

Post-Acute Rehabilitation Levels of Care—Inpatient Care

	Long-Term Care Hospital (LTCH)	Inpatient Rehabilitation Facility (IRF)	Skilled Nursing Facility (SNF)	Long-Term/Custodial Care
Functional Status	<ul style="list-style-type: none"> ▪ Patient has medically complex needs that cannot be met at a lower level of care. ▪ Patient has complex wounds ▪ Patient has experienced failure of two or more major organ systems. ▪ Patient failed ventilator weaning after more than 3 weeks at a prior hospitalization. 	<ul style="list-style-type: none"> ▪ Patient has some degree of ADL and mobility impairment. ▪ Patient is cognitively able to participate in therapy. ▪ Significant practical functional improvement is expected. 	<ul style="list-style-type: none"> ▪ Patient has some degree of ADL and mobility impairment or other skilled need. ▪ Some functional improvement is expected. 	<ul style="list-style-type: none"> ▪ Patient has some degree of mobility or ADL impairment and cannot be managed at a lower level of care. ▪ Patient may or may not have cognitive deficits. ▪ Patient has not reached independent level to be managed at home setting. ▪ Patient is no longer making progress where they can benefit from skilled intervention.
Nursing & Medical Services Required	<ul style="list-style-type: none"> ▪ Requires ongoing acute medical management ▪ Requires 24 hour licensed nursing care 	<ul style="list-style-type: none"> ▪ Requires ongoing acute medical management ▪ Requires 24-hour rehabilitation nursing care ▪ Need for coordinated, interdisciplinary care 	<ul style="list-style-type: none"> ▪ Involvement of skilled nursing staff is required to meet individual's medical needs, promote recovery, and ensure medical safety. 	<ul style="list-style-type: none"> ▪ Involvement of nursing staff does not require daily skilled nursing observation or intervention, but staff ensure that the patient's medical safety needs are met.
Therapies Required	<ul style="list-style-type: none"> ▪ Therapy as an adjunct to medical treatment 	<ul style="list-style-type: none"> ▪ Requires two or more therapies, one of which must be PT or OT 	<ul style="list-style-type: none"> ▪ Requires one or more therapies OR ▪ Patient has daily skilled nursing need 	<ul style="list-style-type: none"> ▪ May require therapy, but the total must be less than 5 times per week ▪ May benefit from Part B therapy if skilled therapy intervention is required

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Number of Therapy Hours Required and Tolerated	<ul style="list-style-type: none"> ▪ No minimum hours required. “Medically complex needs” is sufficient of admission. 	<ul style="list-style-type: none"> ▪ Tolerates at least 3 hours per day of therapy, 5 days per week 	<ul style="list-style-type: none"> ▪ There is no minimum number of tolerated hours required for SNF admission. Skilled need is sufficient 	N/A
Discharge Plan & Social Support		<ul style="list-style-type: none"> ▪ Probable discharge to community ▪ Adequate community support resources are available to meet needs based on functional prognosis. 	<ul style="list-style-type: none"> ▪ Completed psychosocial needs assessment ▪ Warm handoff completed between SNF and SNF coordinator or SNF MDs ▪ Possible discharge to community 	<ul style="list-style-type: none"> ▪ SNF transfer must include long-term plan of care. ▪ Completed psychosocial needs assessment and discussion with family regarding financial requirements ▪ Warm handoff completed between SNF and SNF coordinator or SNF MDs

Post-Acute Rehabilitation Levels of Care—Home-Based Care

	Integrated Outpatient Therapy/Day Treatment	Home Health	Standard Outpatient Therapy
Functional Status	<ul style="list-style-type: none"> ▪ Patient is able to be cared for at home. ▪ Patient requires skilled multidisciplinary intervention with potential to make significant functional improvement in ADLs, mobility, or cognition/language. 	<ul style="list-style-type: none"> ▪ Patient is homebound due to some degree of ADL and mobility impairment. ▪ Patient completed cognitive evaluation. 	<ul style="list-style-type: none"> ▪ Patient has impairments and requires only supervision or minimal assistance with mobility or ADLs. ▪ Patient is cognitively able to participate in therapy.

	Integrated Outpatient Therapy/Day Treatment	Home Health	Standard Outpatient Therapy
	<ul style="list-style-type: none"> ▪ Patient is able to do a home exercise/activity program. 		
Nursing & Medical Services Required	<ul style="list-style-type: none"> ▪ Outpatient rehab RN, PM&R, case manager, and medical social worker are part of the multidisciplinary team as need 	<ul style="list-style-type: none"> ▪ May require home health nursing 	<ul style="list-style-type: none"> ▪ Referred to outpatient rehab RN, case manager, and medical social worker if needed
Therapies Required	<ul style="list-style-type: none"> ▪ Requires at least two therapies 	<ul style="list-style-type: none"> ▪ Requires one or more therapies with a nurse or social worker 	<ul style="list-style-type: none"> ▪ Requires one or more therapies
Number of Therapy Hours Required and Tolerated	<ul style="list-style-type: none"> ▪ Tolerates at least 1 hour per day <p style="text-align: center;">OR</p> <ul style="list-style-type: none"> ▪ Patient has a skilled need and a functional goal with good rehab prognosis. 	<ul style="list-style-type: none"> ▪ Tolerates at least 0.5 hour per day <p style="text-align: center;">OR</p> <ul style="list-style-type: none"> ▪ Patient has a skilled need and a functional goal with good rehab prognosis. 	<ul style="list-style-type: none"> ▪ Tolerates at least 0.5 hour per day either in the clinic or doing at-home exercises <p style="text-align: center;">OR</p> <ul style="list-style-type: none"> ▪ Patient has a skilled need and a functional goal with good rehab prognosis.
Discharge Plan & Social Support	<ul style="list-style-type: none"> ▪ Patient must have transportation to therapy location ▪ Has accessible environment at home and appropriate durable medical equipment to meet needs. ▪ Has support to continue exercise and activity program at home 	<ul style="list-style-type: none"> ▪ Confined to home ▪ Has accessible environment at home and appropriate durable medical 	<ul style="list-style-type: none"> ▪ Patient must be able to get to/from therapy visits ▪ Has accessible environment at home and appropriate durable medical ▪ Has social support to continue exercise and activity program at home