Inpatient Rehabilitation and Long-Term Acute Care (LTAC) Level of Payment Guidelines

Applies to the following CarePartners of Connecticut products:

☒ CareAdvantage Preferred

☒ CarePartners Access

Level R1 – Rehabilitation – Revenue Code 0128

Description of Level R1

Daily medical management and monitoring and skilled rehab services, physiatrist available daily, MD/NP/PA sees patient at least three days per week for assessment and oversight.

Skilled Nursing Services

- Skilled nursing available 24 hours per day
- Nursing interventions/treatments four to five hours daily including,
  but not limited to:
  - Patient/caregiver teaching/education
    (e.g., medication adherence, ADLs, chronic disease management)
  - IV Management including antibiotics and heparin
  - Physical assessment requiring functions
    (e.g., bowel and bladder management)

Skilled Rehabilitation Services

- Skilled rehabilitation services two to three hours of therapy per day, at least five days per week
- At least two disciplines per day

Combined Services

Combined Nursing and Rehab minimum of six hours

Inclusions

Per diems include, but are not limited to:

- Room and board (private or semi-private room)
- All Durable Medical Equipment (DME), including specialized DME (e.g., Clinitron Bed, CPM)
- All Ancillary Services such as:
  - Laboratory Services
  - Medical/Surgical Supplies
  - Medications
  - Diagnostic Testing
  - Dialysis
  - Total Paternal Nutrition (TPN)
  - Wound Vacuum
  - Bed Enclosure
  - Non-Customized Orthotic and Prosthetic Devices
  - Telemetry
  - Overlay Air Mattress
  - PAP Therapy Devices (e.g., C-PAP/BiPAP)
  - Bariatric Equipment
  - Modified Barium Swallow

Exclusions

Per diem exclusions– requires prior authorization:

- Physician coverage
- Ambulance Transportation
- Customized Orthotic and Prosthetic Devices
- Neuro-psychological evaluation
- Botox
- IV Chemotherapy
- Radiation Therapy

Examples of Diagnoses, Surgeries and Procedures

New amputation, bilateral joint replacements, single joint with active co-morbidities that limits functional impairment, incomplete spinal cord injury, progressive neurological disease, CVA with significant functional impairment, pulmonary rehab including but not limited to cardiac rehab, traumatic brain injury.

Level R2 – Acute Complex Rehabilitation – Revenue Code 0129

Description of Level R2

Daily medical management and monitoring and skilled rehab services, MD/NP/PA sees member at least three times per week if stable, and daily if member is moderately stable, physiatrist available daily.

Skilled Nursing Services – with complex specialized medical equipment

- Rehab nursing 24 hours per day
- Nursing interventions/treatments 5-6.5 hours daily, including but not limited to:
  - Patient/caregiver teaching/education (e.g., medication adherence, ADLs, chronic disease management)
  - Wound management requiring complex dressing and equipment
  - IV management including antibiotics & heparin
  - Bowel and bladder management
- Assessment and management of chronic diseases and co-morbidities (e.g., nebulizer and other respiratory treatments)
- Complex specialized medical equipment (i.e., halo traction, ventilation management, trach w/ mist)

Skilled Rehabilitation Services

- Skilled rehabilitation services at least three hours of therapy per day, at least five days per week
- Respiratory therapy twice per day
- At least two disciplines per day

Combined Services

Combined Nursing and Rehab minimum of eight hours

Inclusions

Per diems include, but are not limited to:

- Room and board (private or semi-private room)
- All Durable Medical Equipment (DME), including specialized DME (e.g., Clinitron Bed, CPM)
- All Ancillary Services such as:
  - Laboratory Services
  - Medical/Surgical Supplies
  - Medications
  - Diagnostic Testing
  - Dialysis
  - Total Paternal Nutrition (TPN)
  - Wound Vacuum
  - Bed Enclosure
  - Non-Customized Orthotic and Prosthetic Devices
  - Telemetry
  - Overlay Air Mattress
  - PAP Therapy Devices (e.g., C-PAP/BiPAP)
  - Bariatric Equipment
  - Modified Barium Swallow

Exclusions

Per diem exclusions – requires prior authorization:

- Physician coverage
- Ambulance Transportation
- Customized orthotic and prosthetic devices
- Neuropsychological evaluation
- Botox
- IV chemotherapy
- Radiation therapy

Examples of Diagnoses, Surgeries and/or Procedures

Acute spinal cord injuries, young stroke, ventilator patient with expectations for weaning, complex burns, traumatic brain injury.

Level C1 – Long Term Acute Care (LTAC) – Revenue Code 0120

Description of Level C1

Daily medical management and monitoring and skilled rehab services, pulmonologist available daily, Daily MD/NP/PA sees member daily, average length of stay is 25 days.

Skilled Nursing Services
– with complex specialized medical equipment

Rehab Nursing available 24 hours per day, Nursing interventions/treatments greater than 6.5 hours per day, which include but may not be limited to:

- Patient/caregiver teaching /education (e.g., medication adherence, ADLs, chronic disease management)
- IV fluids, antibiotics and heparin
- Physical assessment requiring functions, which include, but may not be limited to:
  - Bowel and bladder management
- Minimum of three IV meds

Skilled Rehabilitation Services
– needs to include one of the following 3 services:

- Skilled rehabilitation services one to three hours per day, greater than or equal to five days per week, **or**
- One to two disciplines, **or**
- Respiratory therapy more than three times per day for complex respiratory diagnosis or vent patient and restorative nursing program

Combined Services

Combined nursing and Rehab 7.5 - 9.5 hours/day

Inclusions

Per diems include, but are not limited to:

- Room and board (private or semi-private room)
- All DME (including specialized DME, e.g., Clinitron Bed, CPM)
- All ancillary services such as:
  - Laboratory services
  - Medical/surgical supplies
  - Medications
  - Diagnostic testing
  - Dialysis
  - TPN
  - Wound vacuum
  - Non-Customized Orthotic and Prosthetic Devices
  - Telemetry
  - Overlay Air Mattress
  - C-Pap
  - Bariatric Equipment
  - Bed Enclosure

Exclusions

Per diem exclusions – requires prior authorization:

- Physician coverage
- Ambulance transportation
- Customized orthotic and prosthetic devices
- Neuropsychological evaluation
- Botox
- IV chemotherapy
- Radiation therapy

Examples of Diagnoses, Surgeries and/or Procedures

Vent management and weaning, complex wound management with significant co-morbidities.

Other Requirements

- All exclusions from the per diem rate for DME must be pre-approved by the member's PCP as well as the assigned CarePartners of Connecticut care manager (CM). **Note:** DME must be purchased from contracting network providers.
- All items and services must be related to the member's diagnosis and treatment and ordered by the primary care provider.
- With the exception of an emergency, the facility must obtain prior authorization and will utilize a contracting provider for any services excluded from the per diem. Any nonemergency service not approved or not provided by a contracting provider will be the responsibility of the ordering facility.
- The Facility will be compensated the agreed upon contracting per diem starting on the day of admission and ending on the evening before day of discharge (facility will not bill for day of discharge).
- NLevel of care will be determined by the CM and will be based on the **aggregate medical needs of the member**, reflecting the needed intensity of nursing services, rehabilitation and pharmacy administration.
- The CM will have access to and knowledge of weekly meetings and family meetings.

- The CM will have the opportunity to participate in plan of care, review of cases with inter-disciplinary team, and discharge planning goals, including collaboration on the need for home visits.
- The CM will have the opportunity to develop systems that identify and report changes of condition of subacute and custodial members within 24 hours, or by the following business day.
- At the point of member discharge from the inpatient rehab/LTAC facility the provider will send a copy of the discharge summary to the CM and the member's PCP within **seven days** of discharge (or the member's post-discharge visit with the PCP, whichever is sooner).
- The facility must deliver a valid Notice of Medicare Noncoverage (NOMNC) no later than two days prior to the last covered day, as required by the Centers for Medicare and Medicaid Services (CMS). All completed NOMNCs must be forwarded to CarePartners of Connecticut within seven days of valid delivery.
- PT, OT, ST will be routinely provided five or more days per week and available seven days per week, as necessary and in accordance with the terms of this agreement.

Related Policies

- Referral, Prior Authorization and Notification Policy

Document History

- July 2025: Annual policy review; administrative edit
- July 2024: Annual policy review; administrative changes

Audit and Disclaimer Information

CarePartners of Connecticut reserves the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in this payment policy. If such an audit determines that a provider/facility did not comply with this payment policy, CarePartners of Connecticut will expect the provider/facility to refund all payments related to noncompliance.

This policy provides information on CarePartners of Connecticut claims adjudication processes. As every claim is unique, this policy is neither a guarantee of payment, nor a final indication of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management requirements (when applicable), adherence to plan policies and procedures, and claims editing logic. An authorization is not a guarantee of payment. Claims for services subject to authorization may be reviewed for accuracy and compliance with payment policies.

This policy applies to the CarePartners of Connecticut products identified by the checkboxes on page one. CarePartners of Connecticut reserves the right to amend a payment policy at its discretion.