Mass General Brigham
Health Plan

Medical Policy
Extended Care Facility

Policy Number: 022

	Commercial and Qualified Health Plans*	MassHealth*	Medicare Advantage
Authorization required	X	X	*
No Prior Authorization			

***Not all plans cover all of these services, please check plan's benefit package to verify coverage and limits.

Overview

The purpose of this document is to describe the guidelines Mass General Brigham Health Plan utilizes to determine the most clinically appropriate level of care for members who require treatment in an Extended Care Facility.

Coverage Guidelines

Mass General Brigham Health Plan covers admissions and continued stays in an Extended Care Facility when care meets medical necessity criteria and is within the member's benefit coverage. Medically necessary Acute Rehabilitation Hospital and Long-Term Care Hospital level of care are covered under a commercial member's available inpatient rehabilitation benefit and under a MassHealth member's extended care facility benefit. Care may also be authorized for coverage within the member's benefit coverage when community care is not appropriate to meet the individual's needs. Members must require and receive the care authorized for their condition and approved level of care. Members not receiving the services approved under the level of care are evaluated for a more appropriate level of care, facility transfer, and/or discharge. The treating provider must request prior authorization for the specific level of care.

Failure to obtain the required prior authorization or to provide the required notification may result in an administrative denial of payment to the facility.

In order to make a medical necessity determination, Mass General Brigham Health Plan requires certain documentation to be provided, including but not limited to: the member's prior level of function, current medical condition, current functional capacity, current ability to participate in any requested rehabilitation plan, the treatment plan, expected level of improvement, and anticipated length of stay necessary to achieve these goals.

Care managers initiate discharge planning as expeditiously as possible on admission to the Extended Care Facility and throughout the concurrent review process. Care managers coordinate post-discharge care, as appropriate, with the treating facility's discharge planners/care managers, treating providers, PCP, community agencies, and specialty providers for members with special needs for managed care organization (MCO)-covered and MCO non-covered services.

Acute Rehabilitation Hospital Level of Care

Mass General Brigham Health Plan covers medically necessary acute rehabilitation hospital level of care when the request meets InterQual® Rehabilitation Level of Care Criteria. To access the criteria, log into Mass General Brigham Health Plan's provider website at MassGeneralBrighamHealthPlan.org and click the InterQual® Criteria Lookup link under the Resources Menu.

Long-Term Care Hospital (LTCH)/Chronic Disease Hospital Level of Care

Medical necessity for LTCH level of care is determined through InterQual® criteria. To access the criteria, log into Mass General Brigham Health Plan's provider website at MassGeneralBrighamHealthPlan.org and click the InterQual® Criteria Lookup link under the Resources Menu. Mass General Brigham Health Plan covers medically necessary LTCH level of care when the request meets InterQual® LTCH Level of Care Criteria.

Subacute Level of Care
Mass General Brigham Health Plan covers medically necessary Subacute Level of Care when InterQual® Subacute Level of Care criteria are met with the exclusion of pediatric nursing homes. To access the criteria, log into Mass General Brigham Health Plan's provider website at MassGeneralBrighamHealthPlan.org and click the InterQual® Criteria Lookup link under the Resources Menu.

Skilled Nursing Facility (SNF) Level of Care
Mass General Brigham Health Plan covers medically necessary subacute level of care when InterQual® SNF criteria is met with the exclusion of pediatric nursing homes. To access the criteria, log into Mass General Brigham Health Plan's provider website at MassGeneralBrighamHealthPlan.org and click the InterQual® Criteria Lookup link under the Resources Menu.

Nursing Facility (MassHealth Members Only)
MassHealth members may qualify for services in a nursing facility when the member has a medical or mental condition requiring at least one daily skilled service listed under *Skilled Services*, or a combination of at least three interventions listed below under *Assistance with Activities of Daily Living* and *Nursing and Therapy Services* with at least one of the three interventions listed under *Nursing and Therapy Services*.

Skilled Services
Skilled services must be performed daily, as defined in the definitions below, by or under the supervision of a registered nurse or therapist. Skilled services consist of the following:

a. Intravenous, intramuscular, or subcutaneous injection, or intravenous feeding;

b. Nasogastric-tube, gastrostomy, or jejunostomy feeding;

c. Nasopharyngeal aspiration and tracheostomy care, however, long-term care of a tracheotomy tube does not, in itself, indicate the need for skilled services;

d. Treatment and/or application of dressings when the physician has prescribed irrigation, the application of medication, or sterile dressings of deep decubitus ulcers, other widespread skin disorders, or care of wounds, when the skills of a registered nurse are needed to provide safe and effective services (including, but not limited to, ulcers, burns, open surgical sites, fistulas, tube sites, and tumor erosions);

e. Administration of oxygen on a regular and continuing basis when the member's medical condition warrants skilled observation (for example, when the member has chronic obstructive pulmonary disease or pulmonary edema);

f. Skilled-nursing observation and evaluation of an unstable medical condition (observation must, however, be needed at frequent intervals throughout the 24 hours; for example, for arteriosclerotic heart disease with congestive heart failure);

g. Skilled nursing for management and evaluation of the member's care plan when underlying conditions or complications require that only a registered nurse can ensure that essential unskilled care is achieving its purpose. The complexity of the unskilled services that are a necessary part of the medical treatment must require the involvement of skilled nursing personnel to promote the member's recovery and safety;

h. Insertion, sterile irrigation, and replacement of catheters, care of a suprapubic catheter, or, in selected residents, a urethral catheter (a urethral catheter, particularly one placed for convenience or for control of incontinence, does not justify a need for skilled-nursing care). However, the insertion and maintenance of a urethral catheter as an adjunct to the active treatment of disease of the urinary tract may justify a need for skilled nursing care. In such instances, the need for a urethral catheter must be documented and justified in the member's medical record (for example, cancer of the bladder or a resistant bladder infection);

i. Gait evaluation and training administered or supervised by a registered physical therapist at least five days a week for members whose ability to walk has recently been impaired by a neurological, muscular, or skeletal abnormality following an acute condition (for example, fracture or stroke). The plan must be designed to achieve specific goals within a specific time frame. The member must require these services in an institutional setting;

j. Certain range-of-motion exercises may constitute skilled physical therapy only if they are part of an active treatment plan for a specific state of a disease that has resulted in restriction of mobility (physical-therapy notes showing the degree of motion lost and the degree to be restored must be documented in the member's medical record);

k. Hot pack, hydrocollator, paraffin bath, or whirlpool treatment will be considered skilled services only when the member's condition is complicated by a circulatory deficiency, areas of desensitization, open wounds, fractures, or other complications; and

l. Physical, speech/language, occupational, or other therapy that is provided as part of a planned program that is designed, established, and directed by a qualified therapist. The findings of an initial evaluation and periodic reassessments must be documented in the member's medical record. Skilled therapeutic services must be ordered by a physician and be designed to achieve specific goals within a given time frame.

Assistance with activities of daily living includes the following services:

a. Bathing, requiring direct care or constant supervision during the entire activity;

b. Dressing, requiring direct care or constant supervision during the entire activity;

c. Toileting, bladder, or bowel, when the member is incontinent of bowel or bladder function day and night or requires scheduled assistance or routine catheter or colostomy care;

d. Transfers when a member must be assisted or lifted to another position;

e. Mobility/ambulation when the member must be physically steadied, assisted or guided or is unable to propel a wheelchair alone or appropriately and requires the assistance of another person; and

f. Eating that requires constant intervention, direct assistance, or constant supervision.

Nursing and therapy services include any of the following interventions performed at least three times a week:

a. Any physician-ordered skilled service outlined under *Skilled Services* (listed above) three times a week;

b. Positioning while in a bed or a chair as part of the written care plan;

c. Medically necessary measurement of input and output;

d. Medication administration that require an RN to monitor dose, frequency, or adverse reactions;

e. Staff intervention required for selected types of behavior that are generally considered dependent or disruptive, such as disrobing, screaming, or being physically abusive to oneself or others; getting lost or wandering into inappropriate places; being unable to avoid simple dangers; or requiring a consistent staff one-to-one ratio for reality orientation when it relates to a specific diagnosis or behavior as determined by a mental-health professional;

f. Physician-ordered occupational, physical, speech/language therapy or some combination of the three (time-limited with patient-specific goals);

g. Physician-ordered nursing observation and/or vital signs monitoring, specifically related to the written care plan and the need for medical or nursing intervention; and

h. Treatments involving prescription medications for uninfected postoperative or chronic conditions according to physician or PCP orders, or routine changing of dressings that require nursing care and monitoring.

Pediatric Nursing Homes

All members less than 22 years of age must first be screened by the Department of Public Health's Medical Review Team and approved for admission into a pediatric nursing home. Medical necessity for nursing homes is established when the following criteria are met:

1. MassHealth Members:
    a. Coverage in a pediatric nursing home is approved when the Department of Public Health Medical Review Team has approved admission into the pediatric nursing home.

    b. Medical Review Team's approval for admissions may also extend to respite care up to 90 days in a benefit period.

2. Commercial Members:
    a. In addition to the Medical Review Team's approval for admissions, the member must meet InterQual® recognized covered level of care.

Pediatric Long-Term Acute Care (LTAC)

The member must be less than 22 years of age and meet at least one of the following two criteria for admission to or continued stay in a pediatric long-term acute care facility:

1. The member must require services that:
    a. can be provided safely and effectively at the long-term acute care level. Such services must be ordered by physician and documented in member's record; and

    b. include at least daily physician intervention or 24-hour availability of medical services and equipment available only in the hospital setting; or

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

A member is considered appropriate for LTAC placement only when medical need exists for an intensive program that includes a multidisciplinary approach to improve the member's ability to function to his or her maximum potential. Factors present in the member's condition indicate potential for functional movement or freedom from pain. A member who requires therapy solely to maintain function is not an appropriate LTAC patient.

Medicare Variation

Mass General Brigham Health Plan uses guidance from the Centers for Medicare and Medicaid Services (CMS) for coverage determinations for its Medicare Advantage plan members. National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Local Coverage Articles (LCAs) and documentation included in the Medicare manuals are the basis for coverage determinations. When there is no guidance from CMS for the requested service, Mass General Brigham Health Plan's medical policies are used for coverage determinations. **Mass General Brigham Health Plan utilizes Change Health Care InterQual® criteria in reviewing medical necessity for services in a long-term care hospital, acute rehabilitation hospital, subacute level of care facility, or a skilled nursing facility**. These criteria align with CMS Medicare Benefit Policy Manual Chapter 8 – Coverage of Extended Care (SNF) Services.

Exclusions

Mass General Brigham Health Plan does not cover stays/days at Extended Care Facilities that do not meet level of care criteria noted above and the specific InterQual® Level of Care criteria. Coverage beyond the benefit period is not available. Mass General Brigham Health Plan does not cover respite care other than that which is noted under Pediatric Nursing Homes.

Definitions

Acute Rehabilitation Hospital/Acute Rehabilitation Unit is a facility or unit within a facility licensed by the state to provide care devoted to the provision of comprehensive services to patients whose handicaps are primarily physical, coordinated with efforts to minimize the patient's mental, social, and vocational disadvantages. The patient has the ability to participate in three hours of rehabilitation at least 5 days a week and requires the oversight of a medical practitioner 3 times a week. The course of treatment is limited to the period in which the patient continues to make progress toward his or her treatment goal.

Daily: For services rendered by a physical therapist, occupational therapist or speech language pathologist, daily means five days a week. For nursing services, daily means seven days a week.

Long Term Care Hospital (LTCH): LTCHs are certified as acute care hospitals, but LTCHs focus on patients who, on average, stay more 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. Services provided in LTCHs typically include comprehensive rehabilitation, respiratory therapy, head trauma treatment, and pain management. Patients typically have multiple complex medical conditions that require daily physician evaluations, skilled nursing of at least 6.5 hours a day, and equipment found in a hospital setting.

Skilled Care: A skilled service is a service that must be provided by a registered nurse, licensed practical nurse (under the supervision of a registered nurse), licensed physical therapist, occupational therapist, speech-language pathologist or a licensed physical therapy assistant and licensed occupational therapy assistant (under the supervision of a licensed therapist) in order to be safe and effective. In determining whether a service meets the requirement of skilled care, the inherent complexity of the service, the condition of the patient and generally accepted standards of clinical practice must be considered. Some services may be considered skilled on the basis of complexity alone. In other cases, a service that is ordinarily considered unskilled may be considered skilled on the basis of the patient's condition. A service is not considered skilled merely because it is performed by or under the direct supervision of a licensed nurse or therapist. When the service could be safely and effectively performed by the average non-medical person without direct supervision, the service would not be considered skilled.

Skilled Nursing Facility (SNF) is a facility, or unit, which is licensed by the state to provide skilled nursing care and related services for patients who require medical and skilled nursing care or skilled rehabilitation services for the treatment of an injury, disability, or illness.

Sub-acute Care: Sub-acute care is generally more intensive than traditional nursing facility care and less than acute care. The focus is short-term care for remediable or rehabilitable problems. Patients typically receive at least four hours of skilled nursing care a day, or two hours of multidisciplinary rehabilitation therapy, i.e., physical therapy, occupational therapy, and/or speech therapy, at least five days per week.

Effective
July 2025: Annual update. Simplified policy sections where InterQual® criteria are used. Medicare Variation language updated. Nursing Facility criteria updated. Pediatric LTAC criteria added. References updated.
June 2024: Annual update.
June 2023: Annual update. Added Medicare Advantage to table. Added Medicare variation language.
June 2022: Annual update.
May 2021: Annual update.
June 2020: Annual update.
June 2019: Annual update. Minor edit to footnote under table on page 1. References updated.
November 2018: Annual update.
April 2017: Changes reflect the addition of InterQual® LTCH criteria.
April 2016: Annual update.
April 2015: Amend coverage guideline statement for clarity
February 2015: Annual update.
January 2014: Annual update reorganized criteria, titled change.
September 2012: Annual update
September 2011: Annual update
September 2010: Annual update
September 2009: Annual update
September 2008: Annual update
December 2007: Annual update
October 2006: Annual update
April 2005: Annual update
June 2003: Annual update
January 2002: Effective date

References
Centers for Medicare & Medicaid Services (CMS). Manuals. Publication # 100-02. Medicare Benefit Policy Manual, Chapter 8 – Coverage of Extended Care (SNF) Services Under Hospital Insurance

Commonwealth of Massachusetts, Massachusetts Executive Office of Health and Human Services, Notice of Final Agency Action, MassHealth: Payment for Pediatric Chronic Disease and Rehabilitation Hospitals, effective October 1, 2024.

Commonwealth of Massachusetts, Division of Medical Assistance, Provider Manual Series: Nursing Facility Manual (130 CMR 456.000)

Commonwealth of Massachusetts, Division of Medical Assistance, Provider Manual Series: Chronic Disease and Rehabilitation Inpatient Manual (130 CMR 435.000)

The Health Strategies Consultancy LLC, Long-Term Acute Care Hospitals: *"Revised Certification Criteria Could Improve Medicare Provider Category"*

Change Healthcare LLC, InterQual ®Level of Care criteria, Acute Care Adult, Acute Care Pediatric, Rehabilitation Adult and Pediatric, Sub acute and Skilled Nursing Facilities Adult and Pediatric.

EOHHS ACPP Contract

450.231: General Conditions of Payments (**D) A Provider is responsible for verifying a Member's eligibility status on a daily basis, including but not limited to members who are hospitalized or in an extended care facility.** In order to receive MassHealth payment for a covered medical service, the person receiving such service must be eligible for MassHealth coverage on the date of service and the provider must comply with any service authorization requirements and all other conditions of payment. A provider's failure to verify a Member's MassHealth status before providing services to the member may result in nonpayment of such services. For payment for services provided before a member's MassHealth eligibility determination, see 130 CMR 450.311.