



MEDICAL COVERAGE GUIDELINES (CLINICAL CRITERIA) FOR UM DECISIONS Long Term Acute Care Hospitalization

Capital Health Plan provides coverage for long term acute care (LTAC) hospitalization for intensive management of complex medical needs when the below medical necessity criteria are met, and prior authorization is obtained. Services must be provided by a CHP contracted or designated provider.

ADMISSION CRITERIA:

The member requires one or more acute or post-acute skilled service(s) (A or B):

A. Ventilator Management and Weaning

1. The member's needs cannot be safely met in a less restrictive setting, such as a skilled nursing facility or an inpatient rehabilitation facility **AND**
2. The expected length of stay is greater than 25 days (for shorter stays consider Skilled Nursing Facility or Rehabilitation Facility) **AND**
3. Member is medically stable for transfer to the LTAC facility and is no longer appropriate for care in the current setting (i.e., acute inpatient hospital) **AND**
4. Documentation of at least two weaning trials prior to transfer or documentation that the pulmonary or critical care physician specialist believes the member can be weaned **AND**
5. Member exhibits respiratory stability, including **ALL** of the following:
 - a. Safe and secure tracheostomy **AND**
 - b. No need for sophisticated ventilator modes **AND**
 - c. Positive end-expiratory pressure (PEEP) requirement of 10 cm H2O (981 Pa) or less **AND**
 - d. Stable airway resistance and lung compliance **AND**
 - e. Adequate oxygenation (oxygen saturation 90% or greater) on FIO2 60% or less **AND**
 - f. Oxygenation stable during suctioning and repositioning

OR

B. Complex Medical Needs with Significant Functional Impairment(s)

1. The member's needs cannot be safely met in a less restrictive setting, such as a skilled nursing facility or an inpatient rehabilitation facility **AND**

2. The expected length of stay is greater than 25 days (for shorter stays consider Skilled Nursing Facility or Rehabilitation Facility) **AND**
3. Preadmission documentation includes the expected level of improvement **AND**
4. The member is medically stable for transfer to the LTAC facility and is no longer appropriate for care in the current setting (i.e., acute inpatient hospital) **AND**
5. There is medical record documentation supporting the member's need for complex medical treatment of **AT LEAST ONE** of the following:
 - a. Multiple and prolonged intravenous (IV) therapies
 - b. Monitoring of significant, medically active condition(s), which require clinical assessment 6 or more times a day
 - c. Cardiac monitoring (such as telemetry)
 - d. Complex wound care:
 - i. Multiple wounds present, stages 3 and above **AND**
 - ii. Negative pressure devices **OR**
 - iii. Repeated debridement **OR**
 - iv. Application of biologically active medications **OR**
 - v. Whirlpool therapy
 - e. Need for specialized, high-tech equipment, such as on-site dialysis or surgical suites
 - f. Comprehensive rehabilitation of physical therapy, occupational therapy and speech therapy

DISCHARGE CRITERIA:

1. When admission was prior authorized based on ventilation management and weaning, discharge is appropriate when the member:
 - a. Is hemodynamically stable without daily medication adjustments **AND**
 - b. Is stable off the ventilator or stable on the ventilator and considered not able to be weaned **AND**
 - c. Is clear of infection or stable on antibiotic regimen **AND**
 - d. All care can be managed at a lower level of care
2. When admission was prior authorized based on complex medical needs with significant functional impairment(s), discharge is appropriate when the member:
 - a. Is hemodynamically stable without daily medication adjustments **AND**
 - b. No longer requires multiple intravenous drug therapy **AND**
 - c. No longer requires cardiac monitoring **AND**
 - d. Has a stable hemoglobin and hematocrit without transfusion and stable electrolytes without daily parenteral adjustments **AND**
 - e. Is stable on current nutritional support (whether parenteral, oral, or percutaneous G/J tube) **AND**
 - f. No longer requires hemodialysis or is stable for transport to and from hemodialysis **AND**
 - g. Is able to participate in therapy but receiving less than 3 hours of therapy a day **AND**
 - h. All care, including wound care, can be managed at a lower level of care

Medical Necessity Approvals to be made by:

- Medical Director
- Physician Reviewer
- Utilization Management Nurse
- Nurse Reviewer
- Authorized CCD staff when UM criteria are met

These criteria apply to the following products when determined to be included in the member's benefit package: Medicare

References:

1. CMS Long-Term Care Hospital PPS Overview at http://www.cms.hhs.gov/LongTermCareHospitalPPS/03_Itch_train.asp#TopOfPage
2. Blue Cross Blue Shield of Rhode Island "Medical Coverage Policy, Long Term Acute Care Hospital (LTACH) Admission and Transition of Care Criteria" at: [2023 Long Term Acute Care Hospital \(LTACH\).pdf \(bcbsri.com\)](#)
3. Tufts Health Plan "Inpatient Rehabilitation and Long-Term Acute Care (LTAC) Level of Care Guidelines" at: [inpt-rehab-ltac-lop-guidelines \(tuftshealthplan.com\)](#)
4. Carelon "Post-Acute Care (PAC) Appropriate Use Criteria: Level of Care – Long Term Acute Care Hospital (LTACH)" at: [Post-acute-care-LTACH-go-live-.pdf \(carelonmedicalbenefitsmanagement.com\)](#)

Approved by QIMT: 6/6/13, 7/17/14

Approved by G&A: 11/3/16, 11/30/17

Approved by UMWG: 8/21/15, 8/30/18, 11/7/19, 12/10/20, 12/9/21, 12/8/22, 12/14/23, 12/12/24

Approved by UM Committee: 12/20/24

Capital Health Plan reserves the right to make changes to these criteria at any time to accommodate changes in medical necessity and industry standards.