Tip Sheet for Justifying Length of Stay on | Inpatient Rehabilitation (ARU level) in the United States Healthcare System

Length of stay determinations for acute rehabilitation unit (ARU) admissions following spinal cord injury (SCI) or similar conditions can be controversial. There are many factors the attending physician and inpatient multidisciplinary team must consider including presence of a concomitant brain injury or other disabling condition, functional status and progress, medical stability, home location and accessibility, and caregiver support. In analyzing a given SCI case for an ARU stay, perhaps the most challenging question for the rehabilitation team is: How will more time on inpatient rehabilitation benefit the patient? Answering this question effectively for the payer is critical to substantiate a planned length of stay for a case, or the extension of an ARU stay. While there may be disagreement between the rehabilitation team and the payer, the attending physician must attempt to understand all perspectives of the case and remain focused on advocating for the best interest of the patient.

When there is no case manager for the payer following the case (e.g. FFS Medicare, Medicaid), the physician and rehabilitation team need to ensure documentation of goals, functional progress, and unique barriers to safe community discharge are able to substantiate the length of stay. The same documentation is critical when there is a payer following the case concurrently, but there may be questions asked from the payer during the stay on why more time on inpatient rehabilitation is necessary. Further, if the payer following concurrently is not satisfied with the documentation of weekly progress, participation, goals, or expected LOS, it is up to the team to justify to the payer. Often in this situation, it is left to the physician to substantiate the LOS further with one of the payer's medical directors through a peer-to-peer discussion. The following tips may be of utility in this situation:

Be objective. While peer-to-peer discussions may engender a sense of conflict and frustration, allowing emotions to dictate the conversation will not likely be productive. Instead, take time to ensure you have a thorough understanding of the case, and attempt to see things objectively prior to the peer-to-peer call. Further, even trying to take on the perspective of the payer may prove useful to you as you justify LOS on a given case.

Know the criteria for justifying LOS. There is more to inpatient rehabilitation than Physical Therapy (PT), Occupational Therapy (OT), and Speech Language Pathology (SLP). For most payers, participation and ongoing goals for at least 2 of these disciplines for $\geq$ 3 hr/day at least 5 days per week is necessary to justify time on ARU. Yet, based on utilization review guidelines such as the McKesson InterQual™ criteria other factors can be used to substantiate progress, including documenting progress in pulmonary function with either aerobic capacity or endurance to allow for more participation in PT, OT, or SLP sessions. Medical management and education, as well as ongoing active work on discharge planning are also recognized areas to help in substantiating further LOS.

Here is a brief summary of criteria to substantiate ARU admission:

- Need at least 2 of these: Respiratory, ADL, or Mobility impairment (Respiratory counts)
- Need to have therapy needs in at least 2 of these: PT, OT, Speech (only counts for high tetraplegia)
- Treatment is precluded in a lower level of care due to: medical assessment or intervention ≥ 3x/wk, specialized therapeutic skills or equipment required, Rehab Nursing services needed and available 24 hr/day

Here is a brief summary of criteria to justify ongoing LOS on ARU:

- Measurable progress documented toward pre-established goals with gains sustained in more than one area:
    - ADLs
    - Functional mobility - PT or OT (transfers, ambulation, or WC mobility)
    - Speech/Swallowing
    - Pulmonary function – PT, OT, or SLP (endurance or aerobic capacity)

- Care coordination documented for both medical management/education and in discharge planning of at least one SCI issue including:
    - Medical management/education:
        - Autonomic Dysreflexia
        - Neurogenic bowel and/or bladder
        - DME or orthotic use
        - Medication management
        - Skin management
        - Precautions
    - Discharge planning:
        - Home assessment
        - Community resources
        - Patient or caregiver education
        - DME needs assessment

In reviewing McKesson InterQual™ criteria for ARU level of care, there is also discussion on "responders", which essentially categorizes a group that has met goals or has plateaued and does not meet the criteria for "partial responder" above. Discharge from ARU is expected for "responders". Yet, there is mention of new onset medical issues for the "partial responders" category, which would independently substantiate longer LOS. Included here are medical issues and skin breakdown complicating progress in rehabilitation, but also uncontrolled pain requiring new pain management regimen. Thus, if an SCI patient is having ongoing issues with pain that require medication changes or non-pharmacological regimen adjustments, that may substantiate more time and longer LOS if documented clearly. Similarly, establishing an appropriate bowel program may take time, but is often critical for those with SCI in order to optimize independence and quality of life. It is important to document such ongoing efforts on ARU in order to justify LOS.

Ask for a specialty-matched peer. Most payers should have a physician who is able to review the case and speak with you. Payer medical directors who are not physicians may not understand the critical differences on how inpatient rehabilitation facilities (IRF) differs from skilled nursing facilities (SNF), including why the investment in more time on IRF may afford the patient a much greater chance of meaningful recovery and successful discharge to community. It is likely useful to ask for a specialty-matched peer when discussing a case, particularly if you are appealing a payer decision.

Reference:
InterQual ™ Acute Rehabilitation Criteria for Spinal Cord Injury, 2015. McKesson Corporation.