



PROVIDER BULLETIN

BT 200366

OCTOBER 31, 2003

**To: All Providers**

**Subject: Prior Authorization Requirements for Long-Term Acute Care Hospital Admissions**

*Note: The information referenced in this bulletin about prior authorization, payment methodology and maximum fees could vary for providers rendering services to members enrolled in the risk-based managed care (RBMC) delivery system.*

## Overview

Long-Term Acute Care (LTAC) hospitals are designed to provide specialized acute care for patients that require a longer recovery period. These patients usually are in an acute care facility and their medical condition has stabilized, but they continue to require an acute level of care. Therefore, it is not appropriate for a lesser level of care, such as skilled nursing facilities (SNFs) or subacute care facilities. Federal regulations require an average inpatient length of stay greater than 25 days, using Medicare program criteria to qualify a facility as a LTAC hospital. Patients are generally discharged to home with or without home care services, to acute inpatient rehabilitation hospitals, subacute rehabilitation programs, or to SNFs. LTAC hospitals are licensed by state acute care licensing standards and are accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

## Coverage Criteria

Prior authorization (PA) is required for LTAC hospital admissions covered by the Indiana Health Coverage Programs (IHCP) and reimbursed under the level of care methodology described in the Indiana Administrative Code (IAC) 405 IAC 1-10.5. Before admission to a LTAC hospital, assessment of the patient's current medical status and discharge goals must be provided to Health Care Excel (HCE) for PA purposes. This information should also be documented in the medical record. Each PA request is reviewed for medical necessity on an individual case-by-case basis.

The LTAC facilities are designated as provider specialty type 013. LTAC facilities are paid a daily rate (per diem) for each day of care provided. The per diem is all-inclusive. No other payments are permitted in addition to the LTAC level-of-care (LOC) per diem. The LTAC LOC per diem payments are in lieu of diagnosis-related group (DRG) and outlier payments. Per diem billing is permitted on a weekly basis. LTAC LOC per diem rates are hospital specific and implemented as budget neutral for the IHCP. LTAC LOC payments will resemble the payments that each facility currently receives. Claims noted as statistical outliers for each facility were not included in the development of each LTAC hospital's LOC per diem.

## Admission Criteria

The proposed admission needs to be a facility that meets the definition of a LTAC hospital in 405 IAC 1-10-2(s) which states, "Long term care hospital means a freestanding general acute care hospital licensed under Indiana Code IC 16-21 that:

- (1) is designated by the Medicare program as a long term hospital; or
- (2) has an average inpatient length of stay greater than twenty-five (25) days as determined using the same criteria used by the Medicare program to determine whether a hospital's average length of stay is greater than twenty-five (25) days."

"Freestanding does not mean a wing or specialized unit within a general acute care hospital."

The patient must be admitted from an acute care facility, or be a readmission from a nursing facility or rehabilitation facility. No PA will be approved for requests for initial admission directly from a nursing facility, physician office, or from home.

**The following documentation must be included with requests for admission to a LTAC hospital and must be available for review by the Prior Authorization Department or Surveillance and Utilization Review (SUR) Department, as applicable:**

- A signed statement from the referring physician indicating medical necessity for transfer to a LTAC hospital.
- The following information must accompany a request for approval and an evaluation by the requesting facility:
  - Diagnosis and premorbid condition(s). If the patient is currently in an acute care hospital, the diagnosis at discharge should be included if it has changed from the time of admission
  - Information about where the patient is being admitted from, if not hospitalized
  - Neurological assessment
  - Complete listing of long and short-term goals
  - Discharge plan with two options, dependent on the member's condition
  - Potential date of admission
  - Projected date of discharge
  - History of any previous rehabilitation therapies
  - Prognosis and documentation that there is a reasonable expectation the member's functional and medical status will improve
  - History, physical, and discharge or case summary, if the member is currently hospitalized
  - Completed IHCP LTAC hospital pre-admission form available from the PA contractor by contacting Health Care Excel PA Department at (317) 347-4511 in the Indianapolis local area or 1-800-457-4518.

*Note: The provider is responsible for compiling and submitting the necessary documentation for the PA request in a timely manner.*

**All of the following situations apply to the patient's status and current requirements before admission to the LTAC hospital.**

- The patient is medically stable.
- The initial diagnostic work up is completed.
- There are no planned major surgical procedures.

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- The patient has a prognosis requiring a prolonged stay in an acute setting and there is a reasonable expectation for an improvement in the status of his or her medical condition.
- The patient requires interactive physician direction with daily on-site assessment.
- The patient requires significant ancillary services dictated by complex, acute medical needs such as, full service and STAT laboratory, radiology, or respiratory care services, and so forth.
- There is a patient-centered, outcome-focused, interdisciplinary approach requiring a physician directed professional team including intensive case management to move the patient efficiently through the continuum of care.
- Education for the patient and family must be provided to manage the patient's present and future health care needs.

**Physician consultants are used during the PA process if assistance is needed in determining the medical necessity of the admission. Admissions requested for categories not specified in the following sections will be reviewed for medical necessity and intensity of service on a case-by-case basis.**

## **Respiratory**

The patient must meet **two or more** of the following requirements for admission and continued stay.

1. Requires ventilator assistance, and has failed attempts to be extubated or maintain adequate ventilation, oxygenation, or functional level after extubation.
2. Requires one or more of the following intravenous medications daily.

Bronchodilators

Corticosteroids

Diuretics

Antiviral agents

Anti-tuberculosis agents

Antiprotozoal agents

Chemotherapy

Antibiotics

Antifungal agents

Anticoagulation medications

3. Requires frequent monitoring of tissue oxygenation (for example, pulse oximetry), frequent respiratory therapy treatments, suctioning or inhalation medications.

## **Impaired Skin Integrity**

Impaired skin integrity means the patient has stage three or four decubitus wounds, infected necrotic skin conditions, surgical wounds, or burns. **The patient must meet each of the following requirements for admission or continued stay:**

1. The patient has non-healing wounds that have failed to improve while receiving home care, SNF, or acute hospital care.
2. The patient requires complex dressing changes using daily whirlpool, debridement, frequent intramuscular or intravenous analgesics or antifungals, frequent positioning, or hyperbaric treatments.
3. The patient requires more than one of the following intravenous medications at least daily:

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Antiviral agents  
Antifungal agent  
Intravenous electrolytes

Antibiotics  
Intravenous plasma expanders  
Total parenteral nutrition (TPN)

## Cardiac

Cardiac care is required if the member is unable to maintain adequate circulation related to mechanical or electrical dysfunction of the cardiovascular system. **The patient must meet each of the following requirements for admission or continued stay:**

1. The patient requires frequent monitoring of tissue oxygenation (for example, pulse oximetry) and continuous telemetry.
2. The patient requires management of hemodynamic instability, cardioversion or valsalva maneuver, temporary pacemaker, or monitoring of a functional permanent pacemaker, monitoring for drug toxicity, defibrillation, pulmonary artery catheterization and arterial monitoring, and monitoring of electrolyte imbalance.
3. The patient requires **two or more** of the following medications intravenously to maintain cardiovascular integrity:

Anticoagulants	Antianginal agents	Sodium channel blockers
Antiarrhythmics	Antibiotics	Thrombolytic enzymes
Anticoagulants	Antihypertensives	Tissue plasminogen activators
Alpha/beta-adrenoreceptor blocking agents	Class mucarinic receptor antagonists	Vasodilators
Betablockers	Corticosteroids	Vasopressors
Calcium channel blockers	Diuretics	
Cardiac glycosides	Inotropic agents	

## Continued Stay Criteria

**All of the following are required to be documented for review of a continued stay in the LTAC hospital.**

- Multidisciplinary team evaluation at least weekly.
- Evidence of participation in a rehabilitation therapy program.
- Continued daily on-site direction of a qualified physician.
- Continued skilled nursing care or supervision required.
- Continued need for acute level of care as evidenced by continuing to meet the admission criteria category requirements.

## Documentation Requirements for Continued Stay

Concurrent review for approval of additional days, must be received by the PA department at least 48 hours before the last approved day, including:

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- Completed IHCP LTAC hospital pre-admission form available from the PA contractor by contacting the Health Care Excel PA Department at (317) 347-4511 in the Indianapolis local area or 1-800-457-4518.
- A summary of the current discharge plans.
- Documentation of family or friend participation in the discharge planning process.
- A neurological assessment update, if appropriate.
- Documentation of the member's cooperation, participation, or progress.

*Note: For review purposes, the PA contractor can request additional or updated information at any time.*

## Discharge Criteria

A further length of stay will not be authorized without the physician consultant review when any of the following conditions occur:

- Evidence in the patient record that the patient has achieved stated goals.
- Medical complications require readmission to inpatient acute facility.
- Multidisciplinary services are no longer needed.
- No additional improvement is anticipated.
- Patient's progress towards goals has remained unchanged for seven days.

## Billing Guidelines

Long-term acute care facilities must submit charges on a UB-92 claim form. The revenue code 101 – *All-inclusive room and board* will be utilized for the PA process and should be reflected on the UB-92 claim form by the billing provider.

The discharging hospital must enter the patient status code 63 in Field Locator (FL) 22 on the UB-92 claim form. This indicates the status of the patient as of the ending service date was “discharged” or “transferred to a long-term care hospital.”

## Additional Information

Direct questions about this bulletin to the Customer Assistance Unit at (317) 655-3250 in the Indianapolis local area or 1-800-577-1276; or the HCE Medical Policy Department at (317) 347-4500. Direct PA questions for Traditional Medicaid and Primary Care Case Management (PCCM) members to the HCE PA Department at (317) 347-4511 in the Indianapolis local area or 1-800-457-4518. Direct PA requests for risk-based managed care members (RBMC) to the PA department of the member's managed care organization.

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