



NHS MEDICAL POLICY

Long Term Acute Care (LTAC) Facility Alternative Care 2014-004

The most cost-effective option that meets the member's needs will be considered.

LTAC admission may be indicated when **ALL** the following are present:

1	The member is medically stable for transfer.
2	The member's medical needs exceed the capacity of a less restrictive setting like a skilled nursing facility or an inpatient rehabilitation facility.
3	<p>Long-term or complex care needs exist. Long term care needs include 1 or more of the following:</p> <ul style="list-style-type: none"> • Dependence on a ventilator requiring long term weaning. • Multiple IV or parenteral medications with adjustments in dose 4 or more times a day • Monitoring of significantly medically active conditions requiring clinical assessment 6 or more times a day • Multiple and frequent intervention of at least 6 or more times a day (e.g., cardiac monitoring, complex wound care for multiple wounds stages 3 and above [including multiple negative pressure devices, wound vac], large draining wounds (extensive undermining/tunneling, high output fistula with caustic drainage, non-healing/open surgical wound), lower extremity wound with severe ischemia, necrotic wounds, or post skin flaps/grafts.) • Repeated debridement • Application of biologically active medications • The need for specialized high-tech equipment like cardiac monitors • On-site dialysis or surgical suites
4	If placement is requested primarily for ventilator weaning, there must be at least 2 properly documented weaning trials prior to transfer or documentation that the pulmonary or critical care physician specialist believes the member can be weaned.

5	<p>Members requiring ventilator weaning must exhibit respiratory stability, including ALL the following:</p> <ul style="list-style-type: none"> • Safe and secure tracheostomy • No need for sophisticated ventilator modes • Positive end-expiratory pressure (PEEP) requirement 10 cm H₂O (981 Pa) or less • Stable airway resistance and lung compliance • Adequate oxygenation (oxygen saturation 90% or greater) on FIO₂ 60% or less • Oxygenation stable during suctioning and repositioning
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SOURCES

1. Boles, J.M., Bion, J., Connors, A., Herridge, M., Marsh, B., Melot, C., et al. (2007). Weaning from mechanical ventilation. *European Respiratory Journal*, 29 (5), 1033-1056.
2. Cook, D., Meade, M., Guyatt, G., Griffith, L., Booker, L. (2000). Criteria for weaning from mechanical ventilation: evidence report/technology assessment no. 23 (Prepared by McMaster University under Contract No. 290-97-0017). AHRQ Publication No. 011-E010. Rockville MD: Agency for Healthcare Research and Quality.
3. Scheinhorn, D.J., Chao, D.C., Hassenpflug, N.S> Gracey, D.R. (2001). Post-ICU weaning from mechanical ventilation: the role of long-term facilities. *Chest*, 120(6 Suppl), 482S-4S

CODE REFERENCE (This may not be a comprehensive list of codes to apply to this policy.)

96.70; 96.71, 96.72, V46.13

POLICY HISTORY/REVISION INFORMATION

Date	Action/Description
09/25/2015	Annual review and approval by UM Committee
06/16/2016	Changed from Post Hospital Care (PHC) to Alternative Care (AC)
06/14/2017	Annual review and approval by UM Committee
06/13/2018	Annual review and approval by UM Committee
06/12/2019	Annual review and approval by UM Committee
06/11/2020	Annual review and approval by UM Committee
06/11/2021	Annual review and approval by UM Committee
06/10/2022	Annual review and approval by UM Committee
05/26/2023	Annual review and approval by UM/QM Committee
05/20/2024	Annual review and approval by UM/QM Committee