Effective Date: 9-25-2014

Nevada Health Solutions LLC

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	Long-term or complex care needs exist. Long term care needs include **1 or more** of the following: • 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	Members requiring ventilator weaning must exhibit respiratory stability, including **ALL** the following: • 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

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