ACUTE INPATIENT REHABILITATION GUIDELINE

Inpatient rehabilitation facilities promote 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 hours rehabilitation services daily. These services may include physical therapy, occupational therapy, speech therapy, cognitive therapy, respiratory therapy, psychology services, and/or prosthetic/orthotic services.

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, brain injuries, major trauma and burns.

Admission to an inpatient rehabilitation facility

Admission to an inpatient rehabilitation facility is medically necessary when ALL of the following apply:

- There is a new medical condition or exacerbation of a chronic condition resulting in a decrease in functional ability that cannot be addressed in a less intensive setting, AND
- There is a risk for medical instability or requirement for a physician and other personnel not available outside of the inpatient setting, AND
- There is a need for an intensive inter-disciplinary rehabilitation program with a minimum of three hours of active participation daily, AND
- The individual is medically stable enough to be able to be discharged from the inpatient hospital medical/surgical setting, AND
- The individual is able to actively participate in the rehabilitation program by responding to verbal, visual, or tactile stimuli, and able to follow simple commands, AND
- The individual's pre-injury or pre-illness status suggests potential for significant improvement, AND
- There is an expectation of measureable functional improvement within 7 to 14 days of admission to the program, AND
- The rehabilitation services are prescribed by a physician and require close medical supervision and skilled care by practitioners trained in rehabilitation medicines, AND
- The rehabilitation program includes a discharge plan.

Admission to an inpatient rehabilitation facility is NOT medically necessary for the following:

- coma stimulation,
- educational training for employment requirements,
- custodial care,
- single joint replacement unless the individual has significant comorbidity (ies) resulting in functional deficits which require acute inpatient rehabilitation in order to achieve a satisfactory outcome in a reasonable time period,
- uncomplicated back surgery without other concomitant diseases,
- uncomplicated compression fractures without neurologic involvement.

Continued stay in an inpatient rehabilitation facility

Weekly documentation of interdisciplinary care showing ALL of the following is required for continued stay in the inpatient rehabilitation facility:

- evidence of active participation a minimum of three hours a day, five days a week, AND
- evidence of progress toward functional goals with objective functional measurements, AND
- documentation of scope of problems and severity (including medical status, self-care, mobility, psychological status, and communication status), AND
- documentation of need for special equipment, AND
- modification of goals based on progress and potential, AND
- education of caretakers for post discharge care, AND
- documentation of barriers to progress.

Discharge from an inpatient rehabilitation facility

Discharge from an inpatient rehabilitation facility is appropriate if one or more of the following are present:

- treatment goals have been achieved, OR
- the individual is unable to participate in the rehabilitation program at least three hours a day at least five days a week, OR
- the individual has reached a plateau in progress and no functional improvement is expected in a reasonable timeframe (7 to 14 days), OR
- rehabilitation services could safely and effectively be delivered at a lower level of care (such as outpatient therapies, skilled nursing facilities, or home health care).

Appendix A: Determination of Level of Care

An individual's degree of disability, ability to participate in a therapy program, and program intensity determine whether an individual is admitted to a skilled nursing facility or an inpatient rehabilitation 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 three hours per day, one or more disciplines (PT, OT, ST), at least five days per week.	Rehabilitation therapy averages a minimum of 30 minutes to 2 hours per day, at least five days per week.
Physicians are actively coordinating multi-disciplinary care and are typically available 24 hours per 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 five hours per 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 stable enough to allow the individual to fully participate in therapies.

Appendix B

Rancho Los Amigos Cognitive Scales

The original and revised Rancho Los Amigos Cognitive Scales are commonly used to categorize an individual's response to stimuli.

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.

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.
- 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 (ADL) 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 carryover 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.
- 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 one 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.
- 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.
- 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

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

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)

Appendix D

Functional Independence Measurement (FIM™) Score

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)	

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			

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

American Academy of Physical Medicine and Rehabilitation. APM&R Recommendations on Post-Acute Care Data Standardization and Quality Measurement. Available at: http://www.aapmr.org/docs/default-source/advocacy/data-standardization-and-quality-measures-final.pdf?sfvrsn=0. Accessed September 30, 2016.

National Institute of Neurological Disorders and Stroke 2001 Jul. Post-Stroke Rehabilitation Fact Sheet. Updated June 18, 2013. Available at: https://stroke.nih.gov/materials/rehabilitation.htm. Accessed September 30, 2016.

National Institute of Neurological Disorders and Stroke 2002 February. Traumatic Brain Injury: Hope Through Research. Updated February 11, 2013. Available at: http://www.ninds.nih.gov/disorders/tbi/detail_tbi.htm#42783218. Accessed September 30, 2016.

Rancho Los Amigos Scales: 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.

Department of Health and Human Services Centers for Disease Control and Prevention. Glasgow Coma Scale. Last reviewed: February 1, 2013. Available at: http://www.cdc.gov/TraumaticBrainInjury/severe.html. Accessed September 30, 2016.

Guide for the Uniform Data Set for Medical Rehabilitation (including the FIM™ instrument), Version 5.1. Buffalo, NY 14214: University at Buffalo; 1997.

Rappaport, et al. Disability rating scale for severe head trauma patients: coma to community. Archives of Physical Medicine and Rehabilitation. 1982; 63:118-123.

MEDICAL ADVISORY COMMITTEE GUIDELINE HISTORY			
Adopted By MAC	**Reapproved**	**Revised**	**Retired**
January 16, 2014			
	October 16, 2014		
	October 29, 2015		
	October 27, 2016		