MEDICA CENTRAL UTILIZATION MANAGEMENT POLICY

Policy Name: **LONG-TERM ACUTE CARE HOSPITAL (LTACH) MP9669 (III-INP.04)**

Effective Date: **July 1, 2024**

IMPORTANT INFORMATION – PLEASE READ BEFORE USING THIS POLICY

These services may or may not be covered by all Medica Central plans. Coverage is subject to requirements in applicable federal or state laws. Please refer to the member's plan document for other specific coverage information. If there is a difference between this general information and the member's plan document, the member's plan document will be used to determine coverage. With respect to Medicare, Medicaid, and other government programs, this policy will apply unless these programs require different coverage.

Members may contact Medica Customer Service at the phone number listed on their member identification card to discuss their benefits more specifically. Providers with questions may call the Provider Service Center. Please use the Quick Reference Guide on the Provider Communications page for the appropriate phone number. https://mo-central.medica.com/Providers/SSM-employee-health-plan-for-IL-MO-OK-providers

Medica Central coverage policies are not medical advice. Members should consult with appropriate health care providers to obtain needed medical advice, care, and treatment.

PURPOSE

To promote consistency between utilization management reviewers by providing the criteria that determines the medical necessity.

MEDICAL NECESSITY CRITERIA

For medical necessity criteria, The Health Plan uses the following MCG™ Care Guidelines:

- For medical necessity criteria, see MCG™ Care Guidelines, 28th edition, 2024: GRG: GRG-050 (LTACH GRG), *Long-Term Acute Care Hospital (LTACH) Level of Care Guideline.*
- For medical necessity criteria, see MCG™ Care Guidelines, 28th edition, 2024: GRG: GRG-049 (LTACH GRG), *Ventilator Management Long-Term Acute Care Hospital (LTACH) Guideline.*

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BENEFIT CONSIDERATIONS

1. Prior authorization **is required** for admission and continued stay of long-term acute care hospital services. Review of these services will occur prior to admission, concurrently or retrospectively to determine if medical necessity criteria were met. Denial may result if criteria were not met. Please see the prior authorization list for product specific prior authorization requirements.
2. Clinical records, when requested by The Health Plan, must be submitted by facilities to The Health Plan within 24 hours or one business day.
3. Coverage may vary according to the terms of the member's plan document.
4. For patients not meeting criteria for long- term acute care services, alternative levels of care may be appropriate such as a skilled nursing facility, hospice, transitional care, observational status, or short-term home health.
5. If the Medical Necessity Criteria Benefit Considerations are met, The Health Plan will authorize benefits within the limits in the member's plan document.
6. If it appears that the Medical Necessity Criteria Benefit Considerations are not met, the individual's case will be reviewed by the medical director or an external reviewer. Practitioners are advised of the appeal process in their Provider Administrative Manual.

CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS)

- For Medicare members, refer to the following, as applicable at: https://www.cms.gov/medicare-coverage-database/new-search/search.aspx

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