

Subject: Acute Inpatient Rehabilitation
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Description

Inpatient rehabilitation hospitals/units are licensed and certified facilities, which primarily promote special rehabilitative health care services rather than general medical and surgical services. Rehabilitation is defined as restoration of a disabled person to self-sufficiency or maximal possible functional independence. An inpatient rehabilitation program utilizes an inter-disciplinary coordinated team approach that involves a minimum of three (3) hours rehabilitation services daily. These services may include physical therapy, occupational therapy, speech therapy, cognitive therapy, respiratory therapy, psychology services, prosthetic/orthotic services, or a combination thereof.

Inpatient rehabilitation may be provided in a hospital, a free-standing facility or skilled nursing facility. The setting for inpatient rehabilitation is principally determined by the individual's medical and functional status and the ability of the rehabilitation facility to provide the necessary level of care. Acute inpatient rehabilitation is required when an individual's medical status is such that the intensity of services required could not reasonably be provided in an alternative setting (subacute facility or outpatient rehabilitation department). Examples of conditions requiring acute inpatient rehabilitation include, but are not limited to, individuals with significant functional disabilities associated with stroke, spinal cord injuries, acquired brain injuries, major trauma and burns.

This document addresses rehabilitation services provided in the inpatient hospital setting and includes the following acute inpatient rehabilitation tools:

Appendix 1 [Inpatient Rehabilitation For Central Nervous System Insult](#)

- Cerebrovascular Accident (CVA)
- Acquired Brain Injury
- Spinal Cord Injury

Appendix 2 [Inpatient Rehabilitation for Neurological Disorders](#)

- Peripheral Nerve Injury
 - Focal Neurologic Disorders
 - Diffuse Neurologic Disorders (Guillain-Barré)
- Central Nervous System Disorders
 - Multiple Sclerosis
- Nerve Root Injury
- Postoperative Deficits

Appendix 3 [Inpatient Rehabilitation for Musculoskeletal/Orthopedic Disorders](#)

- Major Joint Replacement
- Back Surgery
- Amputations
 - Loss of more than one body part (excluding digits)
 - Single foot amputation

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- Single leg amputation
- Major/Multiple Trauma
- Severe Arthritis and Lupus Erythematosus
 - Rheumatoid arthritis
 - Osteoarthritis
 - Polyarthritis
- Other Conditions
 - Simple fractures
 - Single extremity deficits
 - Simple (minor) trauma
 - Generalized weakness or general debility

Appendix 4 [Additional Clinical Considerations for Review](#)

- Motor Functional Impairment Status
- Cognitive Status
- Multidisciplinary Team Support

Frequently Used Assessment Tools

- Levels of Care ([Appendix A](#))
- Rancho Los Amigos Cognitive Scale ([Appendix B](#))
- Glasgow Coma Scale ([Appendix C](#))
- Functional Independence Measurement ([Appendix D](#))
- Disability Rating Scale ([Appendix E](#))

Please see the following documents for additional information regarding non-skilled and skilled services in other settings:

- CG-MED-19 Custodial Care
- CG-MED-23 Home Health
- CG-MED-31 Skilled Nursing Facility
- CG-MED-29 Inpatient Subacute Care
- CG-REHAB-04 Physical Therapy
- CG-REHAB-05 Occupational Therapy
- CG-REHAB-07 Skilled Nursing and Skilled Rehabilitation Services (Outpatient)
- CG-REHAB-08 Private Duty Nursing in the Home Setting
- CG-REHAB-09 Acute Inpatient Rehabilitation, [Appendix A](#): Determination of Levels of Care
- MED.00081 – Cognitive Rehabilitation

Clinical Indications

Admission Criteria

Medically Necessary:

Acute inpatient rehabilitation services are **medically necessary** when all of the following are present:

1. Individual has a new (acute) medical condition or an acute exacerbation of a chronic condition that has resulted in a significant decrease in functional ability such that they cannot adequately recover in a less intensive setting; AND

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2. Individual's overall medical condition and medical needs either identify a risk for medical instability or a requirement for physician and other personnel involvement generally not available outside the hospital inpatient setting; AND
3. Individual requires an intensive inter-disciplinary, coordinated rehabilitation program (as defined in the description of service) with a minimum of three (3) hours active participation daily; AND
4. Individual is medically stable enough to no longer require the services of a medical/surgical inpatient setting; AND
5. The individual is capable of actively participating in a rehabilitation program, as evidenced by a mental status demonstrating responsiveness to verbal, visual, and/or tactile stimuli and ability to follow simple commands. For additional information regarding cognitive status, please refer to the Rancho Los Amigos Cognitive Scale ([Appendix B](#)); AND
6. Individual's mental and physical condition prior to the illness or injury indicates there is significant potential for improvement; (See *Note* below) AND
7. Individual is expected to show measurable functional improvement within a maximum of seven (7) to fourteen (14) days (depending on the underlying diagnosis/medical condition) of admission to the inpatient rehabilitation program; AND
8. The necessary rehabilitation services will be prescribed by a physician, and require close medical supervision and skilled nursing care with the 24-hour availability of a nurse and physician who are skilled in the area of rehabilitation medicine; AND
9. Therapy includes discharge plan.

Note: It is not necessary that there is an expectation of complete independence in the activities of daily living; but there should be a reasonable expectation of improvement that is of practical value to the individual, measured against his condition at the start of the rehabilitation program. Additionally, the individual must have no lasting or major treatment impediment that prevents progress. (For example severe dementia).

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Not Medically Necessary:

Acute inpatient rehabilitation services are considered **not medically necessary** for individuals who do not meet the medical necessity criteria set forth above and the following:

1. Coma stimulation;
2. Educational training related to specific employment requirements;
3. Care is custodial.

Regarding major joint replacements:

If a single joint is replaced, typically postoperative acute inpatient rehabilitation is considered **not medically necessary** unless the individual has significant comorbidity(ies) resulting in functional deficits which would necessitate an acute inpatient level of rehabilitation in order to achieve a satisfactory outcome within a reasonable time period. Of note, postoperative acute inpatient rehabilitation may be medically necessary for individuals undergoing more than one major joint replacement during a single hospitalization.

Regarding back surgery and compression fractures:

Acute inpatient rehabilitation is considered **not medically necessary** for the following:

- Uncomplicated back surgery without other concomitant diseases;
- Uncomplicated compression fractures without neurologic involvement.

Continuation of Services Criteria

Acute inpatient rehabilitation requires evidence of an inter-disciplinary, coordinated rehabilitation team review at least once **weekly**, which should document ALL of the following:

- Evidence of active participation in a multidisciplinary rehabilitation program; AND
- Evidence of progress toward stated goals documented by objective functional measurements; AND
- Identification of range and severity of the individual's problems, including medical status and stability, self-care, mobility, psychological status, communication status, etc.; AND

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- Consideration of special equipment needs when appropriate; AND
- Goal modification based on current status, progress, and potential for improvement; AND
- Projected length of stay and discharge/disposition planning; AND
- Status of education of the individual and family members/caregivers regarding post discharge care; AND
- Identification of barriers to progress, including any medical complications likely to impair progress; AND
- Information regarding the status of the underlying medical condition.

In general the documentation should provide evidence that the individual is benefiting from the program, that there is progress towards reasonable goals, and that acute inpatient rehabilitation continues to be the most appropriate level of care.

Discharge Criteria

Discharge from acute inpatient rehabilitation is appropriate if one or more of the following is present:

1. Treatment goals necessitating the inpatient setting were achieved; OR
2. Absence of participation in an interdisciplinary rehabilitation program; OR
3. The individual has limited potential for recovery (e.g. The individual's functional status has remained unchanged or additional functional improvement appears unlikely within a reasonable time frame ([7 to 14 days])); OR
4. Individual is unable to actively participate in at least 3 hours of intensive therapies per day, at least 5 days per week; OR
5. The level of rehabilitative/restorative care required could be safely and effectively rendered in an alternate, less intensive setting, e.g., outpatient, SNF, or home health, (still may require 24 hour supervision).
6. The overall medical status is such that no further progress is anticipated or only minimal gains that could be expected to be attained with either less intensive therapy program or regular daily activities.

Additional Clinical Review

Additional clinical consideration to determine if the individual is a suitable candidate for acute inpatient rehabilitation services may be necessary when any of the following occur:

- Overnight and 24-hour passes are generally appropriate only for short periods of time if required to evaluate the individual's ability to function at home or in the community before discharge; OR
- All medical/rehabilitation issues have been adequately met but the transfer is delayed for non-medical reasons; OR
- A request is made for direct admission from home

Notes:

- *In general, individuals are admitted to an inpatient rehabilitation facility, for acute inpatient rehabilitation from acute care hospitals, subacute units or facilities, or skilled nursing facilities (SNFs), rather than directly from the home. Direct admission from the home may require additional review.*
- *When the illness or injury leading to the need for rehabilitation is one affecting the central nervous system, concomitant cognitive, and physical issues may exist. Cognitive issues are routinely addressed as part of acute inpatient rehabilitation. When physical rehabilitation needs no longer exist, the cognitive issues may be addressed either as part of a formal cognitive rehabilitation program, or if there are continuing speech therapy or occupational therapy needs, with the continuation of these services. For more information on cognitive rehabilitation, please see MED.00081 Cognitive Rehabilitation.*

Place of Service/Goal Length of Stay

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- Place of Service:** Inpatient
- Goal Length of Stay:** Varies depending on the cause and severity of the original injury. Please refer to the following Appendices for additional information:
- Appendix 1 – [Inpatient Rehabilitation for Central Nervous System Insult](#)
 - Appendix 2 – [Inpatient Rehabilitation for Neurological Disorders](#)
 - Appendix 3 – [Inpatient Rehabilitation for Musculoskeletal/Orthopedic Disorders](#)

Case Management

Individuals with more complex cases may require specific case management. A discharge plan of care should be developed with input from the individual, caregiver, physician, therapists and other involved providers. Discharge planning should be an integral part of all rehabilitation stays and should be an ongoing activity throughout the entirety of the confinement.

It is recognized that, in some circumstances lay family members and friends can be trained to safely and effectively provide chronic services that are typically considered skilled, e.g., pharyngeal suctioning, or gastrostomy feedings.

Discharge Plan

- Usual:** Home Health Care (HHC), or outpatient therapy setting
- Alternate:** Skilled nursing facility (SNF), subacute

Coding

- Please refer to the following Appendices for coding information:
- Appendix 1 – [Inpatient Rehabilitation For Central Nervous System Insult](#)
 - Appendix 2 – [Inpatient Rehabilitation For Neurological Disorders](#)
 - Appendix 3 – [Inpatient Rehabilitation For Musculoskeletal/Orthopedic Disorders](#)

Discussion/General Information

Acute Inpatient Rehabilitation refers to a rehabilitation program provided in an acute care institution (or a distinct part of an institution) which provides an intensive multidisciplinary, coordinated team approach to rehabilitation services for the injured or disabled to restore lost function following an acute illness or accidental injury. The aim of the treatment is achieving the maximum level of function possible.

Comprehensive acute inpatient rehabilitation programs offer a wide range of therapeutic services provided by registered, certified, licensed, or degreed professionals utilizing a multidisciplinary, goal oriented, team approach with treatment plans designed specifically for the individual’s needs. Acute inpatient rehabilitation programs must follow a multidisciplinary, coordinated team approach by providing services not available in the outpatient setting or skilled nursing facilities.

Examples of Inpatient Rehabilitation Disciplines/Services Provided as Part of an Interdisciplinary Team Program:

1. Skilled Rehabilitation Nursing:

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- A. Bowel/bladder management;
 - B. Skin & wound assessment/care/treatment;
 - C. Medication management;
 - D. Individual/family/caregiver training;
 - E. 24-hour reinforcement of therapy goals/objectives;
 - F. Ongoing assessment of individual's status.
2. Physical Therapy
 - A. Treatment of limited mobility; e.g., inability to transfer, impaired coordination/truncal balance, functional ambulation less than 100 feet, passive and active range of motion of lower extremities;
 - B. Instruction in use of durable medical equipment (DME);
 - C. Fitting of prosthetic or orthotic device(s);
 - D. Individual/family/caregiver training.
 3. Occupational Therapy
 - A. ADL training; e.g., toileting, grooming, dressing, feeding;
 - B. Perceptual motor training (spatial orientation, depth or distance perception) directly impacting ability to initiate or maintain freedom of movement in a safe environment;
 - C. Individual/family/caregiver training;
 - D. Safety skills or problem-solving techniques; e.g., emergency procedures and injury prevention;
 - E. Splinting of upper body extremities.
 4. Speech Therapy
 - A. Treatment of communication disorders (expressive or receptive dysphasia or aphasia) resulting in less than basic communication levels;
 - B. Treatment of swallowing dysfunction (dysphagia);
 - C. Teaching simple, problem-solving techniques or safety skills;
 - D. Individual/family/caregiver training.
 5. Social Services Medical Social Worker (MSW)
 - A. Integrates the individual's and the family's social needs into the plan of care;
 - B. Coordinates discharge planning activities;
 - C. Makes community referrals and consults with other agency personnel.
 6. Neuropsychological Services
 - A. PhD., SCi.D prepared disciplines;
 - B. Cognitive screening and neuropsychological testing.
 7. Physical Medicine and Rehabilitation Services Specialist (Physiatrist)
 - A. Daily medical supervision of the individual's rehabilitation treatment plan.

Examples of Services that Typically Do Not Require Admission to an Inpatient Rehabilitation Program

The following services are examples of services that do not require the skills of a licensed nurse or rehabilitation personnel and are therefore considered **not medically necessary** in the acute inpatient rehabilitation or skilled nursing facility settings unless there is documentation of comorbidities and complications that require individual consideration.

1. Routine services directed toward the prevention of injury or illness;

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2. Routine or maintenance medication administration. Admissions solely for the administration of routine or maintenance medications, including daily IV, IM and SQ medications are not considered skilled. Parenteral medication administration in medically stable individuals is most often managed in the home setting by a home health or home infusion therapy provider;
3. Care solely for the administration of oxygen, and nebulizer treatments;
4. Routine enteral feedings;
5. Routine colostomy care;
6. Ongoing intermittent straight catheterization for chronic conditions;
7. Custodial care;
8. Emotional support or counseling;
9. Suctioning of the nasopharynx or nasotrachea. Suctioning daily or PRN less frequently than every four hours PRN is not considered skilled;
10. Administration of suppositories or enema;
11. Routine foot and nail care;
12. Individuals on established levels of ventilatory support (excludes teaching of care to caregivers);
13. Urinary catheters. The presence of a stable indwelling or suprapubic catheter, the need for routine intermittent straight catheterization, catheter replacement or routine catheter irrigation does not qualify a individual for acute inpatient rehabilitation or SNF placement unless other skilled needs exist;
14. Heat treatment – wet or dry:
 - A. Whirlpool baths, paraffin baths or heat lamp treatments do not qualify an individual for care in an acute inpatient rehabilitation or SNF;
 - B. There may be a rare instance when a severely compromised individual with desensitizing neuropathies or sever burns requires skilled observation during the above treatments. These cases are to be reviewed on an individual consideration basis. Documentation must support the medical necessity for such observation.

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Status	Date	Action
Reviewed	08/28/2008	Medical Policy & Technology Assessment Committee (MPTAC) review. Updated references and history sections.
Revised	08/23/2007	MPTAC review. Added language to indicate inpatient rehabilitation is considered not medically necessary for uncomplicated back surgery and uncomplicated compression fractures without neurological involvement. Under Additional Clinical Review section, removed requirement that cases be sent to physician for review and added note about patients with concomitant cognitive and physical issues. Moved information regarding Motor Functional Impairment Status, Cognitive Status, Multidisciplinary Team Support and Frequently Used Assessment Tools, Discharge Indications from appendices 1-3 to appendix 4. Inserted additional links in document. Updated references and history sections.
Reviewed	05/17/2007	MPTAC review. Updated review date and references.
Revised	06/08/2006	MPTAC. Review.
Revised	03/23/2006	MPTAC review. Revision based on Pre-merger Anthem and Pre-merger WellPoint Harmonization.

Pre-Merger Organizations	Last Review Date	Document Number	Title
Anthem, Inc.			None
Anthem Connecticut	01/2005	None	Anthem Utilization Management Guidelines for Acute Rehabilitation
Anthem Midwest	04/08/2005	RA-001	Rehabilitation: Acute Inpatient – Introduction and Other Diagnosis
Anthem Midwest	05/27/2005	RA-002	Inpatient Rehabilitation and Alternative Settings: Closed Head Injury/Traumatic Brain Injury
Anthem Midwest	09/01/2004	RA-004	Inpatient Rehabilitation and Alternative Settings: Neuromuscular Degenerative Diseases
Anthem Midwest	05/27/2005	RA-005	Inpatient Rehabilitation and Alternative Setting: Musculoskeletal
Anthem Midwest	05/27/2005	RA-006	Inpatient Rehabilitation and Alternative Settings: Cerebral Vascular Accident (CVA)
WellPoint Health Networks, Inc.	04/28/2005	None	Acute Inpatient Rehabilitation

Federal and State law, as well as contract language including definitions and specific coverage provisions/exclusions, and Coverage Guidelines take precedence over Clinical UM Guidelines and must be considered first in determining eligibility for coverage. The member's contract benefits in effect on the date that services are rendered must be used. Clinical UM Guidelines, which address medical efficacy, should be considered before utilizing medical opinion in adjudication. Medical technology is constantly evolving, and we reserve the right to review and update Clinical UM Guidelines periodically.

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APPENDIX 1

ACUTE INPATIENT REHABILITATION FOR CENTRAL NERVOUS SYSTEM INSULT

(Cerebrovascular Accident [CVA], Acquired Brain Injury and Spinal Cord Injury)

The information provided in this Appendix does not supersede the criteria set forth in the clinical indications section of this document. Candidates for acute inpatient rehabilitation must meet the criteria set forth in the clinical indications section of this document. Please refer to the [clinical](#) indications section for additional criteria.

Clinical Considerations

Regarding cerebrovascular accident

Acute inpatient rehabilitation is considered **medically necessary** for individuals who have suffered a cerebrovascular accident (stroke) that results in a significant impairment (contracture, paralysis, severe ataxia or paresis) in at least two extremities or at least one extremity in addition to higher central nervous system functions, including both mentation and autonomic nervous functions such as speech, swallowing and control of secretions.

Regarding acquired brain injury

Acute inpatient rehabilitation is considered **medically necessary** for individuals who have suffered an acquired brain injury that results in a significant impairment (contracture, paralysis, severe ataxia or paresis) in at least two extremities or at least one extremity in addition to higher central nervous system functions, including both mentation and autonomic nervous functions such as speech, swallowing and control of secretions.

Regarding spinal cord injury

Acute inpatient rehabilitation is considered **medically necessary** if a spinal cord injury leads to a significant impairment (contracture, paralysis or severe paresis) of at least two extremities.

Length of Stay - Acute Inpatient Rehabilitation Setting for Individuals with Central Nervous System Insult

This is variable and generally related to the severity of the original injury and the duration of coma or loss of consciousness. Those with longer periods of coma will generally recover more slowly. This is also applicable to CNS injury related to non-traumatic intracranial insults (stroke, intracranial hemorrhage, metabolic insult).

Length of stay for spinal cord injuries is related to the level of the injury. Injuries occurring higher in the spinal cord result in more profound loss of function and generally require longer periods of rehabilitation for adaptation.

Routine (typically weekly) reviews are completed to assess how the individual is progressing and to determine the expected length of time inpatient rehabilitation will be required.

Please refer to the appendices for additional information regarding the following:

- **Appendix 4 [Additional Clinical Considerations for Review](#)**
 - Motor Functional Impairment Status
 - Cognitive Status
 - Multidisciplinary Team Support

Federal and State law, as well as contract language including definitions and specific coverage provisions/exclusions, and Coverage Guidelines take precedence over Clinical UM Guidelines and must be considered first in determining eligibility for coverage. The member's contract benefits in effect on the date that services are rendered must be used. Clinical UM Guidelines, which address medical efficacy, should be considered before utilizing medical opinion in adjudication. Medical technology is constantly evolving, and we reserve the right to review and update Clinical UM Guidelines periodically.

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Acute Inpatient Rehabilitation

▪ Frequently Used Assessment Tools

- Levels of Care ([Appendix A](#))
- Rancho Los Amigos Cognitive Scale ([Appendix B](#))
- Glasgow Coma Scale ([Appendix C](#))
- Functional Independence Measurement ([Appendix D](#))
- Disability Rating Scale ([Appendix E](#))

Coding

The following codes for treatments and procedures applicable to this document are included below for informational purposes. Inclusion or exclusion of a procedure, diagnosis or device code(s) does not constitute or imply member coverage or provider reimbursement policy. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

Revenue Code

0118	Room and board, private; rehabilitation
0128	Room and board, semi-private; rehabilitation
0138	Room and board, semi-private; rehabilitation
0148	Room and board, private, deluxe; rehabilitation
0158	Room and board, ward, rehabilitation

ICD-9 Diagnosis

Including, but not limited to, the following:

434.01	Cerebral thrombosis, with cerebral infarction
434.11	Cerebral embolism, with cerebral infarction
434.91	Cerebral artery occlusion, unspecified, with cerebral infarction
438.0-438.9	Late effects of cerebrovascular disease
800.00-804.99	Fracture of skull
806.00-806.9	Fracture of vertebral column with spinal cord injury
850.0-854.19	Intracranial injury, excluding those with skull fracture
905.0	Late effect of fracture of skull and face bones
907.0	Late effect of intracranial injury without mention of skull fracture
907.2	Late effect of spinal cord injury
952.00-952.9	Spinal cord injury without evidence of spinal bone injury

The criteria set forth in this document are based in part on the recommendations set forth in the Centers for Medicare & Medicaid Services (CMS). LMRP #L13627- Inpatient Rehabilitation.

Federal and State law, as well as contract language including definitions and specific coverage provisions/exclusions, and Coverage Guidelines take precedence over Clinical UM Guidelines and must be considered first in determining eligibility for coverage. The member's contract benefits in effect on the date that services are rendered must be used. Clinical UM Guidelines, which address medical efficacy, should be considered before utilizing medical opinion in adjudication. Medical technology is constantly evolving, and we reserve the right to review and update Clinical UM Guidelines periodically.

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APPENDIX 2

ACUTE INPATIENT REHABILITATION FOR NEUROLOGICAL DISORDERS *(Peripheral Nerve Injury, Multiple Sclerosis, Nerve Root Injury and Postoperative Deficits)*

The information provided in this Appendix does not supersede the criteria set forth in the clinical indications section of this document. Candidates for acute inpatient rehabilitation must meet the criteria set forth in the clinical indications section of this document. Please refer to the clinical indications section for additional criteria.

Clinical Considerations

Regarding peripheral nerve injury

Acute inpatient rehabilitation is considered **medically necessary** for individuals with focal neurologic disorders which involve the peripheral nerves provided there are multiple injuries that result in a significant impairment (contracture, paralysis, or severe paresis) in at least two extremities.

Acute inpatient rehabilitation is considered **medically necessary** for individuals with diffuse peripheral nervous system disorders (e.g., Guillain-Barré), which involve at least two extremities and result in significant impairment (contracture, paralysis, or severe paresis) AND the weakness is not limited to a qualitative difference since a prior inpatient admission.

Regarding multiple sclerosis

Acute inpatient rehabilitation is considered **medically necessary** for individuals with central nervous system disorders (e.g. multiple sclerosis) that result in generalized weakness provided:

- There has been a significant decline in the individual's functional status; AND
- The functional decline is such that it will not self correct without treatment; AND
- Compensatory training is needed in addition to physical therapy.

Regarding nerve root injury

Acute inpatient rehabilitation is considered **medically necessary** following nerve root injury when the individual experiences a persistent significant impairment (contracture, paralysis, or severe paresis) in at least two extremities and the deficit is not expected to be self-limited after surgical intervention (e.g. decompression).

Regarding postoperative deficits

Acute inpatient rehabilitation is considered **medically necessary** for individuals recovering from neurosurgical procedures provided there are neurological deficits as a result of the surgery and there is significant impairment such that it involves at least one extremity in addition to higher central nervous system functions.

Length of Stay - Acute Rehabilitation Setting for Individuals with Neurological Disorders

This is variable and generally related to the severity of the original injury or surgical procedure. Progress may be slower in members of the geriatric population as well as in individuals with comorbidities, complications, or decreased cognitive status.

Federal and State law, as well as contract language including definitions and specific coverage provisions/exclusions, and Coverage Guidelines take precedence over Clinical UM Guidelines and must be considered first in determining eligibility for coverage. The member's contract benefits in effect on the date that services are rendered must be used. Clinical UM Guidelines, which address medical efficacy, should be considered before utilizing medical opinion in adjudication. Medical technology is constantly evolving, and we reserve the right to review and update Clinical UM Guidelines periodically.

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Because the length of stay varies depending on the complexity of the individual's condition, it is not unusual that routine (typically weekly) reviews are completed to assess how the individual is progressing and to determine the expected length of time inpatient rehabilitation will be required.

Please refer to the appendices for additional information regarding the following:

- **Appendix 4 [Additional Clinical Considerations for Review](#)**
 - Motor Functional Impairment Status
 - Cognitive Status
 - Multidisciplinary Team Support
- **Frequently Used Assessment Tools**
 - Levels of Care ([Appendix A](#))
 - Rancho Los Amigos Cognitive Scale ([Appendix B](#))
 - Glasgow Coma Scale ([Appendix C](#))
 - Functional Independence Measurement ([Appendix D](#))
 - Disability Rating Scale ([Appendix E](#))

Coding

The following codes for treatments and procedures applicable to this document are included below for informational purposes. Inclusion or exclusion of a procedure, diagnosis or device code(s) does not constitute or imply member coverage or provider reimbursement policy. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

Revenue Code

0118	Room and board, private; rehabilitation
0128	Room and board, semi-private; rehabilitation
0138	Room and board, semi-private; rehabilitation
0148	Room and board, private, deluxe; rehabilitation
0158	Room and board, ward, rehabilitation

ICD-9 Diagnosis

Including, but not limited to, the following (see clinical considerations):

340	Multiple sclerosis
342.00-342.92	Hemiplegia and hemiparesis
344.00-344.9	Other paralytic syndromes
357.0-357.9	Inflammatory and toxic neuropathy (including Guillain-Barré syndrome)
907.3	Late effect of injury to nerve root(s), spinal plexus(es), and other nerves of trunk
907.4-907.5	Late effect of injury to peripheral nerve
953.0-953.9	Injury to nerve roots and spinal plexus
955.0-956.9	Injury to peripheral nerves

The criteria set forth in this document are based in part on the recommendations set forth in the Centers for Medicare & Medicaid Services (CMS). LMRP #L13627- Inpatient Rehabilitation.

Federal and State law, as well as contract language including definitions and specific coverage provisions/exclusions, and Coverage Guidelines take precedence over Clinical UM Guidelines and must be considered first in determining eligibility for coverage. The member's contract benefits in effect on the date that services are rendered must be used. Clinical UM Guidelines, which address medical efficacy, should be considered before utilizing medical opinion in adjudication. Medical technology is constantly evolving, and we reserve the right to review and update Clinical UM Guidelines periodically.

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APPENDIX 3

ACUTE INPATIENT REHABILITATION FOR MUSCULOSKELETAL/ORTHOPEDIC DISORDERS

(Major Joint Replacement, Amputations, Major/Multiple Trauma, and Other Conditions)

The information provided in this Appendix does not supersede the criteria set forth in the clinical indications section of this document. Candidates for acute inpatient rehabilitation must meet the criteria set forth in the clinical indications section of this document. Please refer to the clinical indications section for additional criteria.

Clinical Considerations

Regarding major joint replacements

If a single joint is replaced, typically postoperative acute inpatient rehabilitation is considered **not medically necessary** unless the individual has significant comorbidity(ies) resulting in functional deficits which would necessitate an inpatient level of rehabilitation in order to achieve a satisfactory outcome within a reasonable time period. Of note, acute postoperative inpatient rehabilitation may be **medically necessary** for individuals undergoing more than one major joint replacement during a single hospitalization.

Regarding back surgery and compression fractures

Acute inpatient rehabilitation is considered **not medically necessary** for the following:

- Uncomplicated back surgery without other concomitant diseases;
- Uncomplicated compression fractures without neurologic involvement.

Regarding amputations

Acute inpatient rehabilitation is considered **medically necessary** for individuals who have experienced the loss of more than one body part (with the exception of digits).

Rehabilitation after a single foot or leg amputation may occur in an acute inpatient or less intensive outpatient setting. This determination is dependent upon: (1) the individual's ability to actively participate in an intensive rehabilitation program; (2) the functional deficit caused by the amputation itself; and (3) the individual's underlying medical condition.

Acute inpatient rehabilitation is considered **not medically necessary** for individuals who have suffered the loss of fingers, toes or a single hand because they do not require the intensive level of constant care provided in the inpatient setting. These individuals typically undergo rehabilitation in a less intensive, outpatient setting.

Regarding major/multiple trauma

Acute inpatient rehabilitation is considered **medically necessary** for individuals who have:

- Suffered massive injuries to a single extremity, OR
- Experienced functional impairments of more than one extremity; OR
- Experienced functional impairment such that it involves at least one extremity in addition to higher central nervous system functions.

Federal and State law, as well as contract language including definitions and specific coverage provisions/exclusions, and Coverage Guidelines take precedence over Clinical UM Guidelines and must be considered first in determining eligibility for coverage. The member's contract benefits in effect on the date that services are rendered must be used. Clinical UM Guidelines, which address medical efficacy, should be considered before utilizing medical opinion in adjudication. Medical technology is constantly evolving, and we reserve the right to review and update Clinical UM Guidelines periodically.

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Regarding arthritis and lupus erythematosus

Acute inpatient rehabilitation is considered **medically necessary** for individuals with severe arthritis (e.g. rheumatoid arthritis, osteoarthritis, polyarthritis, and lupus erythematosus) provided joint pathology involvement has progressed to the extent that the individual has experienced a significant functional decline in range of motion in the joint or related contractures in at least two extremities.

Regarding other conditions

Acute inpatient rehabilitation is considered **not medically necessary** for individuals with the following musculoskeletal/orthopedic disorders because they do not require the intensive level of constant care provided in the inpatient setting. These individuals typically undergo rehabilitation in a less intensive, outpatient setting.

- Simple fractures;
- Single extremity deficits;
- Simple (minor) trauma;
- Generalized weakness or general debility.

Length of Stay - Acute Rehabilitation Setting for Individuals with Musculoskeletal/Orthopedic Disorders

This is variable and generally related to the severity of the original injury or surgical procedure. Progress may be slower in members of the geriatric population as well as in individuals with comorbidities, complications, or decreased cognitive status.

Because the length of varies depending on the complexity of the individual's condition, it is not unusual that routine (typically weekly) reviews are completed to assess how the individual is progressing and determine the expected length of time inpatient rehabilitation will be required.

Please refer to the appendices for additional information regarding the following:

- **Appendix 4 [Additional Clinical Considerations for Review](#)**
 - Motor Functional Impairment Status
 - Cognitive Status
 - Multidisciplinary Team Support
- **Frequently Used Assessment Tools**
 - Levels of Care ([Appendix A](#))
 - Rancho Los Amigos Cognitive Scale ([Appendix B](#))
 - Glasgow Coma Scale ([Appendix C](#))
 - Functional Independence Measurement ([Appendix D](#))
 - Disability Rating Scale ([Appendix E](#))

Coding

The following codes for treatments and procedures applicable to this document are included below for informational purposes. Inclusion or exclusion of a procedure, diagnosis or device code(s) does not constitute or imply member coverage or provider reimbursement policy. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

Federal and State law, as well as contract language including definitions and specific coverage provisions/exclusions, and Coverage Guidelines take precedence over Clinical UM Guidelines and must be considered first in determining eligibility for coverage. The member's contract benefits in effect on the date that services are rendered must be used. Clinical UM Guidelines, which address medical efficacy, should be considered before utilizing medical opinion in adjudication. Medical technology is constantly evolving, and we reserve the right to review and update Clinical UM Guidelines periodically.

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Acute Inpatient Rehabilitation

Revenue Code

0118	Room and board, private; rehabilitation
0128	Room and board, semi-private; rehabilitation
0138	Room and board, semi-private; rehabilitation
0148	Room and board, private, deluxe; rehabilitation
0158	Room and board, ward, rehabilitation

ICD-9 Diagnosis

Including, but not limited to, the following (see clinical considerations):

710.0-710.9	Diffuse diseases of connective tissue
711.00-711.99	Arthropathy associated with infections
712.10-712.99	Crystal arthropathies
713.0-713.8	Arthropathy associated with other disorders classified elsewhere
714.0-714.9	Rheumatoid arthritis and other inflammatory polyarthropathies
819.0-819.1	Multiple fractures involving both upper limbs, and upper limb with rib(s) and sternum
828.0-828.1	Multiple fractures involving both lower limbs, lower with upper limb, and lower limb(s) with rib(s) and sternum
887.0-887.7	Traumatic amputation of arm and hand
896.0-896.3	Traumatic amputation of foot
897.0-897.7	Traumatic amputation of leg(s)
959.8	Injury, other specified sites (multiple)
V54.81	Aftercare following joint replacement

The criteria set forth in this document are based in part on the recommendations set forth in the Centers for Medicare & Medicaid Services (CMS). LMRP #L13627- Inpatient Rehabilitation.

Federal and State law, as well as contract language including definitions and specific coverage provisions/exclusions, and Coverage Guidelines take precedence over Clinical UM Guidelines and must be considered first in determining eligibility for coverage. The member's contract benefits in effect on the date that services are rendered must be used. Clinical UM Guidelines, which address medical efficacy, should be considered before utilizing medical opinion in adjudication. Medical technology is constantly evolving, and we reserve the right to review and update Clinical UM Guidelines periodically.

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APPENDIX 4

ADDITIONAL CLINICAL CONSIDERATIONS FOR REVIEW

The information provided in this Appendix does not supersede the criteria set forth in the clinical indications section of this document. Candidates for acute inpatient rehabilitation must meet the criteria set forth in the clinical indications section of this document. Please refer to the clinical indications section for additional criteria.

Motor Functional Impairment Status

The motor functional status of individuals in this category is characterized by:

- Requires moderate to maximum assistance of another person to perform most self-care activities (i.e. feeding, grooming, dressing, bathing); AND
- Requires moderate to maximum assistance of another person to perform mobility skills, i.e. bed activities (rolling, rise to sitting position), wheelchair locomotion and transfers; AND
- Able to tolerate three or more hours per day of therapy services within the first week on the rehabilitation unit; AND
- Able to actively participate in therapies every day, at least 5 days per week; AND
- Requires an intensive level of constant care which cannot be adequately delivered in a less intensive setting (skilled nursing facility, subacute setting, outpatient rehabilitative setting or individual's home).

Note: See [Appendix D for the Functional Independence Measurement](#) and [Appendix E for the Disability Rating Scale](#).

Cognitive Status Required to Benefit from Inpatient Rehabilitation

The individual must be able to follow simple command (verbal or demonstrated) with reasonable consistency (e.g. 50% of the time). Individuals who have experienced a head injury, multiple traumas, cerebrovascular (CV) or central nervous system (CNS) insult may start at a lesser level but must show some potential for progressive improvement in following commands during the first 2 weeks of the rehabilitation program.

Notes:

- *When the illness or injury leading to the need for rehabilitation is one affecting the central nervous system, concomitant cognitive, and physical issues may exist. Cognitive issues are routinely addressed as part of acute inpatient rehabilitation. When physical rehabilitation needs no longer exist, the cognitive issues may be addressed either as part of a formal cognitive rehabilitation program, or if there are continuing speech therapy or occupational therapy needs, with the continuation of these services. For more information on cognitive rehabilitation, please see MED.00081 Cognitive Rehabilitation..*
- *See [Appendix B for the Rancho Los Amigos Cognitive Scale](#).*

Multidisciplinary Team Support

The specific needs of an individual will vary, however, care frequently required for individuals and which cannot be achieved at less acute levels of care such as skilled nursing facility (SNF), subacute, home health care (HHC), or outpatient therapy setting, may include the following. *Please refer to the [Discussion/General Information section of this document for additional information regarding these services](#).*

- Nursing care;

Federal and State law, as well as contract language including definitions and specific coverage provisions/exclusions, and Coverage Guidelines take precedence over Clinical UM Guidelines and must be considered first in determining eligibility for coverage. The member's contract benefits in effect on the date that services are rendered must be used. Clinical UM Guidelines, which address medical efficacy, should be considered before utilizing medical opinion in adjudication. Medical technology is constantly evolving, and we reserve the right to review and update Clinical UM Guidelines periodically.

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Acute Inpatient Rehabilitation

- Physical therapy;
- Occupational therapy;
- Social services;
- Psychological services
- Neuropsychological services (as required);
- Speech therapy (may or may not be required).

Please refer to the appendices for additional information regarding the following:

- **Frequently Used Assessment Tools**
 - Levels of Care ([Appendix A](#))
 - Rancho Los Amigos Cognitive Scale ([Appendix B](#))
 - Glasgow Coma Scale ([Appendix C](#))
 - Functional Independence Measurement ([Appendix D](#))
 - Disability Rating Scale ([Appendix E](#))

Note: Individuals discharged from the inpatient rehabilitation setting are frequently transferred to an environment where a lesser degree of skilled medical care is required such as to a Skilled Nursing Facility, a Custodial Care setting or home. Please refer to the documents on [Custodial Care](#), [Skilled Nursing and Skilled Rehabilitative Services \(Outpatient\)](#), [Skilled Nursing Facility](#) and [Home Health](#) for additional information.

Federal and State law, as well as contract language including definitions and specific coverage provisions/exclusions, and Coverage Guidelines take precedence over Clinical UM Guidelines and must be considered first in determining eligibility for coverage. The member's contract benefits in effect on the date that services are rendered must be used. Clinical UM Guidelines, which address medical efficacy, should be considered before utilizing medical opinion in adjudication. Medical technology is constantly evolving, and we reserve the right to review and update Clinical UM Guidelines periodically.

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APPENDIX A

DETERMINATION OF LEVELS OF CARE

Rehabilitative care in an acute inpatient setting is appropriate for individuals who require a more coordinated, intensive program of multiple services than is generally found in a SNF or outpatient setting. Individuals are likely to require an inpatient level of rehabilitation if they have one or more conditions requiring intensive and multidisciplinary rehabilitation care, or a medical complication in addition to their primary condition which requires the continuing availability of a physician to ensure safe and effective treatment.

Whether an individual is admitted to a skilled nursing facility or an inpatient rehabilitation center is principally determined by the individual's degree of disability, his/her ability to actively participate in therapy, and the intensity of the program. This table is provided as a tool to help the user distinguish acute rehabilitative care from the care provided in a skilled nursing facility.

Acute Inpatient Rehabilitation	Skilled Nursing Facility
Rehabilitation therapy averages a minimum of 3 hours per day, one or more disciplines (PT, OT, ST), at least 5 days per week.	Rehabilitation therapy averages a minimum of 0.5 – 2.0 hours per day, at least 5 days per week.
Physicians are actively coordinating multi-disciplinary care and are typically available 24 hours/day.	Physicians are typically available intermittently.
Rehabilitation nurses, as part of the integrated team, provide direct, skilled care, assessments and teaching every shift. Direct nursing care averages 5 hours/day.	Nurses provide direct, skilled care assessments at least once per day.
Management of complicated surgical wound requires care and assessments several times per day, if applicable.	Management of stable wound requires care and assessments at least once per day, if applicable.
Individual may have a medical or surgical condition that is stable enough to allow the individual to fully participate in therapies.	Individual may have a medical or surgical condition that does not require hospitalization but is not be stable enough to allow the individual to fully participate in therapies.

Federal and State law, as well as contract language including definitions and specific coverage provisions/exclusions, and Coverage Guidelines take precedence over Clinical UM Guidelines and must be considered first in determining eligibility for coverage. The member's contract benefits in effect on the date that services are rendered must be used. Clinical UM Guidelines, which address medical efficacy, should be considered before utilizing medical opinion in adjudication. Medical technology is constantly evolving, and we reserve the right to review and update Clinical UM Guidelines periodically.

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APPENDIX B

Rancho Los Amigos Cognitive Scale

The Rancho Los Amigos Cognitive Scale is a widely accepted tool which is used to serve as a guidepost of cognitive levels from admission through discharge. The Rancho Los Amigos Cognitive Scale does not require participation from the individual but is based on the clinician's observation of the individual's response to environmental stimuli. There are currently two versions of this scale; the original scale includes 8 categories, while the revised scale addresses 10 categories. Both scales are included below for easy reference.

Los Amigos Cognitive Scale - Revised

Level I - No Response: Total Assistance

- Complete absence of observable change in behavior when presented visual, auditory, tactile, proprioceptive, vestibular or painful stimuli.

Level II - Generalized Response: Total Assistance

- Demonstrates generalized reflex response to painful stimuli.
- Responds to repeated auditory stimuli with increased or decreased activity.
- Responds to external stimuli with physiological changes generalized, gross body movement and/or not purposeful vocalization.
- Responses noted above may be same regardless of type and location of stimulation.
- Responses may be significantly delayed.

Level III - Localized Response: Total Assistance

- Demonstrates withdrawal or vocalization to painful stimuli.
- Turns toward or away from auditory stimuli.
- Blinks when strong light crosses visual field.
- Follows moving object passed within visual field.
- Responds to discomfort by pulling tubes or restraints.
- Responds inconsistently to simple commands.
- Responses directly related to type of stimulus.
- May respond to some persons (especially family and friends) but not to others.

Federal and State law, as well as contract language including definitions and specific coverage provisions/exclusions, and Coverage Guidelines take precedence over Clinical UM Guidelines and must be considered first in determining eligibility for coverage. The member's contract benefits in effect on the date that services are rendered must be used. Clinical UM Guidelines, which address medical efficacy, should be considered before utilizing medical opinion in adjudication. Medical technology is constantly evolving, and we reserve the right to review and update Clinical UM Guidelines periodically.

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Level IV - Confused/Agitated: Maximal Assistance

- Alert and in heightened state of activity.
- Purposeful attempts to remove restraints or tubes or crawl out of bed.
- May perform motor activities such as sitting, reaching and walking but without any apparent purpose or upon another's request.
- Very brief and usually non-purposeful moments of sustained alternatives and divided attention.
- Absent short-term memory.
- May cry out or scream out of proportion to stimulus even after its removal.
- May exhibit aggressive or flight behavior.
- Mood may swing from euphoric to hostile with no apparent relationship to environmental events.
- Unable to cooperate with treatment efforts.
- Verbalizations are frequently incoherent and/or inappropriate to activity or environment.

Level V - Confused, Inappropriate Non-Agitated: Maximal Assistance

- Alert, not agitated but may wander randomly or with a vague intention of going home.
- May become agitated in response to external stimulation, and/or lack of environmental structure.
- Not oriented to person, place or time.
- Frequent brief periods, non-purposeful sustained attention.
- Severely impaired recent memory, with confusion of past and present in reaction to ongoing activity.
- Absent goal directed, problem solving, self-monitoring behavior.
- Often demonstrates inappropriate use of objects without external direction.
- May be able to perform previously learned tasks when structured and cues provided.
- Unable to learn new information.
- Able to respond appropriately to simple commands fairly consistently with external structures and cues.
- Responses to simple commands without external structure are random and non-purposeful in relation to command.
- Able to converse on a social, automatic level for brief periods of time when provided external structure and cues.

Federal and State law, as well as contract language including definitions and specific coverage provisions/exclusions, and Coverage Guidelines take precedence over Clinical UM Guidelines and must be considered first in determining eligibility for coverage. The member's contract benefits in effect on the date that services are rendered must be used. Clinical UM Guidelines, which address medical efficacy, should be considered before utilizing medical opinion in adjudication. Medical technology is constantly evolving, and we reserve the right to review and update Clinical UM Guidelines periodically.

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- Verbalizations about present events become inappropriate and confabulatory when external structure and cues are not provided.

Level VI - Confused, Appropriate: Moderate Assistance

- Inconsistently oriented to person, time and place.
- Able to attend to highly familiar tasks in non-distracting environment for 30 minutes with moderate redirection.
- Remote memory has more depth and detail than recent memory.
- Vague recognition of some staff.
- Able to use assistive memory aide with maximum assistance.
- Emerging awareness of appropriate response to self, family and basic needs.
- Moderate assist to problem solve barriers to task completion.
- Supervised for old learning (e.g. self care).
- Shows carry over for relearned familiar tasks (e.g. self care).
- Maximum assistance for new learning with little or no carry over.
- Unaware of impairments, disabilities and safety risks.
- Consistently follows simple directions.
- Verbal expressions are appropriate in highly familiar and structured situations.

Level VII - Automatic, Appropriate: Minimal Assistance for Daily Living Skills

- Consistently oriented to person and place, within highly familiar environments. Moderate assistance for orientation to time.
- Able to attend to highly familiar tasks in a non-distraction environment for at least 30 minutes with minimal assist to complete tasks.
- Minimal supervision for new learning.
- Demonstrates carry over of new learning.
- Initiates and carries out steps to complete familiar personal and household routine but has shallow recall of what he/she has been doing.
- Able to monitor accuracy and completeness of each step in routine personal and household ADLs and modify plan with minimal assistance.

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Acute Inpatient Rehabilitation

- Superficial awareness of his/her condition but unaware of specific impairments and disabilities and the limits they place on his/her ability to safely, accurately and completely carry out his/her household, community, work and leisure ADLs.
- Minimal supervision for safety in routine home and community activities.
- Unrealistic planning for the future.
- Unable to think about consequences of a decision or action.
- Overestimates abilities.
- Unaware of others' needs and feelings.
- Oppositional/uncooperative.
- Unable to recognize inappropriate social interaction behavior.

Level VIII - Purposeful, Appropriate: Stand-By Assistance

- Consistently oriented to person, place and time.
- Independently attends to and completes familiar tasks for 1 hour in distracting environments.
- Able to recall and integrate past and recent events.
- Uses assistive memory devices to recall daily schedule, "to do" lists and record critical information for later use with stand-by assistance.
- Initiates and carries out steps to complete familiar personal, household, community, work and leisure routines with stand-by assistance and can modify the plan when needed with minimal assistance.
- Requires no assistance once new tasks/activities are learned.
- Aware of and acknowledges impairments and disabilities when they interfere with task completion but requires stand-by assistance to take appropriate corrective action.
- Thinks about consequences of a decision or action with minimal assistance.
- Overestimates or underestimates abilities.
- Acknowledges others' needs and feelings and responds appropriately with minimal assistance.
- Depressed.
- Irritable.
- Low frustration tolerance/easily angered.
- Argumentative.
- Self-centered.

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- Uncharacteristically dependent/independent.
- Able to recognize and acknowledge inappropriate social interaction behavior while it is occurring and takes corrective action with minimal assistance.

Level IX - Purposeful, Appropriate: Stand-By Assistance on Request

- Independently shifts back and forth between tasks and completes them accurately for at least two consecutive hours.
- Uses assistive memory devices to recall daily schedule, "to do" lists and record critical information for later use with assistance when requested.
- Initiates and carries out steps to complete familiar personal, household, work and leisure tasks independently and unfamiliar personal, household, work and leisure tasks with assistance when requested.
- Aware of and acknowledges impairments and disabilities when they interfere with task completion and takes appropriate corrective action but requires stand-by assist to anticipate a problem before it occurs and take action to avoid it.
- Able to think about consequences of decisions or actions with assistance when requested.
- Accurately estimates abilities but requires stand-by assistance to adjust to task demands.
- Acknowledges others' needs and feelings and responds appropriately with stand-by assistance.
- Depression may continue.
- May be easily irritable.
- May have low frustration tolerance.
- Able to self monitor appropriateness of social interaction with stand-by assistance.

Level X - Purposeful, Appropriate: Modified Independent

- Able to handle multiple tasks simultaneously in all environments but may require periodic breaks.
- Able to independently procure, create and maintain own assistive memory devices.
- Independently initiates and carries out steps to complete familiar and unfamiliar personal, household, community, work and leisure tasks but may require more than usual amount of time and/or compensatory strategies to complete them.
- Anticipates impact of impairments and disabilities on ability to complete daily living tasks and takes action to avoid problems before they occur but may require more than usual amount of time and/or compensatory strategies.
- Able to independently think about consequences of decisions or actions but may require more than usual amount of time and/or compensatory strategies to select the appropriate decision or action.

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- Accurately estimates abilities and independently adjusts to task demands.
- Able to recognize the needs and feelings of others and automatically respond in appropriate manner.
- Periodic periods of depression may occur.
- Irritability and low frustration tolerance when sick, fatigued and/or under emotional stress.
- Social interaction behavior is consistently appropriate.

Los Amigos Cognitive Scale - Original

Rancho Level	Clinical Correlate
I	No Response
II	Generalized response
III	Localized response
IV	Confused-agitated
V	Confused-inappropriate
VI	Confused-appropriate
VII	Automatic-inappropriate
VIII	Purposeful and appropriate

References

Original Scale co-authored by Chris Hagen, Ph.D., Danese Malkmus, M.A., Patricia Durham, M.A. Communication Disorders Service, Rancho Los Amigos Hospital, 1972. Revised 11/15/74 by Danese Malkmus, M.A., and Kathryn Stenderup, O.T.R. Revised scale 1997 by Chris Hagen. Available at <http://www.braininjury.com/recovery.html> Accessed on July 2, 2008.

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APPENDIX C

Glasgow Coma Scale (GCS)

Eye Opening Response

- Spontaneous--open with blinking at baseline **4 points**
- To verbal stimuli, command, speech **3 points**
- To pain only (not applied to face) **2 points**
- No response **1 point**

Verbal Response

- Oriented **5 points**
- Confused conversation, but able to answer questions **4 points**
- Inappropriate words **3 points**
- Incomprehensible speech **2 points**
- No response **1 point**

Motor Response

- Obeys commands for movement **6 points**
- Purposeful movement to painful stimulus **5 points**
- Withdraws in response to pain **4 points**
- Flexion in response to pain (decorticate posturing) **3 points**
- Extension response in response to pain (decerebrate posturing) **2 points**
- No response **1 point**

Head Injury Classification:

- Severe Head Injury----GCS score of **8 or less**
- Moderate Head Injury----GCS score of **9 to 12**
- Mild Head Injury----GCS score of **13 to 15**

(Adapted from: Advanced Trauma Life Support: Course for Physicians, American College of Surgeons, 1993).

References

1. Department of Health and Human Services Centers for Disease Control and Prevention. Glasgow Coma Scale. Available at <http://www.bt.cdc.gov/masscasualties/gscale.asp> Accessed on July 2, 2008.
2. Teasdale G, Jennett B. Assessment and prognosis of coma after head injury. Acta Neurochir 1976; 34:45-55.
3. Teasdale G, Jennett B. Assessment of coma and impaired consciousness. Lancet 1974; 81-84.

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APPENDIX D

Functional Independence Measurement (FIM™)

Score (1-7)		Score (1-7)	
Self-care		Transfers	
	Eating		Bed, Chair, Wheelchair
	Bathing		Toilet
	Dressing Upper Body		Tub, Shower
	Dressing Lower Body	Communication	
	Toileting		Comprehension
	Bladder Management		Expression
	Bowel Management		Social Interaction
Locomotion			Problem Solving
	Walking, Wheelchair		Memory
	Stairs		

Scoring Guidelines		
Complete Dependence		
1	Total Assist (Subject = 0% +)	
2	Maximal Assist (Subject = 25% +)	
Modified Dependence		HELPER
3	Moderate Assist (Subject = 50% +)	
4	Minimal Assist (Subject = 75% +)	
5	Supervision	
6	Modified Independence (Device)	NO HELPER
7	Complete Independence (Timely, Safely)	

References:

1. Getting Started with the Uniform Data System for Medical Rehabilitation, Version 5.0. Buffalo, NY 14214: State University of New York at Buffalo; 1996.
2. Guide for the Uniform Data Set for Medical Rehabilitation (including the FIM™ instrument), Version 5.1. Buffalo, NY 14214: University at Buffalo; 1997.

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APPENDIX E

Disability Rating Scale (DRS)			
Category	Item	Instructions	Score
Arousability, Awareness and Responsivity	Eye Opening	0 = spontaneous 1 = to speech 2 = to pain 3 = none	
	Communication Ability	0 = oriented 1 = confused 2 = inappropriate 3 = incomprehensible 4 = none	
	Motor Response	0 = obeying 1 = localizing 2 = withdrawing 3 = flexing 4 = extending 5 = none	
Cognitive Ability for Self Care Activities	Feeding	0 = complete 1 = partial 2 = minimal 3 = none	
	Toileting	0 = complete 1 = partial 2 = minimal 3 = none	
	Grooming	0 = complete 1 = partial 2 = minimal 3 = none	
Dependence on Others	Level of Functioning	0 = completely independent 1 = independent in special environment 2 = mildly dependent 3 = moderately dependent 4 = markedly dependent 5 = totally dependent	
Psychosocial Adaptability	Employability	0 = not restricted 1 = selected jobs 2 = sheltered workshop (non-competitive) 3 = not employable	
Total DRS Score			

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Disability Categories

Total DR Score	Level of Disability
0	None
1	Mild
2-3	Partial
4-6	Moderate
7-11	Moderately Severe
12-16	Severe
17-21	Extremely Severe
22-24	Vegetative State
25-29	Extreme Vegetative State

References:

1. Rappaport, et al. Disability rating scale for severe head trauma patients: coma to community. Archives of Physical Medicine and Rehabilitation. 1982; 63:118-123.
2. Recovery and Rehabilitation available at <http://www.braininjury.com/recovery.html> Accessed on July 2, 2008.

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