilled rehabilitation services, as ordered by a physician, must be required and provided on a daily basis. Daily may be defined to be at least five (5) days a week. A break of a day or two in service where rehabilitation services are not furnished and discharge is not indicated is also permissible.
 - b. The medical director of the rehabilitation unit or the physician designee must perform patient evaluation and final determination regarding transfer of the patient to the rehabilitation service.
 - c. Admission medical record (admission physical examination) must include all of the following:
 - 1) Treatment goals - what functional improvements might be realistically expected from rehabilitation
 - 2) Potential - what is the realistic possibility of achieving above stated goals - excellent, good, fair, guarded
 - 3) Treatment plan - how will treatment goals be achieved. Specifically what therapies will be utilized - Physical Therapy, Occupational Therapy, Speech, Psychology, Social Service
 - 4) Duration of stay - realistic estimate of time required to achieve stated goals
- C. CONTINUED STAY CRITERIA
(These criteria will only be applied up to the limit of rehabilitation coverage.)
1. A treatment plan, as outlined on admission physical examination, must be reviewed and revised as needed, at least weekly, in consultation with rehabilitation nursing, all involved therapies and social services.
 2. There must be documented, weekly continued improvement in one or more functional abilities in at least one therapy.
 3. If there is development of a complicating medical or emotional problem which requires temporary suspension of rehabilitation therapies, but which is of such a nature as to expect a return to an active rehabilitation program within one week (seven days), then rehabilitation services may be continued.
- D. DISCHARGE CRITERIA
1. Must meet either a., b., c., or d. below:
 - a. The patient has met the goals established at, and subsequent to, the time of admission.
 - b. The patient no longer requires rehabilitative nursing and is receiving treatment in only one therapy area, i.e., occupational therapy, physical therapy, speech therapy, psychology, neuropsychology.
 - c. There is no evidence of progress toward documented goals.
 - d. There are intercurrent medical conditions that require acute care and suspension of rehabilitative services.
 2. A weekend pass may be given the week prior to planned discharge to determine problems or issues that might exist that would need to be addressed before patient is sent home.

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E. CASE REVIEW CONFERENCES

Partnership Members in acute rehabilitation facilities are reviewed in case review conferences.

1. Weekly review conferences are held to discuss select hospitalized Members.
2. Participants include, but are not limited to, Nurse Coordinators, Care Coordination staff, UM Team Manager, Chief Medical Officer and/or Regional Medical Director and the Associate Director of UM.
3. The purpose of the meeting is to collaborate and facilitate timely medical services and transition to the next level of care.
4. UM Nurse Coordinators are expected to follow the review guidelines outlined in policy MCUG3024 Inpatient Utilization Management, including, but not limited to, admission review and concurrent review.

NOTE: The above criteria are neither mutually inclusive nor exclusive. The final judgment must be reached using professional nursing judgment of the variety of the care needs and the availability of other care alternatives to determine the need for rehabilitation level of care.

VII. REFERENCES:

- A. [Medi-Cal Provider Manual/ Guidelines](#): TAR Criteria for Acute Inpatient Intensive Rehabilitation (*tar crit aiir*)
- B. California Code of Regulations (CCR) [Title 22 Health Care Services](#)

VIII. DISTRIBUTION:

- A. Partnership Department Directors
- B. Partnership Provider Manual

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Senior Director, Health Services

X. REVISION DATES: 03/23/95; 08/98; 06/21/00; 04/18/01; 01/16/02; 08/20/03; 09/15/04; 10/19/05; 08/20/08; 05/19/10; 11/28/12; 01/20/16; 08/17/16; 06/21/17; *08/08/18; 08/14/19; 08/12/20; 08/11/21; 10/12/22; 10/11/23; 10/09/24, 01/14/26

*Through 2017, Approval Date reflective of the Quality/Utilization Advisory Committee meeting date. Effective January 2018, Approval Date reflects that of the Physician Advisory Committee’s meeting date.

PREVIOUSLY APPLIED TO: N/A

In accordance with the California Health and Safety Code, Section 1363.5, this policy was developed with involvement from actively practicing health care providers and meets these provisions:

- Consistent with sound clinical principles and processes
- Evaluated and updated at least annually
- If used as the basis of a decision to modify, delay or deny services in a specific case, the criteria will be disclosed to the provider and/or enrollee upon request

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The materials provided are guidelines used by Partnership to authorize, modify or deny services for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under Partnership.

Partnership's authorization requirements comply with the requirements for parity in mental health and substance use disorder benefits in 42 CFR 438.910.