

Guidelines for Physiatric Practice and Inpatient Review Criteria

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GUIDELINES FOR PHYSIATRIC PRACTICE

1. Physiatric involvement in patient care is indicated for the evaluation, diagnosis, and treatment of patients with neuromusculoskeletal pain, sensory or motor dysfunction, loss of selfcare abilities, mobility, or bowel or bladder dysfunction. Depending upon the severity of coexisting medical conditions, the physiatrist may choose to evaluate and treat the patient alone or concurrently with another physician.
2. The physiatrist is qualified to order, monitor and perform diagnostic studies and treatments for patients with neuromusculoskeletal pain, sensory and/or motor dysfunction, and loss of functional abilities.
3. The physiatrist has the responsibility to identify any potential complications that may occur as part of the patient's condition during treatment, and if the patient is at high risk for such complication, to take appropriate prophylactic measures. When a complication does occur, it is the responsibility of the physiatrist to perform any diagnostic tests in a timely manner that would expedite making a diagnosis as to the cause of this complication and initiate appropriate and adequate treatment for that condition.
4. The physiatrist should be skilled and knowledgeable in the direction of physical therapy, occupational therapy, recreational therapy, speech-language pathology services, prosthetic and orthotic services, rehabilitation nursing services, psychological and neuropsychological services, and social services.
5. The physiatrist has the responsibility to document the plan of evaluation, diagnosis and treatment and direct the type, amount, frequency, duration, goals, and precautions of physical therapy, occupational therapy, recreational therapy, speech-language pathology, prosthetic and orthotic, psychological and neuropsychological rehabilitation, and social services performed when one or more of these health professionals will be providing the treatment itself.



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6. The physiatrist has the responsibility to direct team conferences. These conferences should include all disciplines of the multidisciplinary staff that are involved in the care of the rehabilitation patient. The team conference is a necessary part of the medical care of the rehabilitation patient.
7. When appropriate, it is the responsibility of the physiatrist to discuss issues relevant to the rehabilitative care of the patient with both the patient and his family. The family conference is a necessary part of the medical care of the rehabilitation patient.
8. The physiatrist has the responsibility to identify the need for continued care by other members of the allied health care team and to modify such care as indicated. It is the responsibility of the physiatrist to identify when the patient has reached a realistic maximum medical and functional improvement.

PART II: INPATIENT REVIEW

PREFACE

The inpatient review criteria that follow are to be utilized only as review criteria. Their purpose is to help reviewers in the process of inpatient rehabilitation chart review. They are not intended to be used as standards of inpatient care. They encourage high quality care, but observing them cannot guarantee any specific patient outcome. They are subject to revision from time to time, as warranted by the evolution of technology and practice.

INSTRUCTIONS: PRE-ADMISSION OR ADMISSION REVIEW

"The pre-admission or admission review process is initiated upon receipt of a consultation to a physiatrist for inpatient admission."

Pre-admission Review and Admission Review are intended to accomplish the same purpose, i.e., reviewing the medical necessity and appropriateness of admission to a comprehensive medical rehabilitation hospital/unit (CMRH/U). The criteria applicable in Pre-admission Review are also applicable to Admission Review. The distinction between Pre-admission Review and Admission Review is the time and place at which the admitting physiatrist screens the case. Pre-admission review of a patient who is being transferred from a short-stay hospital to a CMRH/U is, in general, integrated with and takes place at the same time as continued stay review in the short-stay hospital. In some instances, Pre-admission Review may be performed in the outpatient setting of the CMRH/U. If Pre-admission Review is not performed, then Admission Review should be performed within three working days after the patient's admission to the CMRH/U.

The Pre-admission/Admission Review criteria, if met, should indicate that a patient with a given condition requires an intensive rehabilitation program through a multidisciplinary coordinated team approach in a CMRH/U which is expected to result in a significant practical improvement within a reasonable period of time.

In the condition/diagnosis specific criteria sets developed, admission is justified if documentation demonstrates that a patient has a primary problem of sufficient severity in an area of functioning specified in the criteria set, and if the chart documentation demonstrates the presence of those items specified in the criteria set which indicate that there is an expectation of effecting significant practical improvement in the patient's functional condition (i.e. mobility, self care, bowel or bladder care and medical instability) within a reasonable

period of time. Admission is also justified where a special surgical procedure which requires postsurgical care and treatment in a CMRH/U has been scheduled or performed. Such special surgical procedures should be reviewed for their medical necessity by review coordinators using explicit criteria.

The primary problems which have been identified as indicating a need for an intensive rehabilitation program through a multidisciplinary coordinated team approach in a CMRH/U are problems in self-care, mobility, bowel/bladder management, medical stability, pain, weakness, or safety precautions. The severity of the problem can be measured by identifying whether or not the assistance of another person is required. Ordinarily, those requiring CMRH/U care need the assistance of others. Once begun, the rehabilitation program should be comprehensive and document the evaluation and treatment of the following: health status, self-care, mobility, social status, psychological status, communication, avocational status, and where appropriate, vocational/educational status.

INSTRUCTIONS: SUBSEQUENT STAY REVIEWS

The purpose of Subsequent Stay Reviews are to:

1. Determine whether the patient has progressed, since the last review, toward stated goals (i.e. those goals established and projected during the evaluation period in the CMRH/U) based on chart documentation provided by the professionals involved with the patient during the rehabilitation phase in the CMRH/U: and whether the patient continues to need an intensive rehabilitation program through a multidisciplinary coordinated team approach in a CMRH/U in order to achieve projected goals. The review coordinator does this by ascertaining from the patient's chart and from the team conferences that the patient has not yet met his/her projected goals, and that an intensive rehabilitation program through a multidisciplinary coordinated team approach will continue to be provided in the treatment of the patient.

-OR-

2. To identify through chart documentation any complication which may temporarily halt (i.e., for no longer than 72 hours) the progress of the patient toward his/her projected goals, but where it would still be necessary and appropriate to continue the patient's stay in the CMRH/U in order to provide ongoing rehabilitation.

If a complication should halt the patient's progress for more than 72 hours, or if the complication should cause rehabilitation efforts in the CMRH/U to cease, then another level of care for the patient may be indicated, and the review coordinator should refer the case to the physician advisor.

At each Subsequent Stay Review, the review coordinator should review the patient's chart to confirm that an intensive rehabilitation program through a multidisciplinary coordinated team approach was provided since the previous review.



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INSTRUCTIONS: DISCHARGE STATUS REVIEW

The purpose of the Discharge Status Review is to evaluate the outcome of the admission. It is based upon chart documentation in the discharge summary. The reviewer should evaluate if admission goals were met within the projected length of stay (as estimated on admission), and if not, why.

Hospital course, final diagnoses, functional outcome, medications and diet at the time of discharge, disposition and follow-up plans are also evaluated at this stage.

INSTRUCTIONS: QUALITY OF CARE AND CRITICAL DIAGNOSTIC & THERAPEUTIC SERVICES REVIEW

Quality of Care and Critical Diagnostic and Therapeutic Services Review can be performed either concurrently as part of "concurrent quality assurance" or retrospectively in Quality Review Studies (QRSs). The purpose of this review is to identify critical elements of care management, i.e., those that are expected to occur as part of the routine management of the patient or those that, if they do occur, may reflect deficiencies in the care provided. The following are the criteria to be applied regardless of the condition/diagnosis of the patient being reviewed:

1. A comprehensive evaluation by a multidisciplinary team documenting medical status, mobility status, self-care status, social assets and limitations, mental and emotional status, communicative status, avocational status, and vocational status when appropriate.
2. A rehabilitation team conference held at least every two weeks which indicates:
 - a. Progress toward meeting goals
 - b. Identification of range and severity of problems such as: medical stability, self-care, mobility, social status, psychological status, communication status, avocational status, vocational/educational training, and projecting length of stay.
3. A documented physician decision with team collaboration of feasible rehabilitation goals, and length of inpatient rehabilitation care required for progress toward these goals.
4. Medical complications that arise during the course of a patient's CMRH/U stay that halts the patient's progress for more than 72 hours toward his/her projected goals may suggest useful topics for audit.

INPATIENT REVIEW CRITERIA

I. Pre-Admission Review

- A. It is recommended that this be done by employees at the comprehensive medical rehabilitation hospital or unit (CMRH/U) knowledgeable about the delivery of rehabilitation services, prior to admission to the CMRH/U.
- B. The indications for admission to the CMRH/U are to include each of the following:



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1. The presence of morphologic or physiologic abnormality in the musculoskeletal, neurosensory, cardiovascular, pulmonary, genitourinary, gastrointestinal or integumentary systems:
 - a. with previously unattained but currently feasible rehabilitation goals, or
 - b. with related complications hospitalization, or
 - c. with unrelated complications requiring special rehabilitation care during hospitalization, or
 - d. requiring application of a new technique or technology not previously applied but in need of hospitalization for implementation, or
 - e. requiring a planned evaluation or re-evaluation, or
 - f. in the absence of locally available rehabilitation services.
2. The presence of a primary problem in one or more of the following:
 - a. self-care deficit
 - b. mobility deficit
 - c. bowel/bladder dysfunction
 - d. unstable medical problem
3. The condition of the patient requires immediate availability of comprehensive diagnostic and/or therapeutic services.
4. The necessary treatments must be prescribed by a physician and administered on a regular basis by or under the direct supervision of a Board certified physiatrist or by a physician who has completed training in Physical Medicine & Rehabilitation.
5. The patient must be able to tolerate and participate in an intensive rehabilitation program through a coordinated, multidisciplinary team approach.
6. There is reasonable expectation of resolving or improving the particular problem necessitating the admission, and there is reasonable expectation that the patient will make significant functional improvement at least every two weeks.

II. Concurrent Admission Review

- A. It is strongly recommended that pre-admission review be done whenever possible.
- B. If it is not possible for a pre-admission review to be done, then it is recommended that concurrent admission review be done, within 24 to 48 hours after the patient's admission to the CMRH/U.
- C. Indications for admission to the CMRH/U (same as pre-admission review).

III. Initial Stay Review

- A. The attending physician should document the following information in the medical record within 24 hours of the admission:

1. history and physical examination including diagnosis, functional status, estimated length of stay, discharge goals and anticipated disposition.
2. medical orders covering diagnostic and therapeutic interventions.

IV. Continued Length of Stay Review

- A. Evidence of periodic rehabilitation team review (at least every two weeks) should identify one or more of the following:
1. progress of treatment toward stated goals (physically, psychosocially and vocationally) as demonstrated by functional capacity
 2. need for special medical or surgical treatment for prevention or correction of additional disability
 3. need for adaptive equipment and ability for care and use of that equipment
 4. need for regular psychological intervention with identification of psychological techniques to enhance patient performance
 5. need for health education and/or social counseling of the patient and family
 6. need for work sampling experiences
 7. goal modification based upon progress, potential for improvement and current medical status
 8. discharge planning and estimate of discharge date

V. Level of Care Review

Same as continued length of stay review.

VI. Discharge Status

- A. At the time of discharge the medical record should reflect the following:
1. status of the primary problems (i.e., self-care, mobility, bowel & bladder function) on admission;
 2. hospital course including any complications, significant laboratory or diagnostic studies, & medical, surgical or therapeutic interventions;
 3. status of the primary problems (i.e., self-care, mobility, bowel/bladder function) on discharge;
 4. diagnoses at the time of discharge;
 5. medications at the time of discharge;
 6. diet and feeding at the time of discharge;
 7. medical appliances or adaptive aids at the time of discharge;
 8. disposition; and
 9. follow-up plans.

VII. Quality of Care Review

- A. Physician directed team consultation should result in the following:
 - 1. identification of appropriate medical precautions and instability
 - 2. identification as to whether rehabilitation potential exists
 - 3. determination of what rehabilitation goals are feasible for this hospitalization
 - 4. determination of what diagnostic and therapeutic services are needed to achieve these goals
 - 5. determination of estimated length of time of inpatient care necessary to achieve these goals
- B. Treatment methods employed should be identifiable as producing one or more of the following:
 - 1. improvement in medical condition
 - 2. prevention or correction of impairment with minimization of disability
 - 3. enhancement of self-care skills, mobility, bowel/bladder function, psychosocial or vocational capacity
 - 4. enhanced ability to use and/or care for adaptive equipment

VIII. Critical Diagnostic and Therapeutic Services

- A. Diagnostic services should include the following:
 - 1. readily available comprehensive medical-surgical consultation
 - 2. 24 hour availability of comprehensive clinical laboratory and radiological services
- B. Therapeutic services should include the following:
 - 1. comprehensive medical and surgical treatments
 - 2. rehabilitation nursing, physical therapy, occupational therapy, speech-language pathology services, audiology services, prosthetics and orthotics, psychology, social casework services, vocational counseling with job station exploration and recreational therapy
 - 3. Coordinated, multidisciplinary team evaluation to assess:
 - a. medical condition(s)
 - b. functional assets and limitations
 - c. social, vocational, and recreational assets and limitations
 - d. attitude toward disability and rehabilitation
 - e. degree of involvement of family unit and other community resources
 - f. patient and family knowledge regarding disability, residual functional capacity and health maintenance

C. PART III: DEFINITIONS

D. DEFINITIONS PART I: LEVELS OF CARE

E. **Intensive Rehabilitation Program Through a Multidisciplinary Coordinated Team Approach in a CMRH/U:**

F. Intensive rehabilitation programs through a multidisciplinary coordinated team approach in a CMRH/U means that the rehabilitation program for a given patient includes close medical supervision by a physician Board-certified in Physical Medicine and Rehabilitation or a physician who has completed training in PM&R, 24-hour rehabilitation nursing, social services, physical therapy, occupational therapy, speech-language pathology, prosthetic and orthotic services, and psychological services. Where indicated in individual cases, PT and/or OT may be substituted for an appropriate time by one or more of the other therapeutic disciplines. In no instance shall the total patient/rehabilitation team contact be less than three hours per day. It is the responsibility of the attending physician to order the appropriate rehabilitation services for each patient. Close medical supervision also means 24-hour physician availability, and physician evaluation of the patient at least five times a week. Twenty-four hour rehabilitation nursing means 24-hour availability of a registered nurse with specialized training or experience in rehabilitation. A multidisciplinary coordinated team approach medically necessitates a physiatrist-directed team conference (involving all disciplines of the staff involved in the care of that patient) to occur no less than once every two weeks.

G. **Differences Between CMRH/U and Acute Medical-Surgical Levels of Care:**

H. Some patients require both rehabilitation and medical-surgical care for a given medical condition. When medical-surgical care is the major need and rehabilitation care is of secondary importance, then the patient belongs on the hospital's acute medical-surgical floor and should be admitted to this level of care.

I. When the rehabilitation needs of a patient become of major importance, then the patient belongs in a CMRH/U. Many medical-surgical problems do not require transfer to an acute medical-surgical floor, and the patient should stay on a CMRH/U if the rehabilitation is the major area of importance. Examples include problems that can be managed by the rehabilitation house staff and attending (medical-surgical consultation and 24-hour clinical laboratories and radiological services should be readily available) when it is anticipated that the problem will be resolved sufficiently within 72 hours so as to allow the patient to participate fully in the program.

J. **Differences Between CMRH/U and Rehab-Certified Skilled Nursing Facility Levels of Care:**

K. Services in both facilities require the close medical supervision of a physician Board-certified in Physical Medicine and Rehabilitation or a physician who has completed training in PM&R.

L. Medical services in the rehab-certified SNF should include a physiatry-directed team conference (involving all disciplines of the staff involved in the care of that patient) no less than once every two weeks.

M. **Differences Between CMRH/U and SNF Levels of Care:**

N. The rehabilitation services offered in the CMRH/U are different from the rehabilitation services offered in the skilled nursing facility (SNF). In addition to 24-hour availability of a physician Board-certified in Physical Medicine and Rehabilitation or a physician



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who has completed training in PM&R, CMRH/U provides 24-hour rehabilitation nursing, a service not usually present in a SNF. The CMRH/U provides an intensive rehabilitation program through a coordinated, multidisciplinary team approach. SNF services are less intense and are less comprehensive as they are in the CMRH/U.

- O. Patients requiring CMRH/U care (1) have the potential for achieving significant practical improvement in a reasonable period of time; (2) are able to participate in a minimum of three hours of therapy daily; (3) require more frequent medical supervision during the rehabilitation program than patients who are suitable for care in a SNF.
- P. **Differences Between CMRH/U and Outpatient Rehab Levels of Care:**
- Q. In the CMRH/U nursing and physician services are available on a 24-hour basis. CMRH/U patients frequently develop complicating medical problems which require the prompt attention of a physician to diagnose, treat or prevent such complications. Such services cannot be provided on an outpatient basis. Lack of access to transportation, availability of outpatient or home health services, and adverse social conditions may also contraindicate outpatient care.

DEFINITIONS PART 2: PRIMARY PROBLEMS

The following definitions identify more specifically the range and severity of the primary problem which should exist before care in a CMRH/U is justified.

(Formal rating scales for functional disability, such as the Barthel Index, PULSES Profile, Uniform National Data Bank System, etc. may be used by the review coordinator performing Pre-admission/Admission Review where such scales are in use in a particular hospital/unit.)

Self-Care Activities (includes drink/feed, dress upper/lower, brace/prosthesis, groom, wash, bathe, perineal care):

- Person is dependent upon assistance or supervision from another person in the above-mentioned self-care activities.

Mobility Activities (includes transfer chair/toilet/tub or shower, walk, stairs, wheelchair):

- Person is dependent upon assistance or supervision in mobility with or without impairment of lower limbs, or else partially independent in a wheelchair, or else there are significant architectural or environmental barriers to mobility.

Bladder Management:

- Person needs assistance from another person to manage internal or external device, or requires another person to help in establishing or maintaining a voiding or excretion pattern, or is continuously or intermittently incontinent, or is in danger of developing renal failure due to bladder dysfunction, and the patient needs further treatment, training, or supervision to decrease dependence on urologic devices, decrease incidence of infection, and maintain renal function.

Bowel Management:

- Person needs assistance from another person to use suppository or take an enema, or requires help in establishing or maintaining an adequate excretory function, or else has frequent or occasional involuntary bowel movements, and the patient needs further treatment, training, or supervision to regain adequate bowel function.



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Medical Instability:

- A person should be considered medically instable if there are medical problems which require intensive medical and/or nursing attention at least daily for the purpose of combating or preventing disease or dysfunction of the organ systems (eg., respiratory, cardiovascular, gastrointestinal, urologic, endocrine, musculoskeletal or integumentary systems).

Pain:

- Person in which pain behavior is such that it limits active motion or functional performance to a marked degree.

Weakness:

- Person who has sufficient loss of strength or endurance so as to limit active motion or functional performance to a marked degree.

Safety:

- Person whose safety needs are such that he/she may need restraints, or assistance or supervision from another person. A problem in safety can relate to medical safety and/or personal safety. A problem in medical safety usually means that acquired secondary complications will potentially intensify medical sequelae such as contractures, decubiti, and urinary tract infections, and that the patient needs to be educated in the proper management of his/her condition in order to avoid such problems and complications. A problem in personal safety means the patient cannot handle self in a manner that is physically safe.

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