Joint HMC/UWMC Policy	
DEPARTMENT: Inpatient Rehabilitation (HMC-4WH, UWMC-8N); Patient Care Services	**DOCUMENT TYPE:** Policy
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APPROVED BY: HMC Inpatient Rehab. Medical Director; HMC Assistant Administrator, Rehab Medicine & Sleep Medicine; UWMC Chief Nursing Officer; UWMC Medical Director, Inpatient Rehabilitation Unit	

Admission Criteria (HMC/UWMC)

STATEMENT OF PURPOSE:

To ensure the patient is admitted to the inpatient rehabilitation unit at the optimal time to maximize the effectiveness of their stay. Each case referred for inpatient rehabilitation is reviewed individually, based on a combination of functional and diagnostic criteria.

Routine and regular audits will be conducted to ensure compliance to federal and state regulations for admission.

POLICY:

ASSESSMENT

The inpatient unit serves patients who are 15 years of age and above (HMC) or 17 years of age and above (UWMC). Before a patient is admitted to the rehabilitation unit, an assessment is made of the patient's:

1. Medical condition & history
2. Functional limitations
3. Prognosis
4. Potential need for diagnostic and/or surgical intervention that may interrupt or interfere with the Rehabilitation process
5. Commitment to and understanding of intensive rehabilitation program.
6. Ability to progress
7. Discharge plan
8. Social and cultural issues which may affect the rehabilitation process
9. Ability to participate and tolerate 3 hours of therapy per day/willingness to participate

PARAMETERS OF ADMISSION

1. General Criteria:
    a. The services must be reasonable and necessary (in terms of duration, frequency, & amount) for the treatment of the patient's condition; and
    b. It must be reasonable and necessary to furnish the care on an inpatient rehabilitation facility, rather than in a less intensive program.
    c. The patient must be sufficiently medically stable to allow for full participation (refer to unit guidelines).
    d. The patient must have completed a pre-admission screening by a PM&R attending physician
    e. The patient requires 24-hour supervision by a Physiatrist.
    f. The patient requires 24-hour supervision by RNs trained in rehabilitation.

g. The patient can tolerate a minimum of 3 hours of combined rehabilitation treatments for no less than 5 of 7 days a week.
    i. In certain, limited, well-documented cases, this intensive rehabilitation therapy program might instead consist of at least 15 hours of intensive rehabilitation therapy within a 7 consecutive day period, beginning with the date of admission to the IRF, and can reasonably be expected to benefit the patient.
h. The patient requires an interdisciplinary approach to treatment (i.e., needs more than one type of therapy).
i. The patient is willing and able to participate in therapy.
j. The patient's diagnosis and prognosis and current therapy participation offers evidence of potential to improve level of function in a reasonable period of time as defined with individualized patient discharge goals.
k. Initial progress has been documented.
l. A viable discharge plan is under development.
m. Insurance benefits are verified by the Financial Access Clearance Team and shared with the Admissions Coordinator team. The Admissions Coordinator submits for pre-authorization based on the financial profile, and as necessary. Determination of admission is shared with patients and family by the primary team. Patients with questions are advised to contact their insurance plan directly to obtain individualized insurance benefit information.
n. Clinical Presentation:
    i. The patient must have a new onset or recent exacerbation of a physical disability or cognitive impairment whose medical condition or functional performance can be realistically improved through intensive rehabilitation.
    ii. The patient must be sufficiently medically and psychologically stable to receive rehabilitation care and capable of active participation in a rehabilitation program.
o. The patient must have at least two of the following:
    i. Mobility impairment, which may include inability to ambulate safely, inability to transfer safely, inability to operate a wheelchair, including transfers to and from the wheelchair or the inability to safely navigate indoors and outdoors.
    ii. Activities of daily living impairment, which may include bathing, grooming, dressing, feeding, and toileting
    iii. Incontinence of bowel or bladder
    iv. Inability to swallow safely without significant risk of aspiration
    v. Aphasia: receptive, expressive, or both
    vi. Dysarthria which limits significantly the patient's ability to communicate
    vii. Cognitive impairment sufficient to limit safety or reasonable function
    viii. Medical complexity that impairs mobility and ADL function (including management of new implanted medical device.)

2. Patient Family Involvement - Prior to admission to the rehabilitation unit the patient/family is oriented to the estimated length of stay and initial rehabilitation goals and agrees to the proposed plan of treatment.
3. Other considerations for admission to the Inpatient Rehabilitation Unit are:
    a. As per Center for Medicare/Medicaid (CMS) guidelines, 60% of patients admitted to a UW Medicine inpatient rehabilitation unit must have a diagnosis that fits into one the following diagnostic categories, in addition to meeting the criteria noted above in section 1 and 2.

Diagnostic Categories

1. Stroke
2. SCI (all etiologies, all levels of injury and AIS grades A-D, including ventilator dependent patients)
3. Congenital deformity
4. Amputation
5. Major multiple trauma
6. Acquired Brain injury (both traumatic and non-traumatic injuries)
7. Neurological disorders, including MS, motor neuron diseases, polyneuropathy, Muscular Dystrophy, Parkinson's
8. Burns (all levels of severity requiring less than 1 ½ hours of daily wound care)
9. Active, polyarticular rheumatoid arthritis, psoriatic arthritis and seronegative arthropathies
10. Systemic vasculidities with joint inflammation
11. Severe or advanced osteoarthritis involving 3 or more major joints (elbow, shoulders, hips, knees) EXCLUDING joints replaced by prostheses
12. Knee or hip joint replacement, or both during an acute hospitalization immediately preceding the inpatient Rehabilitation stay and also meets one of the following:
    a. Bilateral knee or hip replacement
    b. Extremely obese with a Body Mass Index of at least 50
    c. Age 85 or older

NOTE: Co-Morbidities: UW Medicine Rehabilitation will accept patients with complex and varied co- morbidities. However, patients who have a co-morbidity requiring Respiratory Isolation will not be considered for admission until the medical condition managed by the respiratory isolation has resolved.

CROSS REFERENCE:

Standards for Assessing Medical Appropriateness Criteria for Admitting Patients to Rehabilitation Hospitals or Units/ by American Academy of Physical Medicine and Rehabilitation (AAPM&R)

ADDENDUM:

Medical Stability Guidelines

Procedure for Preadmission Screening and Admission

REVIEW/REVISION DATES:

04/1998, 05/2011, 01/2013, 01/2014, 09/2015, 12/2016, 08/2017, 08/2018, 08/2019, 07/2020, 10/2021, 09/2022, 08/2023, 08/2024, 08/2025, 12/2025, 10/2016

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Medical Stability Guidelines

Ability to participate in Discharge Planning

1. Not actively psychotic
2. Ability to learn and demonstrate carry-over
3. Placement options and treatment plan established
4. SNF placement is not definitely established as long-term plan

Vital Signs

1. Vital Signs required no more than every 4 hours
2. Afebrile for 48 hours or fever work-up completed
3. No bradycardia (pulse less than 50) for last 48 hours

Pulmonary Status

1. Suction required no more than every 3-4 hours
2. Off ventilator for 48 hours (if off ventilator) or on portable ventilator for 48 hours
3. Oxygen saturation managed with portable oxygen
4. Supplemental Oxygen less than 40%
5. Off CPAP except for sleep apnea

Other Medical Criteria

1. Nutritional, pain, and wound issues do not interfere with therapies
2. Able to tolerate at least 1 hour out of bed.
3. No skin breakdown affecting out of bed tolerance.
4. Blood pressure controlled when sitting
5. Tolerate minimum of 30 minutes of therapy at a time
6. Weight bearing status does not unduly inhibit participation in inpatient rehabilitation program
7. Rehabilitation staff trained in use of implanted or attached medical devices.
8. Procedure for admission (HMC)

Procedure/Guidelines for Pre-Admission Screening & Admission to Inpatient Rehabilitation Unit

Internal Admissions: Rehabilitation Consult MD in conjunction with Rehabilitation Attending and acute care therapists determines that the patient is expected to have appropriate goals and will likely meet admission criteria when medically stable for discharge from acute care.

Rehabilitation Consult MD contacts the Admission Coordinator, who works with financial- counseling to determine patient's payer source and resolve any issues related to coverage for inpatient rehabilitation. Admission Coordinator Preadmission Screener begins preadmission note, per CMS guidelines.

Rehabilitation MDs, in conjunction with acute care Social Worker and Coordination of Care Nurse (CCN), confirm patient/family preference for HMC/UWMC Rehabilitation and explore options for post-Rehabilitation discharge location/plan.

Rehabilitation Consult MD and Preadmission Screener monitor notes and ensure timely updates as patient approaches Rehab readiness. Admission coordinator monitors bed availability and works closely with Rehabilitation Consult MD to determine anticipated date of admission.

Admission Coordinator obtains authorization for admission from payer once documentation confirms readiness to participate and medical stability is ensured.

On date of admission, Rehabilitation Consult MD verifies medical stability. Admission Coordinator notifies all acute care and inpatient parties when patient is ready and authorized. Preadmission screener enters note and notifies Rehabilitation Consult Attending. Rehabilitation Consult Attending confirms that the information in the note is correct, that the patient is appropriate for admission and signs note prior to admission. Rehabilitation consult attending enters the admission order in the pre-admission rehab encounter. Inpatient charge RN and/or Unit Patient Services Specialist ensure discharge summary is in chart prior to transfer. Admission coordinator or Case manager visits patient/family within 2 business days and provides Financial Disclosure information as well as packet of information about the rehabilitation unit.

External Admissions: As above, except that the Admissions Coordinator requests pertinent medical records from the referring physician/hospital and records are reviewed by the Rehabilitation Attending physician to determine if patient meets admission criteria. Preadmission screener enters the preadmission screen and notifies the inpatient Rehabilitation Attending. Payer is contacted and pre-authorization is obtained. Rehabilitation Attending confirms that the information in the note is correct, that the patient is appropriate for admission and signs note prior to admission. Rehabilitation attending enters the admission order in the pre-admission rehab encounter. Discharge summary and other pertinent updated medical records accompany the patient at admission.