

Hospital Guide

Introduction

This Topic is discussed on four parts:

- Definitions
- Benefits
- Legal Considerations
- Plan Document Language.

Definitions

In General

A hospital must provide care to sick and injured on an inpatient basis. It must have a staff of physicians and 24-hour nursing care. It must have facilities for diagnosis and treatment as well as for major surgery. It must be legally accredited and qualified to receive Medicare payments. It must not be, except incidentally, any of the following:

- Nursing home
- Place for rest
- Home for age
- Facility for mentally or emotionally disturbed
- Place to treat drug or alcohol abuse.

Facilities Requiring Special Consideration

Several facilities have uniqueness which require special consideration.

College and School Infirmaries. Apply the *hospital* definition. Few private school or summer camp infirmaries and clinics meet this requirement. For the most part, treat all confinements in these institutions on the same basis as if the patient were house confined and receiving medical services at home. Ordinarily, a student or other person requiring hospital care is transferred to a nearby hospital.

State Homes and State Training Schools. Apply the *hospital* definition. The majority of state schools/homes do not qualify as hospitals, and confinement in such facilities does not constitute hospital confinement.

Institutions for Children with Emotional Disorders (Residential Treatment Centers). Most facilities provide a 24 hour, 7 days a week program with a professional staff consisting of psychiatrists, nurses, psychologists, family therapists, social workers, and mental health specialists. Charges by these institutions for services of a physician, services of therapists who are under the supervision of a physician, and other medical expenses, however, may be covered.

Institutions for Children with Learning Disabilities. The terms *learning disabilities* and *dyslexia* are used to denote reading and spelling disabilities which appear to have a primary cause in their own right and which are not caused by retardation, emotional disturbances, aphasia, autism, etc. Many learning disabilities are caused by a complex combination of neurophysiological irregularities which affect both perception and development of function with respect to written language. Although therapy for the neurophysiological causes of learning disabilities involves retraining in the areas of neurophysiological deficiency and is basically educational in nature, the irregularities can be considered *disease*, and the resulting learning disability a symptom of that disease. The majority of institutions treating learning disabilities are not hospitals. Charges by

these institutions for services of a physician, services of therapists who are under the supervision of a physician, and other medical expenses, however, may be covered under some other coverage.

Hospital Definition Analyzed

Legal Accreditations. Some states do not require government (federal, state, county, city) owned facilities to submit to licensing; therefore, a government owned hospital may not hold a hospital license. It will still qualify as a *hospital*, however, as long as it meets all other policy criteria. Whether or not the facility is subject to hospital licensing, it must be operating as a hospital in order to satisfy the requirements. For example, some multi-purpose institutions provide nursing home facilities in addition to hospital facilities; only the hospital (acute care) sections of such institutions meet the *hospital* definition.

Twenty-Four Hour Nursing Care. The definition requires that the institution provide continuous nursing care. Some rural hospitals, which do not provide 24 hour nursing care, may be licensed by their respective states and/or approved to participate in the Medicare program; however, they do not meet the policy requirements, and are not recognized as *hospitals*, as defined.

Facilities for Diagnosis. The institution must provide facilities and staff for diagnosis such as clinical laboratory services and diagnostic x-ray services. Specialty hospitals must provide for such diagnostic services as are appropriate for the specified medical condition(s) for which medical services are provided.

Surgery Facilities. This requirement is waived where the treatment is primarily concerned with chronic disease. Surgery facilities means operating room(s) used primarily for surgery. The average operating room contains these necessary items: a sterile environment, an operating table, overhead light, instrument tables, anesthesia equipment, suction machines, solution basins, blood transfusion equipment, and special accessories for emergency cases. Such facilities can accommodate most surgical procedures requiring hospitalization. These criteria are used to distinguish between an operating room and an emergency room, which is primarily designed to furnish immediate medical and minor surgical care on an emergency basis. Except for institutions specializing in chronic disease(s), a hospital with an emergency room but without operating room facilities does not satisfy our definition of a hospital. Tuberculosis and psychiatric disorders fall within the broad classification of chronic diseases. Institutions primarily concerned with treatment of such conditions which satisfy all requirements of our hospital definition except *facilities for major surgery* qualify as hospitals.

Nursing Rest Home, Etc. The definition of a hospital excludes sanatoria, health resorts, mineral spring resorts, hotels, and similar domiciliary institutions where services for illness, injury, deformity, infirmity or abnormality are limited to board and room, personal services and nursing care.

Drug and Alcohol Abuse. Excluded are places used primarily for confinement or treatment of drug addicts or alcoholics. This restriction would exclude clinics, treatment

facilities, or residential facilities even if licensed or approved for the treatment of alcoholism or drug abuse by the appropriate jurisdictional authority.

American Hospital Association Accreditation. Hospitals listed in the American Hospital Association (AHA) Guide to the Health Care Field are AHA registered and/or osteopathic hospitals.

Multi-Purpose Hospital. Some facilities provide more than one level of care. Whenever a multi-purpose facility provides extended and/or custodial care in addition to acute care, only the acute care sections of such institutions meet the *hospital* definition.

Institutions for Children with Severe Brain Injuries. Brain injuries include those resulting from trauma, subdural hematomas, hydrocephalus, vascular malformation and postencephalitic damages. These injuries are primarily neurological problems and not nervous or medical conditions. The majority of institutions treating brain injured children do not qualify as hospitals, as defined, and no benefits are provided under Hospital Coverage. However, certain medical expense items incurred at these institutions may be covered under other coverages provided by the policy. Examples of covered items include medical treatment and diagnostic evaluations by a physician, and physiotherapy.

Institutions for Children which Qualify as Hospitals. Some institutions for children, although not acute care facilities, qualify as *hospitals*, i.e., they are licensed as hospitals and meet the policy definition of hospitals, and may be AHA registered or JCAH accredited. They qualify as hospitals even though, in addition to rendering medical/hospital services, they provide academic and social instruction. However, confinement in the institution may not necessarily be medically necessary to the care and treatment of disease. Sometimes, although treatment rendered during the confinement is medically appropriate, the confinement itself may be custodial in nature.

Joint Committee on Accreditation of Hospitals

The Joint Committee on Accreditation of Hospitals (JCAH) is a committee which is made up of representatives of the American Medical Association, the American College of Surgeons, the American College of Physicians and the American Hospital Association. This committee reviews and approves hospitals which meet a rigid set of standards and agree to permit only ethical and qualified physicians to be members of their staffs. The findings of the JCAH are published annually in the American Hospital Association Directory. Therefore, the AHA Directory may be used as a guide in determining the presence of hospital qualifications, as specified in medical plans.

Rehabilitative Hospital

In General

Physicians generally agree on the circumstances that justify a medical or surgical patient's hospitalization. In most cases, an admission to a rehabilitation hospital or to the short term rehabilitation services of a hospital may be justified. In other cases, however, a patient's medical or surgical needs alone may not warrant inpatient hospital care, but

hospitalization may nevertheless be necessary because of the patient's need for rehabilitative services.

A hospital level of care is required by a patient needing rehabilitative services if the patient needs a relatively intense rehabilitation program that requires a multi-disciplinary coordinated team approach to upgrade his ability to function. There are two basic requirements which must be met for inpatient hospital stay for rehabilitation care to be covered:

- *Reasonableness of Service.* The services must be reasonable and necessary (in terms of efficacy, duration, frequency and amount) for the treatment of the patient's condition.
- *Reasonableness of Setting.* It must be reasonable and necessary to furnish the care on an inpatient hospital basis, rather than in a less intensive facility such as a skilled nursing facility, or on an outpatient basis.

Preadmission Screening

Before a patient is admitted to a rehabilitation hospital for treatment a preadmission screening is normally done. This screening is a preliminary review of the patient's condition and previous medical record to determine if the patient is likely to benefit significantly from an intensive hospital program or extensive inpatient assessment.

While preadmission screening is a standard practice in most rehabilitation hospitals and many provide useful information for claims review purposes, the absence of a preadmission screening in a particular case is not adequate reasons for denying a claim. However, in a case where an inpatient assessment showed that a patient clearly was not a good candidate for an inpatient hospital program, the presence or absence of preadmission screening information is important in determining whether the inpatient assessment itself was reasonable and necessary. If preadmission screening information indicated that the patient had the potential for benefiting from an inpatient hospital program, a period of inpatient assessment could be covered, up to the point where it was determined that inpatient hospital rehabilitation was not appropriate, since preadmission screening cannot be expected to eliminate all unsuitable candidates.

Inpatient Assessment of Individual's Status and Potential for Rehabilitation

General. Coverage is available for inpatient assessment of a patient's potential for benefiting from an intensive coordinate rehabilitation program only if it was reasonable and necessary to perform the assessment in the hospital. This determination is made on the basis of information available in the patient's medical record. It is important to note that the assessment process is not merely a paperwork review, but rather an on-site professional review of the patient's condition by the necessary disciplines. Inpatient assessments conducted by a rehabilitation team through examination of the patient usually require between 3 to 10 calendar days, but on occasion may require more. This 3-10 day period is often one where the patient is receiving therapies rather than simple

screening assessments. Where more than 10 days are required, the case is carefully reviewed to ensure that such additional time was necessary. An inpatient assessment may be covered even if the assessment subsequently indicates that a patient is not suitable for an intensive inpatient hospital rehabilitation program, if the patient's condition on admission was such that an extensive inpatient assessment was considered reasonable and necessary for a final decision to be made on a patient's actual rehabilitation potential. Where the initial assessment has resulted in a conclusion that the individual is a poor candidate for rehabilitation care, coverage for further inpatient hospital care is limited to a reasonable number of days needed to permit appropriate placement of the patient. The fact that an individual received therapy prior to admission to a hospital for a rehabilitation program does not necessarily mean that the initial assessment period was not reasonable and necessary. However, if during a previous hospital stay an individual completed such a program for essentially the same condition for which inpatient hospital care is now being provided, the assessment period could be covered only if: (1) some intervening circumstances rendered such an assessment reasonable and necessary; or (2) the subsequent admission is to an institution utilizing techniques or technology not previously available or not available in the first institution.

Rehabilitative Hospital Screening

Rehabilitative care in a hospital, rather than a skilled nursing facility or on an outpatient basis, is reasonable and necessary for a patient who requires a more coordinated, intensive program of multiple services than is generally found out of a hospital. A patient who has one or more conditions requiring intensive and multi-disciplinary rehabilitation care, or who has a medical complication in addition to this primary condition, so that the continuing availability of a physician is required to ensure safe and effective treatment, probably requires a hospital level of rehabilitation care.

At the initial screening, the patient is deemed to require a rehabilitative hospital level of care if all of the following screening criteria are met.

Close Medical Supervision by a Physician With Specialized Training or Experience in Rehabilitation. A patient's condition must require the 24-hour availability of a physician with special training or experience in the field of rehabilitation. This need should be verifiable by entries in the patient's medical record that reflect frequent and direct, and medically necessary physician involvement in the patient's care; i.e., at least every 2-3 days during the patient's stay.

Twenty-Four-Hour Rehabilitation Nursing. The patient requires the 24-hour availability of a registered nurse with specialized training or experience in rehabilitation. This degree of availability represents a higher level of care than is normally found in a skilled nursing facility. While a skilled nursing facility patient may require nursing care, specialized rehabilitation nursing is generally not as readily available in such a facility.

Relatively Intense Level of Rehabilitation Services. The general threshold for establishing the need for inpatient hospital rehabilitation services is that the patient must require and receive at least 3 hours a day of physical and/or occupational therapy. (The furnishing of services no less than 5 days a week satisfies the requirement for *daily* services.) While most patients requiring an inpatient stay for rehabilitation need and

receive at least 3 hours a day of physical and/or occupational therapy, there can be exceptions because individual patient needs vary. In some instances, patients who require inpatient hospital rehabilitation services may need, on a priority basis, other skilled rehabilitation modalities such as speech-language pathology services, or prosthetic-orthotic services and their stage of recovery makes the concurrent receipt of intensive physical therapy or occupational therapy services inappropriate. In such cases, the 3-hour a day requirement can be met by a combination of these other therapeutic services instead of or in addition to physical therapy and/or occupational therapy. An inpatient stay for rehabilitation care can also be covered even though the patient has a secondary diagnosis or medical complication that prevents him from participating in a program consisting of 3 hours of therapy a day. Inpatient hospital care in these cases may be the only reasonable means by which even a low intensity rehabilitation program may be carried out. Secure documentation of the existence and the extent of complicating conditions affecting the carrying out of a rehabilitation program to ensure that inpatient hospital care for less than intensive rehabilitation care is actually needed.

Multi-Disciplinary Team Approach to Delivery of Program. A multi-disciplinary team usually includes a physician, rehabilitation nurse, social worker and/or psychologist, and those therapists involved in the patient's care. At a minimum, a team must include a physician, rehabilitation nurse and one therapist.

Coordinated Program of Care. The patient's record must reflect evidence of a coordinated program, i.e., documentation that periodic team conferences were held with a regularity of at least every 2 weeks to: (a) assess the individual's progress or the programs impeding progress; (b) consider possible resolutions to such problems; and (c) reassess the validity of the rehabilitation goals initially established. A team conference may be formal or informal; however, a review by the various team members of each other's notes does not constitute a team conference. The decisions made during such conferences, such as those concerning discharge planning and the need for any adjustment in goal or in the prescribed treatment program, must be recorded in the clinical record.

Significant Practical Improvement. Hospitalization after the initial assessment is covered only in those cases where the initial assessment results in a conclusion by the rehabilitation team that a significant practical improvement can be 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 is of practical value to the patient, measured against his condition at the start of the rehabilitation program. For example, a multiple sclerosis patient's condition may have deteriorated as a result of a secondary illness. To be restored to a level of function before the secondary illness, the patient may require an intensive inpatient hospital rehabilitation program. While such a program does not restore the level of function before multiple sclerosis developed, a return to presecondary illness level is considered to be a *significant practical improvement* in the condition.

Realistic Goals. While there may be instances where an intense rehabilitation program may enable a Medicare patient to return to the labor market, vocational rehabilitation is generally not considered a realistic goal for most aged or severely disabled individuals. The most realistic rehabilitation goal for most Medicare beneficiaries is self-care or independence in the activities of daily living; i.e., self-

sufficiency in bathing, ambulation, eating, dressing, homemaking, etc., or sufficient improvement to allow a patient to live at home with family assistance rather than in an institution. Thus, the aim of the treatment is achieving the maximum level of function possible.

Length of Rehabilitation Program

Coverage stops when further progress toward the established rehabilitation goal is unlikely or it can be achieved in a less intensive setting. In deciding whether further care can be carried out in a less intensive setting, both the degree of improvement which has occurred and the type of program required to achieve further improvement must be considered. In some cases, an individual may be expected to continue to improve under an outpatient program. There are other situations whether further improvement in the individual's ability to function relatively independently in the activities of daily living can be expected only if a multi-disciplinary team effort is continued.

While occasional home visits and other trips into the community are factors in determining whether continued stay in the hospital is necessary, such excursions are not alone a basis for concluding that further hospital care is not required. Planned home visits and trips to the community are frequently used to test the individual's ability to function outside the institutional setting and assist in discharge planning for the individual.

Christian Science Sanitaria

The services furnished by a Christian Science sanatorium are covered by the Plan if the institution is operated or listed and certified by the First Church of Christ, Scientist, Boston, Mass. Such a sanatorium qualifies as both a hospital and a skilled nursing facility. Thus, two separate types of benefits are payable for the services furnished: inpatient Christian Science sanatorium, whether as hospital services or as extended care services. Inpatient care in a Christian Science sanatorium, whether as hospital services or as extended care services, can either begin or prolong a spell of illness, but payment may not be made for services furnished by a Christian Science practitioner, a Christian Science nursing home, a Christian Science rest home, or a Christian Science visiting nurse service.

Sanatorium services are considered to be furnished by the sanatorium in its capacity as a hospital, unless the individual elects to have them treated as a sanatorium extended care services. The election must be in writing and signed by the individual or proper party on his behalf. Regardless of the capacity in which they are provided, these services are covered only if the patient is receiving skilled Christian Science nursing care, that is, intensive care or a lesser degree of skilled nursing care. Custodial care and rest and study are not covered.

Coverage and Exclusions

Covered sanatorium services, whether furnished by a Christian Science sanatorium in its capacity as a hospital or as a skilled nursing facility, include items and services ordinarily received by the inpatients of a Christian Science sanatorium, but only to the extent that such items and services are comparable to, or are the Christian Science equivalent of, items and services which would constitute inpatient hospital services if furnished by a hospital. Similarly, items and services comparable to those which are not covered as inpatient hospital services are not covered as sanatorium services. Thus, if the services of a Christian Science nurse are those of a private-duty nurse or attendant, they are not covered. Also the services of a Christian Science practitioner, who is the Christian Science counterpart of a physician, are not covered.

The primary items and services covered as sanatorium services include nursing and related services, bed and board, and certain supplies, equipment and appliances used as part of the Christian Science method of healing. Coverage of bed and board is on the basis of the standard private sanatorium accommodation. Where more expensive accommodations than the standard private accommodation are furnished, payment is made on the basis of the reasonable cost of the standard private accommodation. The patient may be charged the amount by which the customary charges for the standard and the deluxe accommodations differ.

Benefits

Hospital

The hospital must be a qualified hospital. See Definitions. These facilities fail to meet the definition of a hospital:

- Hotel, rest home, home for the aged, place for custodial care, nursing home or convalescent care home. Further excluded are sanatoria, health resorts, spa's, even though there may be nursing and medical staff.
- A facility primarily for care and treatment of drug and alcohol abuse.
- College and school infirmaries usually are not qualified hospitals.
- Institutions for children with emotional disorders do not qualify as hospitals.
- State schools or homes would not qualify as hospitals.

Room And Board

The hospital room and board charges covers bed, board and general nursing. Higher charges will be found for special purpose rooms. There may be per admission deductibles. The Schedule of Benefits sets forth the losses for determining the maximum room and board charge (average semi-private, e.g.) and the intensive care charge (three times average semi-private, e.g.).

A confinement is established with one day of confinement. DOA (dead on arrival) does not constitute confinement.

The plan will pay the hospital's average semi-private room and board rate. Where several semi-private rates are used, the most common or prevailing rate will be used. Where only private rooms are available, the acceptable charge is 80% of the lowest semi-private room rate. Private rooms are not allowed even if medically necessary.

Intensive Care

The intensive care unit (ICU) or special care unit is a special facility set up by most hospitals in order to care for the critically ill or injured. It has equipment to treat any possible emergency and is staffed by specially trained nurses and doctors.

Some hospitals have special ICU's devoted to the care of parties who have suffered from a heart attack or a serious burn. These are known as coronary care units or burn units.

Due to its unique nature, daily charges for confinement in an ICU unit are usually significantly higher than the charges for a semi-private room where most patients stay.

In view of the extra expense and necessity involved with this type of care, medical plans often provide higher benefits for ICU's than that allowed for the semi-private room.

The plan document shown in the Schedule of Benefits the limit of ICU expenses such as *3x Average Semi-Private or Reasonable and Customary Charges*.

Alternatives To Inpatient Care

Where such alternatives to inpatient care are appropriate and do not diminish the quality of care, they are paid as covered expenses.

Day Treatment Programs. Partial hospitalization for patients who would otherwise become or remain confined in full-time in-patient facilities. Programs may make a daily care charge and may charge for ancillary services such as treatment materials.

Early Discharge. Discharge for hospital sooner than would otherwise be possible by providing care at patient's home.

Hemophiliac Home Care. Instructional course and supplies of blood product, needles, syringes, etc. for self-infusion at home by hemophiliac patient who would otherwise require hospital confinement for transfusion.

Instructional Course for Patient. Education for patient and/or family members to help patient avoid complications of his/her disease.

Dialysis Facilities. Independently owned, limited day care facilities, which provide outpatient dialysis as their only service, have developed as a less expensive alternative to inpatient dialysis.

Birthing Centers. Provide the low-risk, healthy maternity patient with a less costly alternative to hospital delivery, while providing safety factors not present with home delivery.

Necessary Supplies and Services

These include all Miscellaneous Hospital Expenses, all hospital outpatient treatments for chronic condition, hospital emergency room care, dialysis and therapies.

Examples of Miscellaneous Hospital Services include:

Anesthetics and the Administration Thereof. Charges for anesthetic agents and the administration of said agents by or under the supervision of a physician are covered. Anesthesia services may include but not limited to general, regional, supplementation of local anesthesia, or other supportive services necessary to afford the patient the optimal anesthesia care during the procedure.

Blood Transfusions. Charges for blood transfusion trays, setups, or similar types of services, excluding professional fees, are covered. Charges for blood, plasma, platelets or other blood components or derivatives, and use of blood banks are also covered.

Blood Transfusion Credits. Payment of Miscellaneous Hospital Expenses benefit for blood, plasma, platelets or other blood components or derivatives, or use of the blood bank is contingent on an actual charge by the hospital or by an outside blood bank. Replacement of blood by a donor, Red Cross, or their replacement agency, producing a credit, revokes the charge. Benefits are not payable for unused blood that has been returned to the blood bank or when a credit appears on the bill.

Braces, Crutches and Prosthesis. Rentals or service charges for braces or crutches, excluding prostheses, used by the patient while hospital confined are covered. Charges for prostheses or crutches to be taken home after patient's discharge from hospital are not covered. Charges for braces are also excluded except where a special therapeutic brace is used in place of a cast.

Drugs and Medicine for Home Use. If a hospital bill specifically shows drugs or medicines were supplied for patient's home use, charges are not covered. When charges for drugs and medicines listed either on the day preceding or the day of discharge from the hospital are high, an attempt should be made to determine whether or not such supplies were furnished for the patient's use at home.

Hospital Admissions Kit. Some hospitals routinely furnish each newly admitted bed patient with a kit of personal hygiene and medical supplies such as a comb, facial tissue, mouthwash, skin lotion, talcum powder, toothbrush, toothpaste, alcohol, bedpan, plastic wash basin and cup, the thermometer for which a single charge is made. Charge for the admissions kit is reimbursable as a hospital charge without itemization.

Medical or Surgical Flat Rates. Some hospitals occasionally make a flat daily charge for such items as aspirin, bandages, surgical sponges, rubber tubing or alcohol and routine drugs not requiring a doctor's prescription. An average charge is made without regard to amount of supplies and materials actually used by patient. This charge is covered as a special hospital service.

Orthoptics. Orthoptic treatment and visual training is essentially training how to use both eyes together. Since it differs from physiotherapy and cannot be considered in that category as a covered expense, it falls into the general category of *medical treatment*, a covered expense. Orthoptics by a hospital technician during a period of inpatient confinement for which the hospital makes a charge is reimbursable. Orthoptics by an ophthalmologist constitutes medical care and treatment.

Outside Agency Services. Some hospitals which lack facilities for performing x-rays, specialized laboratory work, CAT scans and providing certain medications or drugs use for services of independent contractors who may be physically located outside of the hospital. These charges are covered if the services were such as are customarily provided in a hospital and were rendered while the patient was hospital confined.

Physicians' Services. Charges for the professional services of physicians are not reimbursable as special hospital services.

Therapy. Any of the following services (exclusive of physician's services), which include use of special equipment, and work of technicians, therapists, or nurses, appearing on hospital bills are covered as special hospital services when separately listed:

- Occupational therapy.
- X-ray therapy.
- Physical therapy.
- Speech therapy.
- Electroshock therapy.
- Speech pathology.
- Respiratory therapy.

Orthopedic Items. Where the hospital bill includes such charges as a dorsal column stimulator, a hip prosthesis, a pacemaker or a heart valve, e.g., such charges should be considered as other covered medical expenses and *not* as hospital extras.

Special Diets. These should be covered as hospital extras.

Surcharge for Nonresidents. Such charges should be covered as a hospital extra.

Speech Therapy

Medical Review Considerations. The following guidelines are helpful in reviewing speech therapy bills:

1. Disorder Typically Not Covered.

- Stuttering (except neurogenic stuttering caused by brain damage)
Fluency Disorder.
Cluttering.
Disprosody.
Disfluency.
- Myofunctional Disorders
Tongue Thrust.
- Behavioral/Psychological Speech Delay

2. Maintenance Programs

Pay claims only when the specialized knowledge and judgement of a qualified speech-language pathologist is required to design and establish a maintenance program. The maintenance program is established when review indicates it has been designed for the patient's level of function and instructions to the patient and supportive personnel have been completed for them to safely and effectively carry them out. The review must give reasonable assurances that this has occurred. After that point, the service are not reasonable and necessary.

3. Group Treatment

Generally, group therapy treatment and attendance at social or support groups, such as stroke clubs or lost cord clubs, are not payable. Ensure that the *reasonable and necessary* requirements are met.

4. Total Laryngectomy

Surgical removal of the larynx. Review includes assessment and any treatment necessary to establish a means of communication using esophageal speech, an artificial larynx (electronic or pneumatic device), a tracheoesophageal puncture prosthesis, and/or other alternate communication methods.

5. Partial Laryngectomy

Surgical removal of part of the larynx. Review includes the voice problems that require assessment and treatment. Review for rehabilitation includes the assessment and type of treatment required for the voice disorders.

6. Total Glossectomy

Surgical removal of the tongue. Total glossectomy results in articulation problems that require assessment and may require treatment. Review includes assessment and type of treatment for the articulation disorders.

7. Partial Glossectomy

Surgical removal of part of the tongue. Review should indicate the articulation problems that require assessment. Review for articulation treatment involves instruction of compensatory techniques and alternate communication methods if needed.

8. Congenital Disorders

Review must always substantiate need, e.g., no previous treatment; the patient's communicative capabilities have recently deteriorated; new, special techniques or instruments have become available; or intervening medical complications have affected communication. Approve claims for maintenance or short-term treatment only if objective review supports that need.

9. Alzheimer's Disease

Objective review must indicate the patient's condition, alertness and mental awareness. Review must justify that services are needed to establish a reasonable and necessary maintenance program. Review these claims carefully for medical necessity.

10. Chronic Condition

Approve claims for patients with chronic conditions such as muscular dystrophy, ALS, Parkinson's Disease or Myasthenia Gravis if they establish a

maintenance program. Approve claims for reasonable and necessary short-term intervention to improve oral and laryngeal strength, speech intelligibility, or vocal intensity, but only when the review supports the need to increase functions, or to establish a maintenance program.

Commonly Used Terms in Speech Therapy

Agnosia. Inability to attach meaning to sensory information although the physiologic receptor mechanism is intact.

Agrammatism. Impairment of the ability to produce words in their correct sequence; difficulty with grammar and syntax.

Agraphia. Disorder of writing. It may result from a central nervous system lesion or from lack of muscular coordination.

Anomia. Loss of the ability to identify or to recall and recognize names of person, places or things.

Aphasia. Communication disorders caused by brain damage and characterized by complete or partial impairment of language comprehension, formulation and use. It excludes disorders associated with primary sensory deficits, general mental deterioration, or psychiatric disorders. Partial impairment is often referred to as dysphagia.

Apraxia. (1) Disruption in the ability to transmit a motor response along a specific molality; involves disruption of voluntary or purposeful programming of muscular movements while involuntary movements remain intact; characterized by difficulty in articulation of speech, formulation of letters in writing, or in movements of gesture and pantomime. (2) In speech, a nonlinguistic sensorimotor disorder of articulation characterized by impaired capacity to program the position of speech musculature and the sequencing of muscle movement (respiratory, laryngeal and oral) for the volitional production of phonemes.

Dysarthria. Term for a collection of motor speech disorders due to impairment originating in the central or peripheral nervous system. Respiration, articulation, phonation, resonance and/or prosody may be affected; volitional and automatic actions, such as chewing and swallowing, and movements of the jaw and tongue may also be deviant. It excludes apraxia and functional or central language disorders.

Dysphagia. Difficulty in swallowing. It may include inflammation, compression, paralysis, weakness or hypertonicity of the esophagus.

Generalization. (1) In conditioning, the eliciting of a conditioned response by stimuli similar to a particular conditioned stimulus. (2) Transfer of learning from one environment to a similar environment; the more similar the environment of situations, the greater transfer takes place.

Hard Glottal Attack. Forceful approximation of the vocal folds during the initiation of phonation.

Intonation. Linguistic system within a language which is concerned with pitch, stress and juncture of the spoken language; a unit with specific communicative import, such as interrogation, exclamation and assertion.

Lexicon. Total accumulation of linguistic signs, words or morphemes, or both, in a given language; the list of all the words in a language.

Morphology. Components of grammar concerned with the formation of words, the smallest meaningful unit in a language, as a bridge between phonology and syntax.

Obturator. (1) Any structure which occludes an opening. (2) Prosthetic appliance, similar to dental plate, that forms an artificial palate to cover a cleft palate, designed so that the musculature of the palate and pharynx are able to contract around it.

Paraphasia. Any error of commission modifying a specific word (sound or morpheme substitution) or of work substitution in the spoken or written production of a speaker or writer.

Perseveration. Tendency to continue an activity, motor or mental, once started, and to be unable to modify or stop even though it is acknowledged to have become inappropriate.

Phoneme. Shortest arbitrary unit of sound in a given language that can be recognized as being distinct from other sounds in the language.

Phonological. Component of grammar determining the meaningful combinations of sounds.

Pitch. Acuteness or gravity of a tone, dependent upon the frequency of the vibrations producing it and their intensity and overtone structure. The greater the number of vibrations per unit of time, the higher the pitch and more acute the tone.

Pragmatics. Functional use of language in context. It includes such factors as intention in communication; sensorimotor actions preceding, accompanying, and following the utterance; knowledge shared in the communicative dyad; and the elements in the environment surrounding the message.

Prosody. (1) Physical attributes of speech that signal linguistic qualities such as stress and intonation. It includes the fundamental frequency intensity of the voice, and the duration of the individual speech sounds. (2) A melody of speech determined primarily by modifications of pitch, quality, strength, and duration; perceived primarily as stress and intonational patterns.

Psychoacoustics. Combined disciplines of psychology and acoustics concerned with the study of man's response of sound.

Semantic. Component of grammar concerned with word meanings and meaningful sentences.

Syntactic. Component of grammar concerned with grammatically well formed structures.

Cardiac Rehabilitation Therapy

These are essentially controlled exercise clinics. The treatment regimen is limited to three heart conditions:

- Stable angina pectoris.
- Coronary bypass surgery.
- Recent myocardial infarction.

The clinic must meet certain standards:

- Physician-operated and supervised.
- Emergency equipment is available (oxygen, cardiopulmonary resuscitation equipment, defibrillator, e.g.).
- Area is exclusively used for heart clinic.
- Staff must be trained and employees of a hospital or physician's office.

Before the covered person is permitted to be in a cardiac rehabilitation clinic stress testing is required. Especially needed is the evaluation of chest pains. The evaluations involve the treadmill and EKG monitor.

There are other services offered by such a clinic:

- Psychological testing and psychotherapy.
- Physical and occupational therapy.
- Education services (diet, exercise, sexual activities, nutrition, e.g.).

The duration of such a program is usually three sessions per week up to a maximum of thirty-six weeks.

The medical goals of a cardiac rehabilitation are these:

- Stable level of exercise tolerance without ischemia or dysrhythmia.
- Symptoms of angina or dyspnea are stable at the patient's maximum exercise level.
- Resting blood pressure and heart rate are within normal limits.
- Stress test is *not* positive during exercise.

Cardiovascular Pulmonary Therapy

Both of these terms refers to increasing the body's maximum capacity for using oxygen by means of planned (prescribed) physical activity of a specific and necessary intensity and duration. Aerobic (endurance) activity performed regularly has the following training effect: increased amount of blood in the system and amount of oxygen-carrying hemoglobin; improved ability of muscle cells to process oxygen; increased working space and efficiency of the lungs; more flexible blood vessels with less tendency to accumulate atherosclerotic deposits; increased collateral circulation. A conditioned cardiovascular pulmonary system has an increased physical working capacity and can accomplish a specific amount of work with less effort. This is evidenced by reductions in resting and working blood pressures and heart rates after conditioning.

The exercise activity used to achieve conditioning appears to produce the following effects in and of itself in addition to the training effect: reduced blood cholesterol and/or triglycerides levels in some people; reduced blood sugar level in some diabetics; increased capacity for withstanding stress and, consequently, stress associated medical disorders.

Occupational Therapy

Involves a prescribed therapy program, such as practical woodworking and handcraft projects, selected by patients for functional exercise with hand or foot-operated tools. Purpose of this treatment is to increase greater range of motion among individual joints, to utilize physical gains, and to assist patient in attaining greater self-sufficiency and productivity. Occupational therapy differs from physiotherapy in that it does not involve application of treatment by a therapist. It is occupation performed by patient under therapist's guidance and supervision. Such treatment cannot be deemed to be medically necessary.

Psychotherapy by Social Worker

Psychotherapy is a method of treatment for nervous and mental disorders which is designed to produce a response by mental rather than by physical effects. It includes the use of suggestion, persuasion, re-education, reassurance and support. Therapeutic services of a psychiatric social worker, not being similar to X-ray therapy, radium therapy and physiotherapy, are not deemed to be medically necessary.

Educational Therapy

A prescribed therapy program of remediation for a learning disabled child. Diagnosis of a learning disability in most cases involves team evaluation by specialists in medicine, psychology and psychoeducation. The team, after ruling out ill health, psychiatric disorders and severe brain damage, does a psychoeducation evaluation. The team's final diagnostic report will commonly include such phrases as *neurologically based, minimal brain (of cerebral) dysfunction, has perceptual/motor/visual deficiencies, and/or has difficulties in visual/perception/spatial/psycholinguistic functioning* when identifying a learning disability which has neurophysiological causes.

Therapy for the neurophysiological causes of learning disabilities is basically educational in nature and involve retraining in the areas of neurophysiological deficiency. Remediation specific to the individual child is prescribed by the diagnostic team. It is usually administered by a psychologist or a teacher with special training. If a concurrent psychiatric problem exists, psychotherapy may also be recommended.

The out-of-hospital therapeutic service of an educational therapists, who uses educational techniques and materials as a means to guide the child in the retraining process, not being similar to x-ray therapy, radium therapy and physiotherapy, are not covered.

X-Ray Therapy

This therapy involves the following:

- X-Ray.
- Radium.
- Radioactive isotope.

The covered charges include the materials and the services of the technician.

Radiotherapy

Radiotherapy uses x-rays to treat an illness. Radiotherapy can only be administered by, or under the supervision of, a physician especially skilled in choosing treatment method, localizing precise treatment area, and determining quantity and duration of treatment for effective safe dosage. Physician may use computer and may employ radiological physicist in performing these services. Treatment method selected to apply radiotherapy to body tissues will be one of the following:

Teletherapy. Massive doses administered at distance from body. Beam of rays is directed from machine to localized body site requiring destruction. Includes x-ray therapy, radium therapy, cobalt therapy, linear acceleration radiation, and other high energy modalities.

Brachytherapy. Radioactive substances in tiny containers applied to body or inserted in body cavity or into body tissues requiring destruction. Radiating substances must be removed as soon as proper dosage is achieved. Includes intracavitary implant or interstitial insertion of radium, iridium, radon seeds, etc.

Therapeutic Nuclear Medicine. Liquid state radioactive isotope form of substance introduced to body by ingestion or injection. Substance used has affinity for specific body cells requiring destruction and concentrates in those cells, e.g., radioactive iodine concentrates in thyroid gland. Radioactive isotopes are more frequently used for diagnostic studies (scanning, imaging) than for therapy.

Physical Therapy

Such will be covered regardless of where such therapy was performed:

- Outpatient Setting

Clinic, rehabilitation center.

- Therapist's Office
Such must be a qualified therapist with an independent practice.
- In Patient Setting
Hospital or convalescent center.

Such will be covered as incidental to a physician's service so long as they were provided under the direct supervision of a physician.

Such therapy must meet certain conditions:

- Follow a written physician-designed regimen.
- Of such complexity as to require an on-site qualified therapist.
- Must be reasonable hope of success.
- Must meet standards of medical practice.
- Must be reasonable and necessary to treatment of the patient.

Outpatient Physical Therapy Screens. The following screens are helpful should the examiner wish to establish reasonable and customary guides for certain therapies.

LEGAL CONSIDERATIONS

Hospital, which was psychiatric only, gained plan credibility as an accredited hospital because it had a contract with a nearby hospital for surgery facilities as well as x-ray, and laboratory services.

When the hospital has no surgery or x-ray facilities on site but has availability to such by the so-called *affiliation contracts*, will the plan's requirement of such facilities be met? The court held that it would.

Participant was treated in a remedial or rehabilitative facility. Plan denied the charges because the facility did not have 24-hour nursing or surgery facilities. The court upheld the plan's denial.

Where psychiatric hospital did not have a major surgery facility and had no arrangement for such with a nearby hospital, it failed to be a hospital within the plan's definition thereof.

Participant was confined to a state-owned mental hospital because of mental retardation caused by a diabetic-coma. The issue was whether the hospital was one which met the definition in the plan. The court held that it was a qualified hospital because it had diagnostic and therapeutic facilities; also, participant's residential care in the home was incidental to his need for hospitalization.

Dependent's child was admitted to the Devereaux Foundation to assist her alleged mental problems. The Foundation charged a flat monthly fee. Plan denied the charges because her condition was not mental and the Devereaux Foundation facility was not a hospital. The court held that a behavior disorder, whether or not organic, is to be covered as a mental illness. Plan wanted to *not* treat that portion of the facility's flat fee related to custodial care; the *global* fee was to pay for *global* care which was medically necessary, which meant that the plan lost.

Participant was being treated in a tubercular sanitarium. Did the sanitarium qualify as a hospital so as to gain a plan benefit? The sanitarium showed it had:

- Surgery facilities.

- 24-hour nursing.
- Round-the-clock physician on call.

Hospital Association indicated it would *not* qualify. The court held for the participant by believing the evidence and not Association's book.

A hopelessly retarded child was placed in a state mental institution. The cost of the support to the parents was \$50 per month. Were such charges payable as health care claims? The court held *no*, the plan did not have to pay since they were custodial in nature.

The participant was in a convalescent wing of a regular hospital. The plan excluded convalescent care. Would such claims be payable? Because hospital's records were *blurry* as to the regular and convalescent wing, the plan was held liable for the claim.

Participant's hospital lacked x-ray and surgical facilities on-site but had them available by *transfer agreement*. Would such agreement meet the plan's definition? The court held that it would. Claim then became payable.

The nursing or convalescent care home was connected to a regular hospital by a covered walkway. The convalescent care center lacked a surgery facility. Did it qualify as a hospital since it was so close to the hospital? The court said *no*, it would not so qualify.

Hospital had surgery facilities but only for minor surgery, lacerations, etc. When Plan denied, Participant sued. Court held that the hospital failed to meet the plan's definition. That it had a contract for major surgery with a nearby hospital did not count.

Participant, following an amputation, had care in a facility for stump conditioning, gait training and observation. The institution was licensed as a rehabilitation facility, not as a hospital. Court held the claim was properly denied under the hospital definition.

Dependent child confined to a Devereaux Foundation facility. Plan believed it was not a defined hospital; Participant believed otherwise. If the Institute was primarily for training, rest or the aged, it was not covered. The plan was reluctant to treat it as a hospital because the institute was unable to itemize its charges. The court said the institute's accounting practices were not of significance. Plan held to be liable for the claim.

Contest hinged around the definition of a hospital, because it had no surgery facilities; *access* to such surgical facilities by contractual arrangement. The court held the hospital failed to meet the plan's definition.

Plan covered hospital benefits only. Participant was transferred from the hospital wing to the skilled nursing wing of a large medical complex. Care in the skilled nursing wing was not covered even though the skilled nursing wing was in some building.

Plan turned back claim because hospital failed as an approved facility in that (a) it had no surgical facilities but (b) no 24-hour RN duty nurse. The defense showed that there was a surgical facility; it just was not ever used. Also, a nurse was either there or *on call*. Court held that substantial compliance resulted.

Child's psychiatric care facility failed to meet the definition of hospital:

- Not primarily engaged in surgical/diagnostic care.
- Accreditation as children's psychiatric facility does not meet the plans accreditation requirements. The court, as a consequence, held the claim deniable.

Hospital definition required surgery facilities and that it treat the *sick and hurt*. A psychiatric facility met both conditions in this way:

- *Surgery*-by a contract with a nearby hospital.
- *Sick and Hurt*-a mental illness is an illness as much as a non mental illness.

Hospital had a single shift nurse who was *on call* for remaining two shifts; it also had a contract with a nearby hospital for surgery. It was a psychiatric hospital. The plan believed that the psychiatric facility failed the plan definition. The court agreed that it failed to meet the plan's definition.

Psychiatric hospital met the operating facility requirements by means of a contract with a nearby hospital. As written, the court held the plan's language ambiguous; had the court wanted such surgical contracts to be ineffective, it should have said so.

Participant, age 84, was transferred by the hospital to its extended care facility, directly across the street. While in the extended care facility, she became critically ill; her physician ordered 24-hour nursing care. Due to dearth of RNs, the extended care facility used an LPN. Plan denied alleging that extended care facility failed as a hospital. Reasons were these:

- No operating room.
- No laboratory.
- No 24-hour RN.

Court held that since extended care facility offered basically the same care as a hospital, the claim should be paid.

Participant wanted his stay at a nursing home paid because the nursing facility was a *hospital*. The court held for the plan in that the nursing facility failed as a hospital:

- It was licensed as a nursing home.
- It did not have major surgery facilities.
- It did not have acute care facilities.
- It did primarily rehabilitative care.

Where participant was in a custodial care institution, the plan could yet be liable for covered charges therefrom where such were identifiable.

- Prescription drugs.
- Physician charges.
- Nursing charges.

Dependent child attended a school of remediation; the son had a severe learning disability caused by brain damage due to childhood accident. The school clearly failed the test of hospital set forth by the plan. The court held that the expenses of the school were properly excluded.

Dependent child was confined to a juvenile psychiatric institute. The facility did not meet the plan's definition because it did not have 24-hour nursing care.

Participant was treated for emotional reasons in a psychiatric hospital. Plan paid only when care was on a regular, full-service hospital. Court held that expenses in a psychiatric hospital were not covered.

Participant, a veteran, received care in a VA hospital without a charge to the Veteran. The federal government sued the insurer to get paid alleging it could charge the plan. The plan excluded expenses which, in the absence of coverage, not be made. Court held that the plan did not have to pay.

Hospital had an attached skilled nursing facility. Plan paid regular hospital, excluded convalescent care facilities. To facilitate treatment, Participant was sent from the regular to the skilled nursing facility; primary reason was the *tilt table* in the skilled nursing facility. Plan picked up on the deficient facilities and denied. Plan was made to pay but did not have to pay any punitive damages.

Plan covered hospital care where facility was properly licensed. Patient transferred from hospital ward to an extended care ward which was physically part of the facility (i.e., adjoining wing). Claim was denied and appealed and contested. Plan held it was not payable because the extended facility had no surgery facilities. Court held the entire wording to be ambiguous and held for the patient. Claim was allowed.

Participant was treated in the 8th floor for alcohol withdrawal. He was transferred to the 9th floor for counseling. Plan excluded the 9th floor charges because of custodial exclusion. Its logic was that Participant could have had such counseling on an outpatient basis. Court agreed that charges were properly excluded.

Facility cared for emotionally disturbed children. It did not have surgery and did not have a 24-hour registered nurse (RN), although it did have 24-hour care of a nursing staff, none of whom were RN's. Plan defined hospital to include surgery facilities and nursing care; RN was not specified. Court said hospital met definition; surgery definition could be waived; nursing was undefined so non-RN could be accepted. Plan was not held subject to punitive damages, however.

Plan covered care in intensive care units and defined such care in the plan document. Plan also excluded care in a coronary care unit. Participant, while in a coronary care unit, received the type of care described in the intensive care unit. Plan denied; participant sued. Court held that plan should pay. Logic of court was that *meaning* should prevail and not *labels*.

Mental and nervous care was provided at a *boys home* which failed the plan's hospital definition. The Participant's argument was the *boys home* had arrangements for medical diagnosis and surgery in related/connected facilities. Court, however, said that such off-premises care were not anticipated or contemplated by the Participant when his boy was placed therein. Claim was held to be deniable.

Plan document made usual distinction between a hospital and a convalescent care center. The participant's convalescent care charges were made as convalescent and not as regular hospital charges. Substantial loss of expense reimbursement prompted participant to sue. Convalescent care center clearly held itself out to be such. Court held plan properly paid the reduced benefits.

Plan covered expenses for hospital, skilled nursing and home health care. The participant wished that a rehabilitation facility which offered transitional care to medically stable patients be deemed a hospital. The court held that such rehabilitation facility failed as either a hospital or a skilled nursing home.

The UB-82 came in showing a San Diego address and a phone number and EIN for a presumably San Diego hospital. Not so. The hospital was a Mexican hospital doing special cancer treatments. After the claim was duly processed as though the hospital were accredited, the error was discovered by an excess loss audit. The plan supervisor ended up having to pay the claim.

Plan Document Language

Hospital

The term *Hospital* shall mean an institution which makes charges and is engaged primarily in providing medical care and treatment to sick and injured persons on an inpatient basis at the patient's expense which fully meets all the requirements set forth below:

1. An institution operating in accordance with the law of the jurisdiction in which it is located pertaining to institutions identified as hospitals. It is primarily engaged in providing diagnosis, treatment and care of injured or sick persons by or under the supervision of a staff of physicians or surgeons for compensation from its patients on an inpatient basis. It continuously provides twenty-four (24) hour nursing services by graduate registered nurses on the premises; maintains facilities on the premises for major operative surgery and is not, other than incidentally, a nursing home, a place for rest, a place for the aged, a place for the mentally ill or emotionally disturbed, or a place for the treatment of drug addiction, or alcoholism. On call or contracted nursing will not be deemed on premises; surgery facilities available by contract will not be deemed on premises.
2. It is accredited by the Joint Commission on Accreditation of Hospitals or is recognized by the American Hospital Association and is qualified to receive payments under the Medicare program.

3. It is a psychiatric hospital, as defined by Medicare, which is qualified to participate in and is eligible to receive payments under and in accordance with the provisions of Medicare.

Intensive Care Unit

The term *Intensive Care Unit* means a section, ward, or wing within the hospital which is separated from other facilities and meets all of these requirements:

1. Is operated exclusively for the purpose of providing professional medical treatment for critically ill patients.
2. Has special supplies and equipment necessary for such medical treatment available on a standby basis for immediate use.
3. Provides constant observation and treatment by registered nurses or other highly trained hospital personnel.

Convalescent Nursing Home

The term *Convalescent Nursing Home* means only an institution meeting the following requirements:

1. Operates pursuant to law and is primarily engaged in providing for compensation from its patients the following services for persons convalescing from sickness or injury: room, board and twenty-four (24) hours-a-day nursing service by one or more professional nurses and such other nursing personnel as are needed to provide adequate medical care.
2. Provides restorative services to help patients meet a goal of self-care in daily living activities.
3. Provides such services under the full-time supervision of a proprietor or employee who is a physician or a registered graduate nurse (R.N.).
4. Maintains adequate medical records.
5. Is supervised by a physician or has an established agreement for the services of a physician to be readily available.

The term *Convalescent Nursing Home* shall not include any institution, or part thereof, which is principally used as a rest facility, a facility for the aged, or a facility used principally for the care of alcohol or drug abuse.

