

## Post-acute and Residential Treatment Facility Stays

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**Policy Number:**

MM.12.016

**Line(s) of Business:**

HMO; PPO

**Section:**

Other/Miscellaneous

**Place(s) of Service:**

Inpatient

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### I. Description

Post-acute care is comprehensive inpatient care designed for an individual recovering from an acute illness. It is goal-oriented treatment rendered to treat one or more specific active complex medical conditions or to administer one or more technically complex treatments. Post-acute care requires the coordinated services of an interdisciplinary team and is part of a specifically designed treatment plan. Examples include, but are not limited to, skilled nursing, inpatient rehabilitation and long-term acute care.

Post-acute care is a distinct form of health care services that focus on providing the skilled medical care needed to transition individuals from the acute care setting. Post-acute care may be rendered in a freestanding facility or in a designated unit of a general or rehabilitation hospital. Post-acute care requires a treatment plan with specific goals attained through the provision of skilled nursing, rehabilitative and medical services by licensed professionals. Specifically, post-acute care should not be confused with custodial care which is designed to assist medically stable individuals with their activities of daily living (for example, ambulating, bathing and dressing). Custodial care does not require the skills of a trained professional or supervision of a physician.

Adult/pediatric mental health or substance abuse residential treatment facilities provide short-term treatment within structured therapeutic environments. A mental health or substance abuse residential treatment facility may be located in a hospital or in a community-based setting. Each program provides intensive treatment and continuous 24-hour supervision for members who do not require the intensive medical treatment or hospital care. Residential treatment facilities serve members who have sufficient potential to respond to active treatment, need a protected and structured environment and for whom outpatient, partial hospitalization or acute hospital inpatient treatments are not appropriate. Treatment is provided on all shifts by appropriately licensed professionals as guided by a comprehensive treatment/care/service plan. Treatment plans are expected to include a discharge plan that focuses on safely and effectively transitioning an individual to a less intensive level of care.

## II. Criteria/Guidelines

### A. Skilled Nursing Facility

Skilled nursing facility (SNF) services are covered (subject to Limitations and Administrative Guidelines) when all of the Section A criteria are met and one or more of the Section B criteria are met:

#### Section A

1. The individual requires skilled nursing or skilled rehabilitation services that must be performed by, or under the supervision of, professional or technical personnel.
2. The individual requires these skilled services on a daily basis. (Note: if skilled rehabilitation services are not available on a 7-day-a-week basis, an individual whose inpatient stay is based solely on the need for skilled rehabilitation services would meet the "daily basis" requirement when he/she needs and receives those services at least 5 days a week).
3. The daily skilled services can be provided only on an inpatient basis in a SNF setting.
4. SNF services must be furnished pursuant to a physician's orders and be reasonable and necessary for the treatment of an individual's illness or injury (i.e., be consistent with the nature and severity of the individual's illness or injury, his particular medical needs and accepted standards of medical practice).
5. Initial admission and subsequent stay in a SNF for skilled nursing services or rehabilitation services must include development, management and evaluation of a plan of care as follows:
  - a. The involvement of skilled nursing personnel is required to meet the individual's medical needs, promote recovery and ensure medical safety (in terms of the individual's physical or mental condition).
  - b. There must be a significant probability that complications would arise without skilled supervision of the treatment plan.
  - c. Care plans must include realistic nursing goals and objectives for the individual, discharge plans and the planned interventions by the skilled staff to meet those goals and objectives.
  - d. Updated care plans must document the outcome of the planned interventions.
  - e. There must be daily documentation of the individual's progress or complications.
6. There is a discharge plan.

Section B

Criteria	Explanations
1. Parenteral nutrition	
2. Parenteral therapy	For hydration (vitamins and electrolytes can be included.)
3. Wound care	Complex wound care involving daily skilled nursing assessment and daily complex intervention(s) such as wound debridement, soaks, irrigation, whirlpool, packing, wound vacuum therapy, and/or complex dressing changes requiring sterile (aseptic) technique.
4. Tube feeding	Appropriate if the patient is pump fed and there is a history of aspiration pneumonia in past 12 months or history of multiple episodes of aspiration pneumonia while on tube feedings. Also appropriate for initiation of tube feeding up to 30 days.
5. Tracheostomy care and suctioning	Requires suctioning at least once a shift and skilled nursing assessment at least once a shift.
6. Ventilator	Ventilator care and/or weaning
7. Rehabilitation therapy services	Daily planned, progressive program with documented short and long term attainable goals require services of therapist to increase functional ability; must be a restorative program.
8. Medications	IV (including IV pumps, PCA pumps) IM and SQ may be appropriate depending on frequency and acuity of patient.
9. Oxygen	Initial phase involving titration
10. Renal dialysis	Appropriate for complicating problems which require skilled nursing services and/or when skilled nursing assessment and monitoring services pre and post dialysis are being provided by the facility.

**B. Acute Inpatient Rehabilitation**

Acute inpatient rehabilitation services are covered (subject to Limitations and Administrative Guidelines) when ALL of the following are present:

1. Individual has a new (acute) medical condition or an acute exacerbation of a chronic condition that has resulted in a significant decrease in functional ability such that they cannot adequately recover in a less intensive setting.

2. Individual's overall medical condition and medical needs either identify a risk for medical instability or a requirement for physician and other personnel involvement generally not available outside the hospital inpatient setting.
3. Individual requires an intensive inter-disciplinary, coordinated rehabilitation program (as defined in the description of service) with a minimum of three (3) hours active participation daily.
4. Individual is medically stable enough to no longer require the services of a medical/surgical inpatient setting.
5. The individual is capable of actively participating in a rehabilitation program, as evidenced by a mental status demonstrating responsiveness to verbal, visual, and/or tactile stimuli and ability to follow simple commands.
6. Individual's mental and physical condition prior to the illness or injury indicates there is significant potential for improvement.
7. The necessary rehabilitation services are prescribed by a physician, and require close medical supervision and skilled nursing care with the 24-hour availability of a nurse and physician who are skilled in the area of rehabilitation medicine.
8. There is a discharge plan.

#### C. Long-term Acute Care Hospital

Long-term acute care (LTAC) services are covered (subject to Limitations and Administrative Guidelines) when all the following criteria are met:

1. The patient is stable for transfer to LTACH.
2. Clinical assessment supports the expectation that the patient will benefit from and improve with the chosen LTACH program.
3. Management of the patient requires resources (e.g., diagnostic services, more intensive skilled services such as specialty nursing care or onsite physician assessments) that are beyond the capabilities of alternative levels of care (e.g., SNF).
4. Clinical assessment supports the expectation that the patient will be discharged to an alternative setting, i.e., that there is a discharge plan.

#### D. Residential Facility-Based Care

1. Traumatic brain injury (TBI) residential facility-based care, is covered (subject to Limitations and Administrative Guidelines) when ALL of the following criteria are met:
  - a. Criteria in II.B.3, II.B.4, II.B.6 and II.B.8 above are met;
  - b. The patient must have sufficient cognitive function to understand and participate in the program as well as adequate language expression and comprehension, i.e., the patient should not have significant aphasia.

2. Mental health residential facility-based care, adult and pediatric, is covered (subject to Limitations and Administrative Guidelines) when ALL of the following criteria are met:
  - a. Appropriate DSM 5 or corresponding ICD diagnosis
  - b. Coordinated services are provided by an interdisciplinary team as part of a specifically designed treatment plan
  - c. The psychiatric condition or emotional disturbance interferes with the member's ability to function in her/his community setting.
  - d. The duration of the exacerbation of the psychiatric or emotional disturbance is expected to be temporary and responsive to treatment.
  - e. The member's condition cannot be appropriately treated in a less restrictive setting.
  - f. Member (and guardian, when appropriate) is willing to participate in treatment voluntarily
  - g. Admission request is not primarily based on a lack of immediate or long term residential housing placement availability.
3. Mental health residential facility-based care, adult and pediatric, is covered for eating disorders (subject to Limitations and Administrative Guidelines) when ALL of the criteria in II.D.2 above are met and ALL of the following criteria are met:
  - a. The member is medically stable and does not require IV fluids, tube feedings or daily lab tests.
  - b. The member has had a recent significant weight change and cannot be stabilized in a less restrictive level of care.
  - c. The member needs direct supervision at all meals and may require bathroom supervisor for a time period after meals.
  - d. The member is unable to control obsessive thoughts or to reduce negative behaviors (e.g., restrictive eating, purging, laxative or diet pill abuse, and/or excessive exercising) in a less restrictive environment.
  - e. There is an indication of progression through stages of change as evidenced by a specific recent event that has significantly impacted motivation, (e.g., a near-lethal overdose, family issue, seizure or other medical issue, change in external/legal motivators, first time seeking services without external motivators, etc.,) sufficient to suggest increased likelihood of benefit from this service from previous treatment episodes.
4. Substance abuse residential facility-based care is covered (subject to Limitations and Administrative Guidelines) when ALL of the following criteria are met:
  - a. Appropriate DSM or corresponding ICD substance use or disorder diagnosis.
  - b. Sufficient cognitive capacity and mental health stability to safely participate in, respond to, and benefit from active substance use treatment.
  - c. Not at substantial risk for severe withdrawal syndrome as determined by initial bio-psychosocial assessment or CIWA evaluation.
  - d. Member presents with significant psychosocial deficit.
  - e. Member's recovery environment is compromised warranting a structured residential treatment to support recovery.

- f. Member's comorbid psychiatric and/or medical conditions are stable enough to be managed in a substance use disorder residential treatment setting.
- g. A less intensive/restrictive level or care is insufficient for effective treatment to continue.
- h. Coordinated services are provided by an interdisciplinary team as part of a specifically designed treatment plan.
- i. Member is considered to be a risk of serious, imminent physical harm to self or others resulting from their continued use of substances.
- j. Admission request is not primarily based on the member's current lack of placement or housing.

### **III. Limitations**

- A. Continued stay is not covered when any ONE of the following occurs:
  - 1. The individual's condition has changed such that skilled medical or rehabilitative care is no longer needed;
  - 2. The individual has met the goals that would permit discharge or transfer to a lower level of care;
  - 3. The individual has failed to make significant progress towards treatment goals during a reasonable period;
  - 4. There is a lack of a consistent individualized therapy program;
  - 5. The individual is unwilling to be actively involved in the care as demonstrated by a refusal to participate in the recommended treatment plan;
  - 6. The individual's activities or behavior prevents attainment of a successful outcome;
  - 7. The individual's primary need becomes psychiatric in nature in which case care should be transitioned to the appropriate setting;
  - 8. The individual has only one (1) skilled need and that need can be met in a less intensive medical care setting;
  - 9. When the discharge to a lesser level of care is appropriate and safe, but there were avoidable delays in implementing the discharge plan;
  - 10. It has been determined that the established goals are not realistic or appropriate;
  - 11. Care has become custodial.
- B. If a determination is made that an individual no longer requires acute inpatient level of care and a lower level of care is appropriate, the individual must accept the first available bed. If the individual does not, they will be responsible for acute inpatient charges from the date it was determined that a lower level of care was appropriate.

### **IV. Administrative Guidelines**

- A. Precertification is required for initial admission and continued stay for out-of-state and non-participating providers of free-standing skilled nursing facilities, acute inpatient rehabilitation and long term acute care facilities. To precertify, please complete HMSA's [Post-Acute Care Services Precertification Request](#) and mail or fax the form as indicated. Medical record documentation supporting that all applicable criteria are met must be submitted.
- B. Precertification is required for residential facility-based care (medical and behavioral health).
  - 1. To precertify for traumatic brain injury (TBI) residential facility-based care please complete HMSA's [Post-Acute Care Services Precertification Request](#) and mail or fax the form as indicated. Medical record documentation supporting that all applicable criteria are met must be submitted.
  - 2. For precertification of residential mental health facility-based care and substance abuse residential facility-based care, please contact Beacon Hawaii at (855) 856-0578 or [BeaconHawaiiAuthorizationRequest@BeaconHS.com](mailto:BeaconHawaiiAuthorizationRequest@BeaconHS.com).

## V. Important Reminder

The purpose of this Medical Policy is to provide a guide to coverage. This Medical Policy is not intended to dictate to providers how to practice medicine. Nothing in this Medical Policy is intended to discourage or prohibit providing other medical advice or treatment deemed appropriate by the treating physician.

Benefit determinations are subject to applicable member contract language. To the extent there are any conflicts between these guidelines and the contract language, the contract language will control.

This Medical Policy has been developed through consideration of the medical necessity criteria under Hawaii's Patients' Bill of Rights and Responsibilities Act (Hawaii Revised Statutes §432E-1.4), generally accepted standards of medical practice and review of medical literature and government approval status. HMSA has determined that services not covered under this Medical Policy will not be medically necessary under Hawaii law in most cases. If a treating physician disagrees with HMSA's determination as to medical necessity in a given case, the physician may request that HMSA reconsider the application of the medical necessity criteria to the case at issue in light of any supporting documentation.

## VI. References

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