Policy Title:	Policy – Long Term Acute Care (LTAC)	Number & Version:	UM03 v.6
Functional Unit:	Utilization Management	Effective Date:	02/11/2025
Policy Owner (Title):	Sr. Director, Utilization Management	Page Number:	1 of 4

I. POLICY STATEMENT and PURPOSE

In its administration of Medicare Advantage plans (Health Plans), the Company shall determine benefits in accordance with the requirements of the Centers for Medicare & Medicaid Services (CMS). Where CMS has established a national coverage policy on an item or service or a local Medicare contractor has done so as authorized by CMS, the Company follows the Medicare coverage policy. In the absence of fully established Medicare coverage criteria, the Company may develop and implement internal criteria based on current evidence in widely used treatment guidelines or clinical literature. Internal criteria are reviewed and approved by the Medical Management Committee and are made publicly accessible.

CMS has not established coverage criteria for Long Term Acute Care (LTAC), therefore the Company has developed and implemented this coverage policy to ensure that patients receive clinically appropriate, medically necessary care at the appropriate level, which allows for the best clinical outcome and prevents harm such as inpatient acquired illness. The purpose of this policy is to describe the circumstances under which Long Term Acute Care hospitalizations and continued stays would be considered medically necessary.

II. BACKGROUND

Long-term acute care hospitals (LTACs) provide inpatient services for patients in the recovery phase of severe acute illness who have complex care needs. CMS defines these facilities as acute care hospitals with average lengths of stay more than 25 days (CMS, 2019).

LTAC patients are frequently transfers from an intensive or critical care unit. LTACs generally specialize in treating patients who may have multiple serious conditions. These patients are expected to improve with time and care, and eventually return home. Services typically include respiratory therapy, head trauma treatment, and pain management (CMS, 2019).

III. SCOPE

This Policy applies to inpatient admissions, continued stays, and discharges from a long-term acute care hospital.

IV. DEFINITIONS

Medically Necessary - Covered Services rendered by a Health Care Provider that the Plan determines are:

1) Safe and effective
2) Not experimental or investigational
3) Appropriate for patients,

a) including the duration and frequency that is considered appropriate for the item or service, in terms of whether it is -
   i) furnished in accordance with accepted standards of medical practice for the diagnosis or treatment of the patient's condition or to improve the function of a malformed body patient,
   ii) furnished in a setting appropriate to the patient's medical needs and condition,
   iii) ordered and furnished by qualified personnel,
   iv) one that meets, but does not exceed, the patient's medical need; and
   v) at least as beneficial as existing and available medically appropriate alternatives.

V. OWNERSHIP & TRAINING

The Sr. Director of Utilization Management is responsible for administration, oversight, and training regarding performance under this Policy.

VI. PROTOCOLS / COVERAGE POLICY

A. Clinical Indications for Admission:
The patient 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). Preadmission documentation must include the expected level of improvement and anticipated length of stay necessary to achieve that level of improvement and the need for medical treatment. Needed services cannot, as a practical matter, be safely provided in a less restrictive clinical setting. And when at least ONE of the following services is required:

1. Ventilator Management that meets ALL the following criteria:
   a. Documentation of at least two weaning trials with tracheostomy in place prior to transfer
   b. Documentation that the pulmonary or critical care physician specialist believes the patient can be weaned
   c. Patient exhibits respiratory stability, including ALL the following:
      i. Safe and secure tracheostomy for at least 7 days
      ii. Sophisticated ventilator modes are not required
      iii. Positive end-expiratory pressure (PEEP) requirement 10cm H_20 (981 Pa) or less
      iv. Stable airway resistance and lung compliance
      v. Adequate oxygenation (oxygen saturation 90% or greater) on FIO2 60% or less
      vi. Oxygenation stable during suctioning and repositioning (Fadila, 2022) (Huang, 2021).

2. Complex medical needs with significant functional impairment, for example:
   a. Multiple prolonged intravenous therapies
   b. Complex antibiotic regimen with no viable alternative, based on sensitivities

c. Monitoring of significantly medically active conditions requiring clinical assessment 6 or more times a day
d. Multiple frequent interventions of at least 6 or more times a day (i.e., ventilator management, cardiac monitoring)
e. Complex wound care for multiple wounds stages 3 and above (i.e., negative pressure devices, repeated debridement, application of biologically active medications, whirlpool therapy)
f. The need for specialized high-tech equipment (i.e., on-site dialysis or surgical suites, and comprehensive rehabilitation such as physical therapy, occupational therapy, and speech therapy)

3. Clinical Indications for Transition of Care:
   a. The patient is hemodynamically stable without daily medication adjustments
   b. Stable off the ventilator or is stable on the ventilator and considered unable to be weaned
   c. Clear of infection or is stable on antibiotic regimen
   d. The patient no longer requires multiple intravenous drug therapy
   e. The patient no longer requires cardiac monitoring
   f. The patient has a stable hemoglobin and hematocrit without transfusion
   g. The patient has stable electrolytes without daily parenteral adjustments
   h. The patient is stable on current nutritional support (i.e., parenteral, oral, or percutaneous G/J tube)
   i. The patient no longer requires hemodialysis or is stable for transport to/from hemodialysis
   j. The patient is physically able to participate in daily therapy
   k. Complete wound healing or a substantial improvement in the wound as evidenced by an increase in granulation tissue or significant reduction in wound volume (Arnold, 2020).

VII. SUMMARY of EVIDENCE

Published evidence evaluating Long-Term Acute Care (LTAC) admissions exhibit positive outcomes for patients requiring acute complex medical care, such as complicated and/or frequent wound care or tracheostomy management and ventilation weaning. Case studies indicated patients admitted to LTAC facilities utilizing specialized beds for wound healing and for early ventilation weaning had a greater chance for positive outcomes.

VIII. REGULATORY REFERENCES / CITATIONS

CMS National Coverage Determinations (NCDs) None
CMS Local Coverage Determinations (LCDs) None

IX. PROFESSIONAL REFERENCES / CITATIONS

1. Arnold, Malgorzata; et. al. Wound Healing in the Long-Term Acute Care Setting Using an Air Fluidized Therapy/Continuous Low-Pressure Therapeutic Bed. Journal of Wound, Ostomy and Continence Nursing. Volume 47; Issue 3; Pg. 284-290; Published 2020. Accessed Feb. 2025. https://journals.lww.com/jwocnonline/fulltext/2020/05000/wound_healing_in_the_long_term_acute_care_setting.14.aspx

2. Centers for Medicare and Medicaid Services (CMS). What Are Long Term Care Hospitals. CMS Product No. 11347. Issued 2019. Accessed Feb. 2025. https://www.medicare.gov/Pubs/pdf/11347-Long-Term-Care-Hospitals.pdf

3. Fadila, Mario; et. al. Ventilator Weaning. National Library of Medicine – National Center for Biotechnology Information. Issued 2022. Accessed Feb. 2025. https://www.ncbi.nlm.nih.gov/books/NBK430712/

4. Huang, Chienhsiu. The Long-Term Survival of Successfully Weaned Prolonged Mechanical Ventilation Patients. National Library of Medicine – National Center for Biotechnology Information. Issued 2021. Accessed Feb. 2025. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8326220/

APPROVALS:

Chief Medical Officer
(MMC Chair): Saria Saccocio, MD ___

VERSION HISTORY:

Version#	Date	Author	Purpose/Summary of Major Changes
01	09/11/2019	Bob Brault	Annual review. Added reference to CMS LTAC criteria and AARC guidelines for weaning and discontinuation of ventilator support.
02	03/26/2021	Julie Braundmeier	Annual review; no substantive changes.
03	07/06/2022	Gina Vehige	Annual review. Updated references. Approved by QMMC on 11/9/2022.
04	12/28/2023	Gina Vehige	Annual review; no substantive changes.
05	04/17/2024	Sheila Gray/Kerrie Stehl	Addition to policy statement and summary of evidence.
06	02/08/2025	Sheila Gray/Kerrie Stehl	Annual review; no substantive changes. Approved by MMC 02/11/2025.