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:

☒ Medicare Advantage (Fallon Medicare Plus, Fallon Medicare Plus Central)
☒ MassHealth ACO
☒ NaviCare HMO SNP
☒ NaviCare SCO
☒ PACE (Summit Eldercare PACE, Fallon Health Weinberg PACE)
☒ Community Care

Fallon Health requires Prior Authorization for admission to Long-Term Acute Care Facilities (LTAC) and continued stay is subject to review.

Medicare Advantage (Fallon Medicare Plus, Fallon Medicare Plus Central)
Fallon Health complies with CMS's national coverage determinations (NCDs), local coverage determinations (LCDs) of Medicare Contractors with jurisdiction for claims in the Plan's service area, and applicable Medicare statutes and regulations when making medical necessity determinations for Medicare Advantage members. When coverage criteria are not fully established in applicable Medicare statutes, regulations, NCDs or LCDs, Fallon Health may create internal coverage criteria under specific circumstances described at § 422.101(b)(6)(i) and (ii).

Section 1886(d)(1)(B)(iv)(I) of the Act defines a LTCH as "a hospital which has an average inpatient length of stay (as determined by the Secretary of Health and Human Services (the Secretary)) of greater than 25 days." Medicare does not have an NCD for Long-Term Care Hospitals. National Government Services, Inc., the Part A/B Medicare Administrative Contractor with jurisdiction in the Plan's service area does not have an LCD for Long-Term Care Hospitals (Medicare Database Search 04/22/2024).

MassHealth ACO
Fallon Health follows Medical Necessity Guidelines published by MassHealth when making medical necessity determinations for MassHealth members. In the absence of Medical Necessity Guidelines published by MassHealth, Fallon Health may create clinical coverage criteria in accordance with the definition of Medical Necessity in 130 CMR 450.204.

Massachusetts licenses hospitals as acute or non-acute under regulations at 105 CMR 130.000. Nonacute hospitals include Chronic Care Hospitals, Rehabilitation Hospitals, Specialty Care Hospitals and others. Chronic Care hospitals are defined as hospitals with an average length of patient stay greater than 25 days. These hospitals typically provide longer-term care, such as ventilator dependent care. Medicare classifies Chronic Care Hospitals as Long-Term Acute Care Hospitals, using the same 25-day threshold.

MassHealth classifies Chronic Care Hospitals as Chronic Disease Hospitals. The Chronic Disease Hospital Group consists of PAM Health Specialty Hospital, New England Sinai Hospital, Vibra Hospital of Western Mass, and Spaulding Hospital-Cambridge.[1] Franciscan Hospital for Children provides both pediatric chronic care and rehabilitation services.

MassHealth regulations at 130 CMR 435.409 have level of care criteria for Chronic Disease Hospitals:

(B) Level-of-Care Criteria. In determining medical necessity, the Division or its agent applies the criteria in 130 CMR 409(B)(1) and (2). In addition, the Medicare Adult Appropriateness Evaluation Protocol (AEP) utilized by the Peer Review Organization (PRO) is used as a guide. To be medically necessary, an admission to or continued stay in a chronic disease or Massachusetts Department of Public Health hospital must meet one of the following two criteria, in compliance with 130 CMR 450.204.

(1) The member must require services that:
   a) can be provided safely and effectively at a chronic disease hospital level. Such services must be ordered by a physician and documented in the member's record; and
   b) include at least daily physician intervention or the 24-hour availability of medical services and equipment available only in a hospital setting.

(2) The member's medical condition and treatment needs are such that no effective, less costly alternative placement is available to the member.

NaviCare HMO SNP, NaviCare SCO
For plan members enrolled in NaviCare, Fallon Health first follow's CMS's national coverage determinations (NCDs), local coverage determinations (LCDs) of Medicare Contractors with jurisdiction for claims in the Plan's service area, and applicable Medicare statutes and regulations when making medical necessity determinations.

When coverage criteria are not fully established in applicable Medicare statutes, regulations, NCDs or LCDs, or if the NaviCare member does not meet coverage criteria in applicable Medicare statutes, regulations, NCDs or LCDs, Fallon Health then follows Medical Necessity Guidelines published by MassHealth when making necessity determinations for NaviCare members.

PACE (Summit Eldercare PACE, Fallon Health Weinberg PACE)
Each PACE plan member is assigned to an Interdisciplinary Team. PACE provides participants with all the care and services covered by Medicare and Medicaid, as authorized by the interdisciplinary team, as well as additional medically necessary care and services not covered by Medicare and Medicaid. With the exception of emergency care and out-of-area urgently needed care, all care and services provided to PACE plan members must be authorized by the interdisciplinary team.

Fallon Health Clinical Coverage Criteria

The below criteria must be met for admission to a long term acute care facility 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

[1] NOTICE OF FINAL AGENCY ACTION SUBJECT: MassHealth: Payments for Chronic Disease and Rehabilitation Hospital Services Effective October 1, 2023. Available at: https://www.mass.gov/lists/special-notices-for-chronic-disease-and-rehabilitation-hospitals.

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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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.