Post-Acute Care Policies – Curative Health Plan

This document compiles definitive medical necessity policies for post-acute care settings under the Curative Health Plan. Each section outlines the specific criteria that must be met to qualify for coverage of the respective level of care.

Policies included:

1. **Skilled Nursing Facility (SNF) Admission Policy** – Defines the medical necessity criteria for admission to a skilled nursing facility, including clinical stability, daily skilled service requirements, expected improvement, and physician-documented plans of care.
2. **Acute Inpatient Rehabilitation (ARU/IRF) Admission Policy** – Specifies the requirements for admission to an inpatient rehabilitation facility, such as intensive therapy needs (three hours/day, five days/week or 15 hours/week), complex nursing and physician oversight, medical stability, and clear rehabilitation diagnoses and goals.
3. **Long-Term Acute Care Hospital (LTACH) Admission Policy** – Describes when admission to an LTACH is medically necessary for patients needing prolonged ventilator weaning, complex wound care, long-term IV antibiotics, dialysis, or management of multiple comorbidities, and outlines stability and potential benefit criteria.
4. **Hospice Care (Continuous Home Care and General Inpatient Hospice) Policy** – Establishes eligibility for hospice enrollment and specific requirements for continuous home care and general inpatient hospice, including terminal illness certification, uncontrolled symptom criteria, service duration, and facility capabilities.

Please consult each policy section for detailed criteria, coverage requirements, and references.

Skilled Nursing Facility (SNF) Admission Policy

Curative Health Plan

Policy Statement

This Curative Health Plan medical policy reflects the judgment of the Curative senior medical policy board regarding the medical necessity of skilled nursing facility (SNF) care. It establishes definitive criteria that must be met for SNF admission based solely on publicly available information, including CMS regulations, society guidelines, and peer-reviewed literature. Proprietary guidelines such as MCG or InterQual are not used in formulating this policy.

Care Planning

Medical Necessity Criteria for Skilled Nursing Facility Admission

This policy establishes definitive criteria for determining when admission to a skilled nursing facility (SNF) is medically necessary. To qualify for SNF admission, **all** of the following must be met:

- **Clinical stability with ongoing skilled needs:** The patient is medically stable and no longer requires the intensity of acute hospital services but exhibits a decline in physical function or requires treatment of a medical condition that cannot be safely managed at home or in an outpatient setting. The patient requires supervised and structured rehabilitation or skilled nursing services, such as intravenous medications (at least every 12 hours), complex wound or ostomy care, enteral feeding, or ventilator/tracheostomy management.
- **Daily skilled services:** The patient needs daily skilled nursing services seven days per week or skilled therapy services at least five days per week. Skilled therapy must be individualized and of sufficient complexity (e.g., physical, occupational, or speech therapy provided one hour per day) and cannot be provided effectively at a lower level of care. General exercise or custodial care does not meet this requirement.
- **Reasonable expectation of improvement or maintenance:** The care plan includes measurable goals with a reasonable expectation that the patient will improve or maintain functional status within a defined timeframe. Patients with end-stage disease may qualify when skilled services are necessary to manage symptoms and maintain comfort.
- **Ability and willingness to participate:** The patient and/or caregiver is willing and able to participate in the care plan, including therapy sessions and training for self-management.
- **Physician evaluation and plan of care:** A physician must evaluate the patient prior to transfer and establish a written plan of care documenting the need for SNF services. The SNF provider must perform an initial assessment soon after admission and implement the care plan.

Patients who do not meet **all** of the above criteria do not qualify for SNF admission and should be considered for alternative levels of care.

Levels of Care for Skilled Nursing Facilities

Curative Health Plan recognizes four levels of skilled nursing facility care based on the intensity of nursing and therapy services provided. These levels correspond to payer revenue codes and help match a patient's needs to the appropriate resource level. To qualify for a given level, the patient must require **all** of the services specified for that level (or a combination of services that fall within the described intensity). Documentation should demonstrate the patient's need for the level of care selected.

- **Level I – Minimal Care (Revenue Code 191):**
  - Room and board and prepared meals consistent with ordered diet.
  - Twenty-four-hour general nursing care, including administration of oral (PO), intramuscular (IM) or subcutaneous (SQ) medications; routine labs and radiologic services; short-term oxygen or respiratory therapy and peripheral IV hydration.
  - Simple ostomy management and new or existing ostomy teaching; diabetic management, bowel and bladder training and patient/caregiver education.
  - Wound management for simple wounds or stage I–II pressure injuries.
  - Therapy services limited to **two hours or less per day** (any combination of physical therapy, occupational therapy, speech therapy or respiratory therapy) provided at least five days per week 【547827198785635†L165-L181】.
- **Level II – Moderate Care (Revenue Code 192):**
  - Includes all Level I services **plus** new or existing tube feedings (nasogastric, gastrostomy or PEG) with nutritional supplements and supplies.
  - Wound management requiring sterile dressings; treatment of stage III or multiple stage II pressure injuries, including use of wound VAC therapy for short-term therapy (typically ≤ two weeks).
  - Administration of simple IV push medications for stable conditions, IM antibiotics, and management of stable tracheostomies without inner cannulas.
  - Respiratory treatments and observation performed by nursing staff, aerosol therapy, small-volume nebulizer treatments, pulse oximetry and high-flow oxygen (≥3 L/min) as needed.
  - Management of cognitive impairment requiring a secure unit or wander-guard supervision.
  - Therapy services **two to three hours per day**, five days per week, across physical, occupational, speech or respiratory therapies 【547827198785635†L187-L203】.
- **Level III – Extensive Care (Revenue Code 193):**
  - Includes Level I and II services **plus** complex wound management beyond pressure injuries, including treatment of stage IV or multiple stage III pressure injuries and other complex wounds; wound VAC therapy beyond two weeks.

- Complex intravenous therapies involving multiple medications, central or peripherally inserted central catheter (PICC) lines, chemotherapy, total parenteral nutrition, lipid infusions or blood products.
  - Management of tracheostomies with inner cannulas requiring frequent suctioning, mist therapy and high-flow oxygen.
  - Therapy services **three to four hours per day**, five days per week 【547827198785635†L209-L221】.
- **Level IV – Intensive Care (Revenue Code 194):**
  - Includes Level I–III services **plus** hemodialysis or peritoneal dialysis provided in the facility.
  - More than **12 hours of skilled nursing care per day**, including one-on-one monitoring by a licensed nurse, for conditions such as ventilator weaning or continuous intravenous drips.
  - Therapy services **four or more hours per day**, five days per week 【547827198785635†L223-L233】.

These levels serve as guidelines for matching patient needs with SNF resources. Admission reviewers should select the lowest level of care that safely meets the patient's needs and document the specific services and therapy intensity required.

Coverage and Documentation Requirements

Prior authorization and coverage requirements may vary by benefit contract; however, the following documentation is essential to support medical necessity:

- **Prior authorization and benefit verification:** Verify benefits and obtain prior authorization, if required, before admission and for continued stay. Confirm benefit limitations (e.g., number of covered days) and cost-sharing obligations.
- **Medical necessity documentation:** Provide documentation that the patient meets each of the medical necessity criteria listed above, including medical stability, functional decline requiring supervised rehabilitation, and need for daily skilled services at the required intensity.
- **Daily skilled nursing or therapy requirement:** Ensure documentation verifies that skilled nursing is needed seven days per week or skilled therapy at least five days per week; therapy must be individualized and of sufficient complexity.
- **Evaluation and reassessment:** Maintain documentation of progress toward goals and conduct weekly reassessments to confirm continued need for daily skilled care. Continued stay is appropriate only if clinical improvement or medical instability justifies ongoing skilled services.
- **Expected improvement and discharge plan:** Document a reasonable expectation of improvement or maintenance of function within a predictable timeframe and establish a clear discharge plan at admission.
- **Compliance with CMS guidelines:** For patients with Medicare coverage, ensure compliance with CMS regulations, such as the three-day qualifying inpatient stay requirement for coverage.

Alternatives to SNF Admission

- **Home health services:** If skilled care can be safely delivered at home and the patient is homebound, home health nursing and therapy may be appropriate. Caregivers and home modifications should be available.
- **Outpatient rehabilitation:** Patients who need therapy but not nursing care may receive physical, occupational, or speech therapy in an outpatient setting.
- **Acute inpatient rehabilitation (ARU) or long-term acute care (LTAC):** Patients requiring more intensive therapy (e.g., ≥3 hours per day) or complex medical management may qualify for an inpatient rehabilitation facility or LTAC instead of SNF.
- **Hospice or palliative care:** Terminally ill patients with a prognosis of ≤6 months who elect comfort-focused care may be better served by hospice services rather than SNF.

Facility Course and Optimal Recovery

Initial admission (Day 0–1):

- Physician, nurse practitioner, or physician assistant evaluates the patient within 24 hours of admission. Goals of care and the plan of care are established with input from nursing, therapy, social services, and the patient/family.
- Comprehensive assessment, medication reconciliation, baseline functional status, and risk screening (falls, nutrition, pressure injury) are completed.
- Rehabilitation assessments (physical therapy, occupational therapy, speech-language pathology) are performed to determine therapy needs and intensity.

Ongoing care (Days 2–14):

- **Skilled nursing:** Registered nurses provide wound care, intravenous medications, enteral feeding, catheter or ostomy management, and monitor vital signs and labs. Nursing assessments occur each shift.
- **Therapy:** Patients receive physical and occupational therapy at least five days per week; speech therapy as indicated. Interventions focus on mobility, transfers, activities of daily living (ADLs), swallowing, and communication.
- **Medical oversight:** The attending physician reviews the patient's status regularly (e.g., once weekly or more frequently as needed) and modifies orders. A team meeting occurs at least weekly to discuss progress and discharge planning.
- **Psychosocial support:** Social workers and case managers address psychosocial needs, coordinate family meetings, and arrange durable medical equipment (DME) and community resources.

Discharge planning (Days 15–20 or as clinically indicated):

- Assess readiness for discharge based on functional gains, medical stability, and ability to manage at a lower level of care.
- Provide caregiver training and education on medications, wound care, and safe transfers.
- Arrange home health services, outpatient therapy, or equipment (e.g., walker, hospital bed) and schedule follow-up appointments.

- Determine whether additional SNF days are needed; if progress plateaus or coverage limits are reached, consider transition to custodial nursing facility or home.

Goal Length of Stay and Extended Stay Criteria

Typical SNF rehabilitation stays range from **12 to 20 days**, with national data showing an average of **approximately 12.4 days** for post-acute care. Extended stays beyond this range may be medically necessary when the patient continues to meet skilled criteria—such as ongoing complex wound care, intravenous therapy, ventilator weaning, or significant functional gains—and lower levels of care remain unsafe. Documentation must support progress toward goals and demonstrate why continued daily skilled services are necessary. When the patient no longer needs daily skilled care, transition to custodial nursing, home health, or other alternatives should be arranged.

Discharge Planning and Community Support

Effective discharge planning should begin at admission. Key elements include:

- **Functional and home safety assessment:** Determine necessary home modifications, equipment, and caregiver support.
- **Interdisciplinary discharge conference:** Engage the patient, family, nursing, therapy, social services, and physician to finalize the discharge plan.
- **Arranging services:** Coordinate home health nursing and therapy, outpatient appointments, community programs, and durable medical equipment.
- **Education:** Provide written instructions on medications, wound care, catheter or ostomy management, and diet. Educate the patient and caregivers on recognizing complications and when to seek medical help.
- **Follow-up:** Ensure the patient has appointments with the primary care provider and specialists within one to two weeks after discharge. Arrange therapy visits and continued nursing support as indicated.

Evidence Summary

Background and clinical evidence: SNFs provide a bridge between acute care and home. Medicare covers SNF services only after a **three-day qualifying inpatient stay** and when patients require **daily skilled nursing or rehabilitation** that can't be provided at home. Skilled therapy is considered "daily" when needed and provided **at least five days per week**. Services must treat the condition that required hospitalization or a related condition that arises during SNF care. The "practical matter" standard requires that skilled services not be feasible on an outpatient basis or at home. Average SNF stays for rehabilitation are about 12.4 days; Medicare pays up to 100 days per benefit period.

Rationale for inpatient SNF care: Patients require SNF care when they need daily professional nursing interventions (e.g., IV antibiotics, complex wound care), intensive rehabilitation to regain independence, or close monitoring after acute hospitalization. Without SNF services, these patients risk medical complications, delayed recovery, rehospitalization, or unsafe discharge. When skilled needs can be provided safely at home or outpatient and the patient has adequate caregiver support, SNF admission may not be necessary.

References

1. **Medicare.gov – Skilled nursing facility care coverage:** Explains that Medicare covers SNF care only after a qualifying inpatient hospital stay of at least three consecutive days, time in observation or the emergency department doesn't count, and the patient must enter the SNF within 30 days. Coverage requires daily skilled care and treatment of the same or related condition.

2. **Commonwealth Care Alliance – Skilled Nursing Facility Services Under Medicare Part A:** Describes the "practical matter" requirement that daily skilled services can only be provided in an SNF if not available on an outpatient basis, and states that daily skilled nursing must be seven days per week or therapy at least five days per week. It also notes that services must treat the condition for which the patient was hospitalized or a new condition arising during SNF care.

3. **Medicare Coverage Guide:** Outlines SNF benefit periods and costs. Days 1–20 are covered by Medicare; days 21–100 have a daily coinsurance; coverage is limited to 100 days per benefit period.

4. **Premera Blue Cross – Skilled Nursing Facility Admission, Continued Stay, and Transition of Care Guideline:** Describes interdisciplinary and goal-oriented 24-hour skilled services delivered by licensed professionals, daily documentation, medical stability requirements, decline in function needing supervised rehabilitation, daily skilled nursing or therapy at an intensity not available in a lower-level setting, and expectations for improvement within a reasonable timeframe.

5. **DMBA Skilled Nursing Facility Levels of Care:** Provides definitions of Level I (minimal care), Level II (moderate care), Level III (extensive care) and Level IV (intensive care) with service and therapy requirements, including duration of nursing care and hours of therapy needed 【547827198785635†L165-L181】【547827198785635†L187-L203】【547827198785635†L209-L221】【547827198785635†L223-L233】.

Acute Inpatient Rehabilitation (ARU/IRF) Admission Policy

Curative Health Plan

Policy Statement

This Curative Health Plan medical policy articulates definitive medical necessity requirements for acute inpatient rehabilitation facility (IRF) admission. It reflects the judgment of the Curative senior medical policy board and draws exclusively from publicly available evidence, including CMS regulations, professional society guidelines, and peer-reviewed literature. Proprietary utilization management tools such as MCG® or InterQual® are not used in this policy.

Care Planning

Medical Necessity Criteria for Inpatient Rehabilitation Facility Admission

This policy defines the criteria used to determine medical necessity for admission to an acute inpatient rehabilitation facility (IRF). Admission is medically necessary only when **all** of the following are met:

- **Requirement for intensive multidisciplinary rehabilitation:** The patient requires and can actively participate in a high-intensity therapy program unique to IRFs. Therapy intensity must reach **3 hours per day, 5 days per week, or at least 15 hours over 7 consecutive days**. Treatments must involve at least two disciplines (e.g., physical, occupational, and speech therapy) delivered one-on-one and tailored to the patient's impairments.
- **Need for complex nursing and physician services:** The patient requires complex nursing interventions (e.g., bowel/bladder programs, wound care, medication titration) and close physician management that cannot be provided in a skilled nursing facility. An interdisciplinary team composed of rehabilitation nurses, therapists, a case manager and social worker, and a rehabilitation physician must provide coordinated care. The rehabilitation physician must evaluate the patient face-to-face **at least three times per week** to supervise the plan of care.
- **Medical stability and participation capability:** The patient is medically stable with vitals controlled and diagnostic evaluations completed. The patient can tolerate and actively engage in intensive therapy and has measurable potential for functional improvement. Pre-admission screening must document cognitive status, physical endurance, behavioral readiness, and any comorbidities affecting participation.
- **Appropriate rehabilitation diagnosis and goals:** The patient has a condition such as stroke, brain or spinal cord injury, major trauma, amputation, complex orthopedic conditions, multiple sclerosis, Guillain-Barré syndrome, or other severe neurological or medical impairments requiring intensive rehabilitation. There must be a reasonable expectation of functional improvement enabling discharge to a community or lesser level of care within a defined timeframe.

- **Absence of exclusionary factors:** The patient does not require mechanical ventilation or chest tubes, continuous intravenous vasopressors or pain medications, telemetry monitoring, or other intensive medical interventions unsuitable for IRF. Severe cognitive or behavioral disorders that preclude participation and unstable medical conditions are contraindications to IRF admission.

The pre-admission evaluation must document the patient's prior functional level, anticipated rehabilitation outcomes, and expected length of stay. It should demonstrate that the patient is likely to improve within a reasonable period (typically 2–3 weeks) and that the intensity and complexity of services cannot be provided effectively in a lower-level setting.

Coverage and Documentation Requirements

To substantiate medical necessity for IRF admission and continued stay, the following documentation is required:

- **Pre-admission screening and prior authorization:** A licensed clinician must perform a comprehensive pre-admission screening within **48 hours** before admission that assesses medical stability, current and prior functional status, anticipated rehabilitation potential, expected length of stay, and discharge plan. The rehabilitation physician must concur with the screening findings. Submit this documentation with the prior authorization request. Failure to obtain prior authorization may result in denial of coverage.
- **Intensity and complexity criteria:** Document that the patient requires intensive therapy (3 hours per day, 5 days per week, or 15 hours over 7 days) and complex nursing and medical management. Therapy must be predominantly one-on-one and provided by licensed therapists across at least two disciplines.
- **Physician oversight:** Include evidence that a rehabilitation physician will evaluate the patient face-to-face at least **three times per week** to oversee the plan of care and modify treatment as needed.
- **Interdisciplinary team and progress documentation:** Describe how an interdisciplinary team—including a rehabilitation physician, nurses, therapists, social worker, and case manager—will coordinate care. Weekly team conferences should be documented, noting each discipline's participation and the patient's progress. Daily progress notes must demonstrate ongoing need for intensive therapy and complex nursing.
- **Recertification and continued stay reviews:** Submit periodic recertification documentation (typically every 7–14 days) that includes updated functional measurements, medical stability, progress toward discharge goals, and justification for continued IRF stay. Continued stay is approved only if the patient continues to meet IRF criteria and shows measurable progress.

Alternatives to Inpatient Rehabilitation

- **Skilled nursing facility (SNF):** Patients who cannot tolerate 3 hours of therapy per day but still need daily skilled nursing or therapy may be better suited for a SNF.

- **Long-term acute care hospital (LTAC):** Patients requiring prolonged mechanical ventilation, complex wound care, or other intensive medical management for >25 days should be considered for LTAC rather than IRF.
- **Home health or outpatient therapy:** Patients with lower intensity needs and adequate support at home may receive therapy through home health or outpatient programs.
- **Hospice or palliative care:** For patients with limited rehabilitation potential and life-limiting illness, palliative/hospice services may be more appropriate.

Facility Course and Optimal Recovery

Pre-admission: Complete a comprehensive assessment and verify that the patient meets intensity and complexity criteria. Obtain rehabilitation physician approval.

Day 0–1 (Admission):

- Conduct a post-admission physician evaluation within 24 hours and confirm the pre-admission screening findings. Establish individualized rehabilitation and medical goals.
- Nursing performs comprehensive assessments and initiates bowel/bladder programs, skin care, fall precautions, and medication reconciliation. A rehabilitation nurse provides 24-hour nursing care.
- Physical, occupational, and speech therapists perform baseline evaluations and schedule therapy sessions.
- Care manager/social worker meets the patient and family to discuss discharge planning and social support.

Ongoing care (Days 2–14):

- **Therapy intensity:** Provide at least **3 hours of therapy per day** for 5–6 days per week (minimum 15 hours per week). Therapies may include gait training, balance and strengthening exercises, ADL training, cognitive/communication therapy, and swallowing therapy.
- **Medical management:** The rehabilitation physician examines the patient at least three times per week, monitors medical issues (pain, spasticity, blood pressure, seizures), and adjusts medications.
- **Nursing care:** Nurses monitor vital signs, manage wounds, catheters or lines, and provide education on self-care. They coordinate bowel/bladder training, spasticity management, and assist with therapy interventions.
- **Interdisciplinary team conferences:** A weekly meeting includes the physician, nursing, therapists, and case manager to review progress, update the plan, and plan for discharge.
- **Patient/family education:** Teach energy conservation, safe transfers, home modifications, and use of adaptive equipment.

Discharge planning (typically Days 10–21):

- Review functional gains and ensure the patient meets rehabilitation goals. Many patients discharge after **10–20 days**, with an **average inpatient rehab stay of ~12.4 days**.
- Arrange follow-up therapy, home modifications, durable medical equipment, and caregiver training. Address transportation, community reintegration, and psychosocial needs.
- Provide written instructions, medication list, and emergency plan.

Goal Length of Stay and Extended Stay Criteria

The expected length of stay in an inpatient rehabilitation facility is generally **10–20 days**, although it varies by diagnosis and patient condition. Data from national registries suggest an average IRF stay of **about 12.4 days** for major orthopedic and neurologic conditions. Extended stays may be approved when:

- The patient has multiple comorbidities or complications (e.g., infections, uncontrolled pain) that delay participation in therapy.
- Additional time is required for the patient to achieve functional goals necessary for safe community discharge.
- There are barriers to discharge such as lack of caregiver support or delays in securing necessary home modifications or durable medical equipment.

Continued stay is justified only if the patient continues to meet all IRF criteria, shows measurable functional gains, and still requires high-intensity therapy and complex nursing services. Recertification reviews should be completed at least weekly to demonstrate ongoing need.

Discharge Planning and Community Support

Discharge planning begins at admission and involves the patient, family, and the interdisciplinary team. Essential elements include:

- **Home safety evaluation:** Determine necessary home modifications (ramps, grab bars, bathroom equipment) and secure durable medical equipment.
- **Caregiver training:** Teach family members safe transfer techniques, proper body mechanics, and assistance with ADLs and exercises.
- **Medication and follow-up:** Provide a reconciled medication list and arrange follow-up with the primary care provider, specialist physicians, and outpatient therapists. Provide instructions for continued home exercises.
- **Community resources:** Link the patient to community support services, such as transportation programs, support groups, vocational rehabilitation, and home care agencies.

Evidence Summary

Background and clinical evidence: Inpatient rehabilitation facilities are intended for patients who require an intensive rehabilitation program combined with complex nursing and physician services. The CMS IRF reference booklet states that IRF admission is reasonable and

necessary only if the patient requires complex nursing, close physician management, an interdisciplinary team, and intensive rehabilitation. Therapy intensity is generally defined as **3 hours per day on at least 5 days per week (15 hours per week)**. The pre-admission screening must occur within **48 hours** before admission and document expected improvement and discharge plan. During the IRF stay, the rehabilitation physician must perform **three face-to-face visits per week**. The Courage Kenny Rehabilitation Institute guidelines specify that patients must be medically stable, capable of participating in 3 hours of therapy per day 5–6 days per week, require two or more therapy disciplines, and have potential to make functional gains; patients on ventilators, with chest tubes, or requiring IV vasopressors/pain medications are not accepted.

Rationale for inpatient rehabilitation: IRF services provide intensive, coordinated therapy for patients with complex functional deficits. The multidisciplinary team and daily physician oversight accelerate recovery compared with SNF or outpatient settings. Patients who cannot tolerate intensive therapy, have unstable medical conditions, or lack rehabilitation potential should be treated in other settings (SNF, LTAC, home health, or hospice).

References

1. **CMS Inpatient Rehabilitation Facility Reference Booklet:** Outlines medical necessity for IRF admission, requiring complex nursing services, close physician management, and an interdisciplinary team, and describes therapy intensity (3 hours/day, 5 days/week, or 15 hours/week). It also mandates a pre-admission screening within 48 hours before admission and notes that the rehabilitation physician must perform three face-to-face visits per week.
2. **Courage Kenny Rehabilitation Institute – Admission Guidelines:** States that patients must be medically stable, able to tolerate 3 hours of therapy per day for 5–6 days per week, require two or more therapy disciplines, and have potential to make significant functional gains; patients with ventilators, chest tubes, or requiring intravenous vasopressors or pain medications are not accepted.

Long-Term Acute Care Hospital (LTAC/LTACH) Admission Policy

Curative Health Plan

Policy Statement

This Curative Health Plan medical policy defines the clinical requirements for admission to a long-term acute care hospital (LTACH). It represents the consensus of the Curative senior medical policy board and is based solely on publicly available sources such as CMS guidance, professional society recommendations, and evidence-based literature. Proprietary utilization review tools are not incorporated into this policy.

Care Planning

Medical Necessity Criteria for LTACH Admission

Long-term acute care hospitals (LTACHs) provide extended hospital-level care for patients who have completed an acute hospitalization but still require complex medical management that cannot be safely delivered in a skilled nursing facility or inpatient rehabilitation unit. Admission to an LTACH is medically necessary when at least **one** of the following conditions is present **and** the patient is medically stable and expected to benefit from extended hospital care:

- **Respiratory complexity requiring daily physician and respiratory therapist intervention:** The patient requires prolonged mechanical ventilation or weaning support (commonly ventilated for **more than 21 days**) and needs daily respiratory therapy with individualized weaning protocols and physician oversight.
- **Complex wound care and medical management:** The patient has large or non-healing wounds requiring advanced dressings, negative-pressure therapy, or frequent debridement that exceed SNF capabilities. The patient may also require long-term intravenous antibiotics for severe or recurrent infections or management of sepsis with daily physician oversight.
- **Renal replacement therapy and multiple comorbidities:** The patient requires dialysis or has multiple complex conditions (e.g., heart failure, COPD, end-stage renal disease, neurologic disorders) necessitating daily practitioner intervention, intensive nursing, and specialized equipment beyond the capacity of a SNF or IRF.
- **Medical stability and potential to benefit:** The patient is hemodynamically stable for transfer—no severe arrhythmias, hypotension, uncontrolled bleeding, or high-dose vasopressor requirements—and has a reasonable expectation of improvement or ability to transition to a lower level of care (home, SNF, or rehabilitation) after an extended stay.

Admission is appropriate only when the patient's medical or respiratory complexity is **too great for a SNF or IRF** and requires daily physician oversight and 24-hour nursing care. Patients who could be managed safely in a SNF, IRF, or home setting should not be admitted to an LTACH.

Coverage and Documentation Requirements

Coverage guidelines follow CMS rules for LTACHs and require specific documentation and prior authorization. The following elements must be addressed in the medical record:

- **Physician order and medical necessity:** A physician order must certify that the patient needs daily monitoring and specialized services that cannot be provided in a SNF or IRF. Preauthorization with submission of clinical documentation showing the patient's medical complexity and anticipated benefit may be required.
- **Expected length of stay:** LTACH stays typically exceed **25 days**, with many patients requiring **25–30 days** to achieve stabilization and meet discharge goals. This expected length of stay is generally required to qualify for LTACH reimbursement, and reimbursement may be limited for shorter stays.
- **Stability criteria for transfer:** Patients must be hemodynamically stable, have manageable respiratory and renal function, and not require emergent surgical or diagnostic procedures. The patient must be safe to leave the acute hospital environment and benefit from LTACH care.
- **Documentation of failure of lower-level care:** The medical record must document why the patient cannot be managed safely in a SNF, IRF, or home setting. Reasons may include ventilator weaning, multiple complex comorbidities requiring daily practitioner intervention, long-term intravenous antibiotics, dialysis combined with other complex care, or severe wounds requiring daily specialty treatment.
- **Recertification and continued stay criteria:** Periodic reviews (e.g., every 7–14 days) may be required to demonstrate ongoing medical complexity, progression toward weaning or healing goals, and preparation for discharge. If progress stalls or the patient no longer requires LTACH-level care, transfer to a lower level may be required.

Alternatives to LTACH Admission

- **Acute inpatient hospital:** Patients who are hemodynamically unstable, require invasive procedures or continuous critical-care interventions, or have new surgical or diagnostic needs should remain in an acute hospital until stabilized.
- **Skilled nursing facility (SNF):** Those needing daily nursing or therapy services but not ventilator weaning, dialysis, or complex medical management may be discharged to a SNF.
- **Inpatient rehabilitation facility (IRF):** Patients with strong rehabilitation potential who can tolerate three hours of therapy per day and do not need prolonged medical management may be better suited for an IRF.
- **Home health or outpatient services:** Individuals whose medical and therapy needs can be safely managed at home with nursing and therapy visits may avoid institutional care.

Facility Course and Optimal Recovery

Initial evaluation (Days 0–2):

- A comprehensive medical evaluation is performed by the LTACH physician within 24 hours of admission. Baseline assessments of cardiopulmonary status, wound status, nutrition, renal function, and infections are completed.
- Multidisciplinary team—physician, nursing, respiratory therapy, physical and occupational therapy, wound care specialists, nutrition, and social work—develops an individualized plan of care and sets long-term and short-term goals.
- Ventilator weaning protocols or dialysis schedules are established as appropriate.

Ongoing management (Days 3–25):

- **Respiratory care:** For ventilated patients, respiratory therapists provide daily weaning trials, tracheostomy management, chest physiotherapy, and oxygen titration. Regular arterial blood gases and pulmonary function assessments guide progress.
- **Wound care:** Nurses and wound care specialists perform advanced dressing changes, negative-pressure therapy, and debridement as ordered. Nutritionists optimize protein and caloric intake to promote healing.
- **Infection management:** Long-term intravenous antibiotics are administered, cultures monitored, and therapy adjusted based on infectious-disease specialist recommendations.
- **Dialysis and renal monitoring:** Dialysis treatments are coordinated with other care to minimize catabolism and maintain fluid balance. Electrolytes and renal function tests are closely monitored.
- **Therapy services:** Physical and occupational therapists provide exercises to maintain strength and prevent deconditioning, focusing on mobility, transfers, and activities of daily living as tolerated.
- **Medical oversight:** Physicians evaluate patients daily or as clinically indicated; adjustments to ventilator settings, medications, and nutrition are made. Weekly multidisciplinary meetings review progress toward transfer and discharge goals.

Preparation for transfer/discharge (Days 26+):

- Evaluate readiness to transition to a lower level of care based on ventilator independence, wound healing, infection resolution, and functional gains.
- Develop a discharge plan that may include transfer to a SNF, IRF, or home with home health services. Arrange durable medical equipment (e.g., oxygen, wheelchair), follow-up appointments, and community resources.
- Educate the patient and caregivers on medication regimens, respiratory care (e.g., tracheostomy care if still in place), wound care, nutrition, and signs of recurrence.

Goal Length of Stay and Extended Stay Criteria

LTACH stays typically range from **25 to 30 days**. This threshold is commonly used to determine eligibility for LTACH reimbursement. Extended stays beyond 30 days may be considered when ventilator weaning is prolonged, wound healing is delayed, recurrent infections occur, or additional time is needed for renal recovery. To justify continued stay, providers must document ongoing progress toward goals, continued need for hospital-level care, and barriers

to discharge. Recertification reviews should occur regularly to ensure the patient still meets LTACH criteria.

Discharge Planning and Community Support

Discharge planning begins at admission. The social worker/case manager coordinates with the patient, family, and healthcare team to:

- Assess caregiver availability and home environment, identifying barriers to safe discharge.
- Arrange appropriate follow-up care (e.g., pulmonology, nephrology, wound care specialists) and outpatient therapy.
- Secure durable medical equipment and supplies (e.g., portable ventilators, wound vac units, dialysis arrangements) and ensure insurance coverage.
- Coordinate transportation and community services such as home nursing, home physical therapy, or palliative care.

Evidence Summary

Background and clinical evidence: LTACHs are designed for patients who require extended hospital-level care beyond the typical acute inpatient stay. Key guidelines state that LTACH admission is indicated when patients no longer require intensive acute care but cannot be managed safely in lower-level facilities; average length of stay is **greater than 25 days** and patients must be medically stable for transfer. General and condition-specific criteria include prolonged ventilator weaning, complex wound care, extended intravenous antibiotics, dialysis, and multiple complex comorbidities. Patients should be hemodynamically stable, have controlled pain and sedation, and show potential for improvement toward a lower level of care.

Rationale for LTACH care: LTACHs bridge the gap between acute hospital and SNF/rehabilitation settings for patients with prolonged recovery needs. Without LTACH care, patients requiring ventilator weaning, complex wound management, or long-term intravenous therapy may experience complications, readmissions, or prolonged dependence on acute hospitals. LTACHs provide the appropriate environment, specialized staff, and equipment to support recovery and prepare patients for eventual transfer.

References

1. **Prominence Health Plan – Long-Term Acute Care Hospital (LTACH) Guidelines:** Defines LTACHs as facilities for patients who no longer require acute hospital care but are not ready for a lower level of care; average length of stay is >25 days; patients must be medically stable for transfer and may require ventilator weaning, complex wound care, dialysis, or prolonged infection management.
2. **Evidence.care – Long-Term Acute Care Hospitals:** Describes LTACHs as providing extended hospital-level care for patients needing ventilator management, dialysis, complex wound care, infection management, and post-surgical care; typical stays are 25–30 days; admission requires physician orders and stability for transfer and includes an expectation of eventual discharge to a lower level of care.

Hospice Care (Inpatient and Outpatient) Policy

Curative Health Plan

Policy Statement

This Curative Health Plan medical policy delineates the requirements for continuous home care and general inpatient hospice services. It reflects the considered judgment of the Curative senior medical policy board and is founded on publicly available information—including CMS regulations, hospice industry guidelines, and peer-reviewed evidence. No proprietary clinical decision tools were used in developing this policy.

Care Planning

Hospice Eligibility and Election

Hospice services are intended for patients with a terminal illness who elect comfort-focused, palliative care rather than curative treatment. Enrollment in hospice is medically necessary when **all** of the following are met:

- **Terminal diagnosis certification:** The patient's attending physician and the hospice medical director (or physician member of the interdisciplinary group) certify that the individual's **life expectancy is six months or less** if the disease follows its usual course. Recertification is required for subsequent benefit periods.
- **Election of hospice:** The patient (or their legal representative) signs a hospice election statement choosing palliative care and foregoing curative treatment for the terminal illness.
- **Qualified hospice provider:** The hospice provider is **certified by Medicare**, accredited by an independent organization, and appropriately licensed in the state. Coverage is subject to contract terms and benefit limits.
- **Palliative plan of care:** The care plan focuses on pain and symptom relief, physical care, counseling, and other supportive services. Hospice services are provided in benefit periods (typically 90-day followed by 60-day periods) as long as eligibility continues. The patient may revoke hospice at any time to pursue curative treatment.

Hospice care may be delivered at different levels of care depending on the patient's needs: **routine home care**, **continuous home care (CHC)** during a crisis, **general inpatient hospice (GIP)** for symptom management that cannot be managed elsewhere, and **inpatient respite care** for temporary relief to caregivers. This policy focuses on CHC and GIP levels of care.

Criteria for Continuous Home Care (CHC)

Continuous home care is a home-based hospice service provided during a crisis when the patient requires constant nursing to remain at home. CHC is medically necessary only when **all** of the following criteria are met:

- **Uncontrolled symptoms requiring constant nursing:** The patient has uncontrolled pain, dyspnea, agitation, nausea, vomiting, diarrhea, restlessness, respiratory distress, or other severe symptoms requiring frequent assessment and medication titration beyond routine home hospice.
- **Minimum service duration and nursing predominance:** CHC services provide **at least eight hours of care within a 24-hour period**, with the **majority of hours provided by registered nurses or licensed practical nurses**. Nurse's aides may supplement care but cannot substitute for nursing. Documentation of nursing and aide hours must verify that CHC criteria are met.
- **Home setting:** CHC is delivered in the patient's home or residence; it is **not appropriate** in a hospital, skilled nursing facility, or inpatient hospice unit. Services lasting less than 8 hours per day are billed as routine home hospice.

CHC is intended for short-term crises. When symptoms are controlled and the need for continuous care resolves, the patient transitions back to routine home hospice.

Criteria for General Inpatient Hospice (GIP)

General inpatient hospice provides a short-term, inpatient level of hospice care when symptoms cannot be managed safely at home. GIP is medically necessary when any **one or more** of the following indications is present:

- **Uncontrolled pain requiring intensive interventions:** Pain necessitating repeated titration of intravenous or subcutaneous opioids or complex analgesic regimens that cannot be safely delivered at home.
- **Intractable nausea, vomiting, or diarrhea:** Persistent gastrointestinal symptoms requiring parenteral medications, hydration, or continuous infusions and close monitoring.
- **Severe respiratory distress or agitation:** Dyspnea, air hunger, or agitation requiring frequent opioid or sedative titration, noninvasive ventilation, or high-flow oxygen.
- **Complex wound care or bleeding management:** Large or infected wounds, fistulas, or bleeding requiring frequent dressing changes, irrigation, or hemostatic interventions.
- **Refractory delirium or agitation:** Severe terminal agitation or delirium requiring continuous assessment and pharmacologic management.
- **Other uncontrolled symptoms or medical needs:** Seizures, severe psychosocial or spiritual distress, or other conditions requiring continuous nursing and physician oversight beyond the capabilities of home hospice.

GIP is **not intended for caregiver respite** or solely because the patient is imminently dying. It is used only when inpatient care is necessary to control symptoms. Typical length of stay is **about five days or less**, after which patients should transition back to home hospice or another appropriate setting once symptoms are controlled.

GIP may be provided in a hospice facility, skilled nursing facility, or acute care hospital when the patient's care becomes too complex for home and requires **greater than eight hours of skilled nursing per day**. Documentation must specify the uncontrolled symptoms requiring

inpatient management and be updated daily to support continued stay. Prior authorization may be required and coverage may be limited by benefit maximums.

Facility Requirements for GIP

A GIP facility must provide 24-hour nursing care, access to physicians, and comprehensive interdisciplinary support:

- **Nursing and medical staff:** Registered nurses available 24/7, with access to physicians for rapid evaluation and medication adjustments.
- **Interdisciplinary team:** Social workers, chaplains, counselors, and volunteers provide psychosocial and spiritual support for patients and families.
- **Home-like environment:** The facility should allow family visitation at any time, provide private rooms when possible, and create a comfortable setting.

Alternatives to Inpatient/Continuous Hospice Care

- **Routine home hospice:** For patients with stable symptoms requiring regular nursing visits, aide services, and interdisciplinary support.
- **Inpatient respite care:** Short stays (up to five days) in an inpatient unit to provide temporary relief to caregivers. Respite care is not covered by this policy but is part of the hospice benefit.
- **Skilled nursing facility or hospital:** If the patient's condition requires therapies or interventions not focused solely on palliation (e.g., active treatment of infection or surgery), a hospital or SNF may be more appropriate.

Hospice Course and Optimal Care

Continuous home care:

- An RN initiates a crisis plan and coordinates visits by nurses and aides to provide at least 8 hours of care in 24 hours. Interventions include frequent assessment, medication titration, wound care, and psychosocial support.
- Nurses monitor symptoms hourly or as needed, communicate with the hospice physician to adjust medications, and educate the family on signs of improvement or decline.
- Once symptoms are controlled and crisis resolves, care transitions back to routine home hospice.

General inpatient hospice:

- Upon admission, the hospice physician evaluates the patient, adjusts medications, and sets goals of care in collaboration with the patient and family.
- Nurses provide continuous assessment, medication administration (e.g., IV opioids, antiemetics), wound care, and monitoring of vital signs and comfort levels.
- Social workers and chaplains provide counseling and spiritual care; volunteers may assist with non-clinical needs.
- The care team meets daily to assess symptom control and determine readiness for discharge back to home hospice or other setting.

Goal Length of Stay and Extended Stay Criteria

Continuous home care is utilized only during crisis periods. Stays typically last **24–72 hours**, and services must total at least 8 hours in each 24-hour period with nursing predominating. Documentation of nursing and aide hours may be required to verify that CHC criteria are met. When symptoms stabilize and the need for continuous care ends, the patient reverts to routine home hospice.

General inpatient hospice stays are generally **5 days or less**, with discharge to routine home hospice or another setting once symptoms are controlled. Prior authorization may be required and coverage may be limited based on benefit maximums or contract terms. Extended stays require documentation of ongoing uncontrolled symptoms and confirmation that care continues to meet GIP criteria. Once symptom control is achieved, GIP care must end.

Discharge Planning and Family Support

Effective discharge planning includes:

- **Communication with caregivers:** Provide education on symptom management, medication administration, and what to expect during the dying process. Discuss goals of care and ensure understanding of the hospice philosophy.
- **Coordination with hospice team:** Arrange routine home hospice visits, including nursing, aides, social work, and chaplaincy. Ensure medication and equipment delivery (e.g., hospital bed, oxygen) for home use.
- **Address caregiver needs:** Offer bereavement counseling, respite resources, and social services to support caregivers during and after hospice care.

Evidence Summary

Background and clinical evidence: Hospice services focus on palliative care for patients with a life expectancy of **six months or less**, requiring certification by two physicians and election by the patient. Continuous home care is a short-term crisis service that must provide at least **8 hours of predominantly nursing care within a 24-hour period** and cannot be delivered in hospitals or nursing facilities. General inpatient hospice (GIP) is reserved for uncontrolled symptoms that cannot be managed at home and is not for respite or routine care; typical stays are about **five days**. GIP facilities must have 24-hour nursing and interdisciplinary support and provide a home-like environment.

Rationale for hospice levels of care: Continuous home care allows patients to remain at home during crises, avoiding unnecessary hospitalization. GIP provides short-term inpatient care when symptoms require intensive management. Appropriate use of these levels ensures that patients receive comfort-focused care in the most suitable setting and that resources are used efficiently. Once symptoms are controlled, patients should transition back to routine home hospice or another appropriate setting.

References

1. **Medicare.gov – Hospice Care:** Explains that hospice eligibility requires certification by two physicians that the patient's life expectancy is six months or less and that the patient chooses palliative care and signs an election statement.
2. **CGS Medicare – Hospice Continuous Home Care Level:** States that continuous home care must provide at least 8 hours of care in a 24-hour period, the majority of which must be nursing, and cannot be provided in a hospital or SNF; fewer than 8 hours of care is billed as routine hospice care.
3. **Palliative Care Network of Wisconsin – General Inpatient Hospice Level of Care:** Notes that general inpatient hospice is for short-term management of uncontrolled symptoms not manageable in other settings, typically lasting around five days, and should not be used for respite or imminent death alone. Criteria include uncontrolled pain, severe nausea/vomiting, respiratory distress, complex wounds, and refractory delirium; GIP facilities must offer 24-hour nursing and interdisciplinary support in a home-like environment.