

Long Term Care Hospitals

Medicare Advantage Medical Policy No.: MNG-005

Original Effective Date: 12/27/2023

Current Effective Date: 01/01/2025

Applies to all products administered or underwritten by the Health Plan, unless otherwise provided in the applicable contract. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

Instructions for Use

Long Term Care Hospitals (LTCH) are certified under Medicare as acute care hospitals and treat medically complex patients who require long-stay hospital level of care. All long term care hospital services must be reasonable and necessary to be covered by the MA Plan. Medical necessity determinations will be made in accordance with generally accepted standards of medical practice, taking into account credible scientific evidence published in peer reviewed medical literature generally recognized by the relevant medical community, physician specialty society recommendations, and the views of the physicians practicing in relevant clinical areas, and other relevant factors, as they related to the member's clinical circumstances.

For Medicare Payment purposes, LTCHs are generally defined as having an average inpatient length of stay (LOS) greater than 25 days. Many of the patients in LTCHs are transferred there from an intensive or critical care unit. LTCHs specialize in treating patients who may have more than one serious condition, but who may improve with time and care, and return home.

When Services May Be Eligible for Coverage

Coverage for eligible medical treatments or procedures, drugs, devices or biological products may be provided only if:

- *Benefits are available in the member's contract/certificate, and*
- *Medical necessity criteria and guidelines are met.*

Based on review of available data, the Health Plan may consider the conditions below to be **eligible for coverage.****

- A member is no longer appropriate for care in the current setting.
- Treatment is precluded at a lower level of care.
- An extended length of stay is required.
- Medical practitioner assessment or intervention is needed daily.
- Skilled Services are needed > 6h/24h.
- There is an overall expectation of improvement in a member's condition.

When Services May Be Considered Medically Necessary

Based on review of available data, the Health Plan **MAY** consider the conditions below to **medically necessary** IF ALL** conditions above are met.

- Ventilator dependence/complex respiratory care,
- Complex wound care, such as frequent skilled debridement,

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- Conditions requiring long term intravenous (IV) treatment, such as antibiotics or total parenteral nutrition (TPN),
- Comprehensive rehabilitation,
- Head trauma treatment,
- Pain management, and/or
- Other acute severe debility or complex medical conditions in which the medical director has determined LTCH would be appropriate care.

When Services Are Not Covered

Based on review of available data, Medicare and the Health Plan considers the following conditions to be **not covered.****

- Wrong surgical or invasive procedure performed on a patient.
- Surgical or other invasive procedure performed on the wrong body part.
- Surgical or other invasive procedure performed on the wrong patient.

Rationale/Source

This medical policy was developed through consideration of peer-reviewed medical literature generally recognized by the relevant medical community, U.S. Food and Drug Administration approval status, nationally accepted standards of medical practice and accepted standards of medical practice in this community, technology evaluation centers, reference to federal regulations, other plan medical policies, and accredited national guidelines.

References

1. Evidence-Based Criteria/Guidelines | Utilization Management | InterQual® | Change Healthcare (n.d.). Interqual Solution. <https://www.changehealthcare.com/clinical-decision-support/interqual>.

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2. (n.d.) Final Rule 2024.

<https://www.federalregister.gov/documents/2023/04/12/202307115/medicare-program-contract-year-2024-policy-and-technical-changes-to-the-medicare-advantage-program>.

Policy History

Original Effective Date: 12/27/2023

Current Effective Date: 01/01/2025

12/21/2023 New policy created.

12/27/2023 Utilization Management Committee review and approval. New Policy.

10/14/2024 Policy reviewed and revised.

10/15/2024 Utilization Management Committee review and approval. Reference sources updated.

No substantive changes made.

Next Scheduled Review Date: 10/2025

****Medically Necessary (or “Medical Necessity”)** - Health care services, treatment, procedures, equipment, drugs, devices, items or supplies that a Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

- A. In accordance with nationally accepted standards of medical practice;
- B. Clinically appropriate, in terms of type, frequency, extent, level of care, site and duration, and considered effective for the patient's illness, injury or disease; and
- C. Not primarily for the personal comfort or convenience of the patient, physician or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, “nationally accepted standards of medical practice” means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of Physicians practicing in relevant clinical areas and any other relevant factors.

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NOTICE: If the Patient’s health insurance contract contains language that differs from the Health Plan Medical Policy definition noted above, the definition in the health insurance contract will be relied upon for specific coverage determinations.

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NOTICE: Medical Policies are scientific based opinions, provided solely for coverage and informational purposes. Medical Policies should not be construed to suggest that the Health Plan recommends, advocates, requires, encourages, or discourages any particular treatment, procedure, or service, or any particular course of treatment, procedure, or service.

NOTICE: Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage.

Medicare Advantage Members

Established coverage criteria for Medicare Advantage members can be found in Medicare coverage guidelines in statutes, regulations, National Coverage Determinations (NCD)s, and Local Coverage Determinations (LCD)s. To determine if a National or Local Coverage Determination addresses coverage for a specific service, refer to the Medicare Coverage Database at the following link: <https://www.cms.gov/medicare-coverage-database/search.aspx>. You may wish to review the Guide to the MCD Search here: <https://www.cms.gov/medicare-coverage-database/help/mcd-benehelp.aspx>.

When coverage criteria are not fully established in applicable Medicare statutes, regulations, NCDs or LCDs, internal coverage criteria may be developed. This policy is to serve as the summary of evidence, a list of resources and an explanation of the rationale that supports the adoption of this internal coverage criteria.