Long-Term Acute Care (LTAC)
Clinical Coverage Criteria

Overview

Long-Term Acute Care (LTAC) facilities provide care for those with complex medical conditions who require long-term, highly skilled nursing and rehabilitation services.

Policy

This Policy applies to the following Fallon Health products:
☒ Commercial
☒ Medicare Advantage
☒ MassHealth ACO
☒ NaviCare
☒ PACE

Fallon Health follows guidance from the Centers for Medicare and Medicaid Services (CMS) for organization (coverage) determinations for Medicare Advantage plan members. National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Local Coverage Articles (LCAs) and guidance in the Medicare manuals are the basis for coverage determinations. When there is no NCD, LCD, LCA or manual guidance, Fallon Health Clinical Coverage Criteria are used for coverage determinations.

Medicare does not have an NCD for Long-Term Care Hospitals. National Government Services, Inc. does not have an LCD or LCA for Long-Term Care Hospitals (MCD search 06-25-2021).

For plan members enrolled in NaviCare and PACE plans, Fallon Health follows Medicare guidance for coverage determinations. In the event that there is no Medicare guidance or if the plan member does not meet medical necessity criteria in Medicare guidance, Fallon Health will follow guidance published by MassHealth. When there is no Medicare or MassHealth guidance, Fallon Health Clinical Coverage Criteria are used for coverage determinations for NaviCare members. Each PACE plan member is assigned to an Interdisciplinary Team. When there is no Medicare or MassHealth guidance, the member's Interdisciplinary Team is responsible for coverage determinations.

Fallon Health requires Prior Authorization for admission to Long-Term Acute Care Facilities (LTAC) and continued stay is subject to review. The below criteria must be met for admission as supported by the treating provider(s) medical records:

1. The member's medical needs are complex and require extensive nursing and rehabilitation (e.g. ventilator weaning, multiple IV therapies)
2. The member requires greater than 6.5 hours of nursing interventions and treatments each day
3. If the member's condition allows it is expected the member participate in 1 to 3 hours of skilled rehabilitation services 5 days a week
4. The member requires and receives daily direct Physician interventions

Continued stay is concurrently reviewed by Fallon Health and the need for continued service must clearly be documented in the medical records.

Covered Services: (Please note these are general examples of what is covered in the per diem and not necessarily all inclusive and may be subject to the particular contract with the facility)

- Ambulance transportation directly related to the plan of care
- Bariatric equipment
- Daily nursing care
- Daily therapies (physical, occupational, speech, respiratory, etc.)
- Dialysis
- Discharge planning
- Durable medical equipment (any specialized DME required for patients should be requested via prior authorization):
  - Non-disposable single patient use DME provided as part of an individual member's inpatient stay is included in the per diem rate and should be sent home with the member upon discharge from the facility. This includes (but is not limited to) bed pans, emesis basins, splints, and tens.
  - Non-disposable/multi-patient use DME provided as part of an individual member's inpatient stay that is owned or rented by the facility is included in the per diem rate and should not be sent home with the member upon discharge. This includes (but is not limited to) wheelchairs, walkers, and canes.
  - If the Plan purchases any DME on behalf of an individual member receiving care within the facility (either purchased from the LTAC facility or from an independent DME provider), those items must be sent home with the patient upon discharge from the facility. These items include but are not limited to: Customized orthotics, prosthetics, adaptive devices, and bariatric equipment.
  - The LTAC facility agrees to not delay obtaining authorization and ordering any custom-type device that is medically necessary to promote discharge and rehabilitation of the member. This type of DME must be authorized by the Plan and ordered through a Plan-contracted DME provider.
- Enteral/parenteral nutrition and supplies
- Infusion pumps and services
- Laboratory services
- Medical/surgical supplies and equipment
- Medications
- Non-custom orthotics or prosthetics
- On-site/mobile x-ray
- Private room, when medically indicated
- Semi-private room and board
- Social services
- Wound vacuum

Exclusion: (please note these are general examples of what is not covered in the per diem and not necessarily all inclusive and may be subject to the particular contract with the facility. These services may require separate authorization):

- Ambulance transportation for services not related directly to the plan of care (Please see Fallon Health's Transportation Service Payment Policy for further rules)
- Custom orthotics or prosthetics
- Professional charges for physician services
- Radiation/Chemotherapy

Exclusions

- Any Long-Term Acute Care admission that does not meet the above criteria.

References

1. Kahn JM, Werner RM, Carson SS, Iwashyna TJ. Variation in long-term acute care hospital use after intensive care. Med Care Res Rev. 2012 Jun;69(3):339-50.
2. Hall WB, Willis LE, Medvedev S, Carson SS. The implications of long-term acute care hospital transfer practices for measures of in-hospital mortality and length of stay. Am J Respir Crit Care Med. 2012 Jan 1;185(1):53-7.
3. Kahn JM, Werner RM, David G, et al. Effectiveness of long-term acute care hospitalization in elderly patients with chronic critical illness. Med Care. 2013 Jan;51(1):4-10.
4. Kahn JM, Barnato AE, Lave JR, et al. A Comparison of Free-Standing versus Co-Located Long-Term Acute Care Hospitals. PLoS One. 2015 Oct 6;10(10):e0139742.
5. Velazco JF, Ghamande S, Surani S. Role of long-term acute care in reducing hospital readmission. Hosp Pract (1995). 2017 Oct;45(4):175-179.

Policy history

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Approval(s):	Technology Assessment Committee: 05/25/2016 (new policy), 05/24/2017 (added/clarified services included in the per diem), 05/15/2018 (annual review, no updates), 05/22/2019 (updated references) *06/25/2021 (Added clarifying language related to Medicare Advantage, NaviCare and PACE under policy section.*

Not all services mentioned in this policy are covered for all products or employer groups. Coverage is based upon the terms of a member's particular benefit plan which may contain its own specific provisions for coverage and exclusions regardless of medical necessity. Please consult the product's Evidence of Coverage for exclusions or other benefit limitations applicable to this service or supply. If there is any discrepancy between this policy and a member's benefit plan, the provisions of the benefit plan will govern. However, applicable state mandates take precedence with respect to fully-insured plans and self-funded non-ERISA (e.g., government, school boards, church) plans. Unless otherwise specifically excluded, federal mandates will apply to all plans.