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Reimbursement Policy

Inpatient Rehabilitation Hospital

Policy Number: SCO 4.71
Version Number: 3
Version Effective Date: 09/01/2021

Product Applicability	☐ **All Plan⁺ Products**
Well Sense Health Plan ☐ Well Sense Health Plan	**Boston Medical Center HealthNet Plan** ☐ MassHealth MCO ☐ MassHealth ACO ☐ Qualified Health Plans/ConnectorCare/Employer Choice Direct ☒ Senior Care Options

Note: Disclaimer and audit information is located at the end of this document.

Policy Summary

The Plan reimburses covered services based on the provider's contractual rates with the Plan and the terms of reimbursement identified within this policy.

Prior-Authorization

Please refer to the Plan's Prior Authorization Requirements Matrix at www.bmchp.org.

⁺ *Plan* refers to Boston Medical Center Health Plan, Inc. and its affiliates and subsidiaries offering health coverage plans to enrolled members. The Plan operates in Massachusetts under the trade name Boston Medical Center HealthNet Plan and in other states under the trade name Well Sense Health Plan.

Provider Reimbursement

The Plan reimburses inpatient rehabilitation services based upon the Centers for Medicare and Medicaid Services (CMS) Inpatient Rehabilitation Facility (IRF) Prospective Payment System (PPS). IRF reimbursement is a single payment for each rehabilitation stay based on Case-Mix Group (CMG), comorbidities, and a Rehabilitation Impairment Category (RIC). Facilities must report the appropriate HIPPS code, which contains identifiers for the CMG, comorbidities, and RIC. The assignment of the HIPPS code is derived from the admission assessment which must be completed by day four of the rehabilitation stay. If it is necessary to perform the assessment in the hospital prior to admission to the IRF, it will be covered as part of the IRF stay.

The Plan reimburses for the following IRF services:

- Rehabilitation nursing
- Physical therapy
- Occupational therapy
- Speech-language pathology
- Social services
- Psychological services
- Prosthetic and orthotic services

Case-Level Adjustments

Case-level adjustments may apply specific to the case and the facility characteristics. These include an interrupted stay, transfer of care, and shorts stays.

Interrupted Stay

An interrupted stay occurs in those cases in which a member is discharged from the IRF and returns to the same IRF within 3 consecutive calendar days. The 3 consecutive calendar days begin with the day of the discharge from the IRF and ends on midnight of the third day. One payment will be made for interrupted stay cases and the payment will be based on the initial assessment. Occurrence code 74 should be used to indicate the interrupted stay.

Transfer of Care

When a member is transferred to another facility and the length of stay of the case is less than the average length of stay for a given CMG, the transferring IRF will be reimbursed a per diem payment.

Short Stays

Separate reimbursement will be made for cases with a LOS of 3 days or less, that do not qualify as a transfer, without consideration of the clinical characteristics of the patient. Cases where the member expires within a LOS of 3 days or less, will also receive additional reimbursement. When the member expires while inpatient, providers are reimbursed for cases with a length of stay that are greater than 3 days.

Facility-Level Adjustments

Facility-level adjustments apply to all cases and based upon individual IRF characteristics. These include an area wage adjustment, an adjustment for treating low-income patients and an adjustment for teaching facilities.

Area Wage Adjustment

The labor-related unadjusted federal payment is multiplied by the IRF's wage index to account for wage differences.

Rural Adjustment

Payments are adjusted for facilities located in rural areas. A facility is considered to be a rural IRF if they are located in a non-urban area.

Low Income Patient (LIP) Adjustment

Payments will be adjusted to account for differences in costs associated with the proportion of low-income patients treated at the IRF facility.

Teaching Status Adjustment

The IRF facilities base rate will be adjusted to account for the higher indirect operating costs experienced by facilities that participate in graduate medical education. The adjustment is based on the IRF's "teaching variable," which is the ratio of the number of FTE residents training in the IRF to the IRF's average daily census (ADC).

Outliers

An IRF is eligible for an outlier payment if the IRF's costs exceed the outlier threshold for that discharge. The outlier payment for the case is equal to 80 percent of the difference between the estimated cost of the case and the outlier threshold.

Applicable Coding and Billing Guidelines

Applicable coding is listed below, subject to codes being active on the date of service. Because the American Medical Association (AMA), Centers for Medicare & Medicaid Services (CMS), and the U.S. Department of Health and Human Services may update codes more frequently or at different intervals than Plan policy updates, the list of applicable codes may not be all inclusive. These codes are not intended to be used for coverage determinations.

Revenue Code Reporting

The Revenue code must contain revenue code 0024 along with the HIPPS code. Revenue code 0024 should be reported with a $0.01 charge. Additional revenue codes are reported to indicate room and board and ancillary services provided.

Policy History

Original Approval Date	Original Effective Date	Policy Owner	Approved by
09/23/2015	01/01/2016	Payment Policy	SCO Product Subgroup

Policy Revisions History			
Review Date	**Summary of Revisions**	**Revision Effective Date**	**Approved by**
10/15/2020	Annual Review	01/01/2020	Payment Policy Committee
08/17/2021	Annual Review	09/01/2021	Payment Policy Committee

Other Applicable Policies

- General Billing and Coding Guidelines, SCO 4.31
- General Clinical Editing and Payment Accuracy Review Guidelines, SCO 4.108
- Inpatient Hospital, SCO 4.110

References

- Medicare Claims Processing Manual 100-04, Chapter 3 Inpatient Hospital Billing
- Medicare Benefit Policy Manual 100-02, Chapter 1 IRF Services
- Title 42 Code of Federal Regulations 412.23(b)(2)

Disclaimer Information

This Policy provides information about the Plan's reimbursement/claims adjudication processing guidelines. The use of this Policy is neither a guarantee of payment nor a final prediction of how specific claim(s) will be adjudicated. Reimbursement is based on many factors, including member eligibility and benefits on the date of service; medical necessity; utilization management guidelines (when applicable); coordination of benefits; adherence with applicable Plan policies and procedures; clinical coding criteria; claim editing logic; and the applicable Plan – Provider agreement. Member cost-sharing (deductibles, coinsurance and copayments) may apply – depending on the member's benefit plan. Unless otherwise specified in writing, reimbursement will be made at the lesser of billed charges or the contractual rate of payment. Plan policies may be amended from time to time, at Plan's discretion. Plan policies are developed in accordance with applicable state and federal laws and regulations, and accrediting organization guidelines (including NCQA). The Plan reserves the right to conduct Provider audits to ensure compliance with this Policy. If an audit determines that the Provider did not comply with this Policy, the Plan will expect the Provider to refund all payments related to non-compliance. For more information about the Plan's audit policies, refer to the Provider Manual.