REHABILITATION HOSPITAL LENGTH OF STAY CRITERIA

It is the hospital's responsibility to provide Molina with the specific information necessary for the case review nurse/LMHP to determine if the patient meets admission criteria as specified on this form. Include the following from the medical record: 1) ED record, if any, 2) admit date, 3) physician's orders, and 4) applicable progress notes.

NAME:	**CASE #:**
MEDICAID ID #:	
ICD CODE #:	

EXTENSION REQUIREMENT: From the Severity of Illness, the patient must meet at least one element from criteria 1 **OR** 2, **AND**, from criteria 3, the patient must meet one element from A through E **AND** F **AND** G. All Intensity of Service criteria must be met.

SEVERITY OF ILLNESS

(Must meet either criteria 1 **or** 2, **and** from criteria 3 any one of the elements A through E **and** elements F **and** G)

☐ **1.** Physical – Inability to function independently as demonstrated by meeting one element from A, B, or C, with the potential for significant practical improvement as measured against his/her condition prior to rehabilitation

☐ **A.** Activities of daily living (any one of)
- ☐ **1)** Feeding
- ☐ **2)** Personal hygiene
- ☐ **3)** Dressing

OR

☐ **B.** Mobility (any one of)
- ☐ **1)** Transfers
- ☐ **2)** Wheelchair
- ☐ **3)** Ambulation
- ☐ **4)** Stair climbing

OR

☐ **C.** Communicative/Cognitive (must be accompanied by either element A or B)
- ☐ **1)** Aphasia and major receptive and/or expressive components
- ☐ **2)** Cognitive dysfunction (e.g., attention span, confusion, memory, intelligence)
- ☐ **3)** Perceptual motor dysfunction area (e.g., spatial orientation, visual-motor, depth and distance perception)

Specifics: _____

_____

OR

☐ **2.** Somatic Dysfunction

☐ **A.** Somatic dysfunction which significantly impairs the individual's efficiency of performance (e.g., spasticity, incoordination, paresis, bowel and bladder dysfunction, gait disturbance, dysarthria, dyskinesia)

Specifics: _____

_____

AND

☐ **3.** Comprehensive Rehabilitative Status (any **one** of A through E **and** F **and** G)

- ☐ **A.** Has had no previous comprehensive rehabilitative effort or previous rehabilitative efforts for the same condition showed little or no improvement, but because of an intervening circumstance, rehabilitation is now considered reasonable
- ☐ **B.** Previously has been unable to attain rehabilitation goals which are currently considered attainable because of techniques or technology not previously available to the patient. This may include previous trials of outpatient therapy with unsatisfactory response
- ☐ **C.** Has lost previous level of attained functional independence due to complicating intercurrent illness, and reattainment of functional independence currently is feasible
- ☐ **D.** The patient is medically stable, but has complications which require special care during rehabilitation goals or attainment of goals
- ☐ **E.** Documented objective evidence of a significant change in a patient's function requiring a planning evaluation or re-evaluation of rehabilitation goals or attainment of goals

AND

- ☐ **F.** Significant practical improvement expected in a reasonable period of time. It is not necessary that there be an expectation of complete independence in the activities of daily living, but there must be a reasonable expectation of improvement that will be of practical value to the patient, measured against his/her condition at the start of the rehabilitation program

AND

- ☐ **G.** The patient has sufficient mental alertness to participate in the program

Specifics: _____

_____

INTENSITY OF SERVICE

(Must meet 1, 2, **and** 3)

☐ **1.** Medical management by a physician and a registered nurse

Specifics: _____

_____

AND

☐ **2.** The provision of at least one of the following services for a minimum of three hours per day and no less than five days a week:

- ☐ **A.** Occupational therapy
- ☐ **B.** Physical therapy
- ☐ **C.** Speech/language pathology services and/or prosthetic/orthotic services (must be a combination of these two services or one in conjunction with OT or PT)

Specifics: _____

_____

AND

☐ **3.** Evidence of periodic multi-disciplinary rehabilitation team review at least every two weeks with documentation of progress and recommendations for continuing rehabilitation program

Specifics: _____

_____

DISCHARGE CRITERIA

(Must meet at least **ONE**)

- ☐ **1.** Evidence is in record that the patient has achieved stated goals
- ☐ **2.** Medical complications preclude intensive rehabilitative effort
- ☐ **3.** Multi-disciplinary therapy is no longer needed
- ☐ **4.** No additional function improvement is anticipated
- ☐ **5.** Patient's functional status has remained unchanged for 14 days

DATE EXTENSION APPROVED: _____ **LOS EXTENSION:** _____