



**LONG TERM ACUTE CARE HOSPITAL:
CRITERIA FOR ADMISSION
HS-162**



Harmony Behavioral Health, Inc.

Harmony Behavioral Health of Florida, Inc.

Harmony Health Plan of Illinois, Inc.

HealthEase of Florida, Inc.

*'Ohana Health Plan, a plan offered by
WellCare Health Insurance of Arizona, Inc.*

WellCare Health Insurance of Illinois, Inc.

WellCare Health Insurance of New York, Inc.

WellCare Health Plans of New Jersey, Inc.

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WellCare of Ohio, Inc.

WellCare of Texas, Inc.

WellCare Prescription Insurance, Inc.

**Long Term Acute
Care Hospital:
Criteria for Admission**

Policy Number: HS-162

Original Effective Date: 4/1/2010

Revised Date(s): 7/21/2011

DISCLAIMER

The Clinical Coverage Guideline is intended to supplement certain standard WellCare benefit plans. The terms of a member's particular Benefit Plan, Evidence of Coverage, Certificate of Coverage, etc., may differ significantly from this Coverage Position. For example, a member's benefit plan may contain specific exclusions related to the topic addressed in this Clinical Coverage Guideline. When a conflict exists between the two documents, the Member's Benefit Plan always supersedes the information contained in the Clinical Coverage Guideline. Additionally, Clinical Coverage Guidelines relate exclusively to the administration of health benefit plans and are NOT recommendations for treatment, nor should they be used as treatment guidelines. The application of the Clinical Coverage Guideline is subject to the benefit determinations set forth by the Centers for Medicare and Medicaid Services (CMS) National and Local Coverage Determinations and state-specific Medicaid mandates, if any.

APPLICATION STATEMENT

The application of the Clinical Coverage Guideline is subject to the benefit determinations set forth by the Centers for Medicare and Medicaid Services (CMS) National and Local Coverage Determinations and state-specific Medicaid mandates, if any.

BACKGROUND

Mechanical ventilation is a method that uses a device to help patients breathe when they are unable to breathe sufficiently on their own. Mechanical ventilation is indicated as a measure to control ventilation in critically ill patients and as prophylaxis for impending collapse of other physiologic functions. It can be given by using positive or negative pressure. Physiologic indications include respiratory or mechanical insufficiency and ineffective gas exchange. Mechanical ventilation devices provide oxygen and carbon dioxide transport between the environment and the alveolar-pulmonary capillary interface. The desired effect of mechanical ventilation is to maintain appropriate levels of P_{O_2} and P_{CO_2} in arterial blood while unloading the ventilatory muscles. Endotracheal intubation is usually performed to facilitate mechanical ventilation.

Ventilator weaning is used to describe the process of gradually removing the patient from the ventilator and restoring spontaneous breathing after a period of mechanical ventilation. This process has also been referred to as discontinuation or liberation from mechanical ventilation. Four modes of discontinuing patients from mechanical ventilation are in general use: trials of spontaneous breathing with or without the addition of continuous positive airway pressure, SIMV, PSV, and NPPV. Although most physicians generally use one of the first three modes alone, some have used them in combination. As a discontinuation mode, the role of NPPV is presently evolving. It is being used as an early extubation and discontinuation technique in intubated patients, as a bridge to avoid reintubation, and to serve a prophylactic role in postoperative patients who are at high risk of respiratory complications. Studies have not consistently shown spontaneous breathing, SIMV, or PSV modes to be superior to the others. A variety of unconventional techniques have been tried for discontinuing mechanical ventilation, including inspiratory resistive training %, mandatory minute-volume ventilation, and biofeedback. Their roles remain to be defined by controlled prospective studies.

Data from observational studies has proven that 34–60% of patients who are discharged from the ICU, as being ventilator dependent, can be successfully weaned when they are transferred to units dedicated to ventilator weaning. Various types of facilities may be considered for patients who require ongoing mechanical ventilation. Those patients who leave the ICU but require hospitalization can receive care in a specialized respiratory care unit of the hospital or a general medical/surgical unit in the hospital. For patients with special medical needs who can be discharged from the hospital, care can be given in a subacute care unit of the hospital, a long-term hospital or a rehabilitation hospital. If the patient is capable of independent living, they can be discharged to a skilled nursing facility or home.

POSITION STATEMENT

Admission to a long-term acute care hospital for the purposes of ventilator management and weaning is **considered medically necessary** if ALL of the following criteria are met:

- Member is medically stable for transfer **AND**,
- Is no longer appropriate for care in the current setting **AND**,
- Member cannot be safely treated in a less restrictive setting like a skilled nursing facility or an inpatient rehabilitation facility **AND**,
- A long-term need exists
 - **Long term care needs include one or more of the following:** (V46.11) Dependence a ventilator, Multiple IV or parenteral medication 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, like ventilator management, cardiac monitoring, complex wound care for multiple wounds stages 3 and above, including multiple negative pressure devices (wound vac), repeated debridement, application of biologically active medications and the need for specialized high tech equipment like cardiac monitors, on-site dialysis or surgical suites **AND**,

- If placement is requested for 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 **AND**,
- The member exhibits respiratory stability, including **ALL** of the following:
 - Safe and secure tracheostomy (V44.0 Tracheostomy Status); **AND**,
 - No need for sophisticated ventilator modes; **AND**,
 - Positive end-expiratory pressure (PEEP) requirement 10 cm H₂O (981 Pa) or less; **AND**,
 - Stable airway resistance and lung compliance; **AND**,
 - Adequate oxygenation (oxygen saturation 90% or greater) on FIO₂ 60% or less; **AND**,
 - Oxygenation stable during suctioning and repositioning

Discharge screens from an Long Term Acute Facility are met when:

- The member is hemodynamically stable without daily medication adjustments **AND**,
- Has a stable hemoglobin and hematocrit without transfusion **AND**,
- Has stable electrolytes without daily parenteral adjustments **AND**,
- No longer requires cardiac monitoring **AND**,
- Is stable off the ventilator or is stable on the ventilator and considered not able to be weaned **AND**,
- Is clear of infection or is stable on antibiotic regimen **AND**,
- Is stable on current nutritional support (whether it is parenteral, oral or percutaneous G/J tube) **AND**,
- Is no longer requiring hemodialysis or is stable for transport to and from hemodialysis **AND**,
- All care including wound care can be managed at a lower level of care.

CODING

CPT®* Codes - No applicable codes

ICD-9-CM Procedure Codes

- 96.70** Continuous Mechanical Ventilation of unspecified duration
96.71 Continuous Mechanical Ventilation for less than 96 consecutive hours
96.72 Continuous Mechanical Ventilation for 96 consecutive hours or more

HCPCS Level II Codes - No applicable codes

Covered ICD-9-CM Diagnosis Codes

V46.13 Encounter for weaning from respirator [ventilator]

*Current Procedural Terminology (CPT) 2010 American Medical Association: Chicago, IL.©©

REFERENCES

Peer Reviewed

1. Boles JM, Bion J, Connors A, Herridge M, Marsh B, Melot C, et al. Weaning from mechanical ventilation. *Eur Respir J*. 2007 May;29(5):1033-56.
2. Cook D, Meade M, Guyatt G, Griffith L, Booker L. 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. 01-E010. Rockville MD: Agency for Healthcare Research and Quality. November 2000.
3. Munoz-Price LS. Long term acute care hospital. *Clinical Infectious Diseases* 2009;49(3):438-43. DOI: 10.1086/600391
4. Pate. NP, Malagoni MA. Antimicrobial agents for surgical infections. *Surgical Clinics of North American* 2009;89(3):611-26. DOI:10.1016/j.suc.2009.03.009
5. Scheinhorn DJ, Chao DC, Hassenpflug MS, Gracey DR. Post-ICU weaning from mechanical ventilation: the role of long-term facilities. *Chest*. 2001 Dec;120(6 Suppl):482S-4S.

Government Agencies, Professional and Medical Organizations

1. American College of Chest Physicians (ACCP). Mechanical ventilation beyond the ICU. 1999.
2. Clinical issues: coverage, coding and medical review. Long-term Hospital Prospective Payment System Training Guide [Internet] Washington, DC; Centers for Medicare and Medicaid Services 2010 Guidelines for developing admission and discharge policies for the pediatric intensive care unit. Pediatric Section Task Force on Admission and Discharge Criteria, Society of Critical Care Medicine in conjunction with the American College of Critical Care Medicine and the Committee on Hospital Care of the American Academy of Pediatrics. *Crit Care Med*. 1999 Apr;27(4):843-5.

HISTORY AND REVISIONS

Date	Action
12/1/2011	<ul style="list-style-type: none">• New template design approved by MPC.
7/21/2011	<ul style="list-style-type: none">• Approved by MPC.