Inpatient Rehabilitation and Long-Term Acute Care (LTAC) Level of Care Guidelines

Applies to the following Tufts Health Plan products:

☒ Tufts Health Plan Commercial (including Tufts Health Freedom Plan)[1]

☒ Tufts Medicare Preferred HMO (a Medicare Advantage product)

☒ Tufts Health Plan Senior Care Options (SCO) (a dual-eligible product)

The following provides descriptions of levels of care (LOC) available for members in inpatient rehabilitation and long-term acute care (LTAC) facilities and is not to be used to determine medical necessity for admission. Tufts Health Plan utilizes nationally recognized medical necessity criteria to determine the appropriateness for admission and the level of care (LOC) with the facility based on the clinical information presented at the time of admission.

Any disagreements with the member's LOC should be discussed directly with the Tufts Health Plan inpatient manager (IM) or care manager (CM).

Providers should only bill the revenue codes as outlined in their provider agreements and in the applicable Inpatient Rehabilitation and Long-Term Acute Care (LTAC) Facility Payment Policy.

Note: The LOC billed must match the authorized LOC and length of stay.

LEVEL R1 REHABILITATION **REVENUE CODE 128**

Daily medical management and monitoring and skilled rehab services, physiatrist available daily, MD/NP/PA sees member at least 3 days per week for assessment and oversight.

Skilled Nursing Services

- Skilled nursing available 24 hours/day
- Nursing interventions/treatments 4-5 hours daily, which include, but may not be limited to:
  - Patient/caregiver teaching /education (e.g., medication adherence, ADLs, chronic disease management)
  - IV Management including antibiotics and heparin
  - Physical assessment requiring functions, which include, but may not be limited to:
  - Bowel and bladder management

Skilled Rehabilitation Services

- Skilled rehabilitation services 2-3 hours of therapy per day, at least 5 days/week
- Greater than or equal to two disciplines per day

Combined Services

Combined nursing and rehab minimum of six hours

[1] Commercial products include HMO, POS, PPO, Tufts Health Freedom Plan, and CareLink℠ when Tufts Health Plan is the primary administrator.

Inclusions
Per diems include, but are not limited to:

- Room and board (private or semi-private room)
- Durable medical equipment (DME), including specialized DME (e.g., Clinitron Bed, CPM)
- All ancillary services such as:
  - Laboratory services
  - Medical/surgical supplies
  - Medications
  - Diagnostic testing
  - Dialysis
  - Total parenteral nutrition (TPN)
  - Wound vacuum
  - Bed enclosure
  - Non-customized orthotic and prosthetic devices
  - Telemetry
  - Overlay air mattress
  - PAP therapy devices (e.g., C-PAP/BiPAP)
  - Bariatric equipment
  - Modified barium swallow

Exclusions
Per diem exclusions may require referral and/or prior authorization. Refer to the Referral, Prior Authorization, and Notification Policy for more information:

- Physician coverage
- Ambulance transportation
- Customized orthotic and prosthetic devices
- Psychological/neuropsychological evaluation
- Botox
- IV chemotherapy
- Radiation therapy

Examples of Diagnoses, Surgeries and Procedures
New amputation, bilateral joint replacements, single joint with active co-morbidities that limits functional impairment, incomplete spinal cord injury, progressive neurological disease, CVA with significant functional impairment, pulmonary rehab including but not limited to cardiac rehab, traumatic brain injury.

LEVEL R2 – ACUTE COMPLEX REHABILITATION **REVENUE CODE 0129**

Daily medical management and monitoring and skilled rehab services, MD/NP/PA sees member at least 3 times/week if stable, and daily if member is moderately stable, physiatrist available daily.

Skilled Nursing Services with Complex Specialized Medical Equipment

- Rehab nursing 24 hours/day
- Nursing interventions/treatments 5-6.5 hours daily, which include but may not be limited to:
  - Patient/caregiver teaching /education (e.g., medication adherence, ADLs, chronic disease management)
  - Wound management requiring complex dressing and equipment
  - IV Management including antibiotics & heparin
  - Bowel and bladder management
- Assessment and management of chronic diseases and co-morbidities (e.g., nebulizer and other respiratory treatments)
- Complex specialized medical equipment (i.e., halo traction, ventilation management, trach w/ mist).

Skilled Rehabilitation Services

- Skilled rehabilitation services at least 3 hours of therapy/day, at least 5 days/week
- Respiratory therapy twice per day
- Greater than or equal to two disciplines per day

Combined Services
Combined nursing and rehab minimum of 8 hours

Inclusions
Per diems include, but are not limited to:

- Room and board (private or semi-private room)
- All DME, including specialized DME (e.g., Clinitron Bed, CPM)
- All ancillary services, such as:
  - Laboratory services
  - Medical/surgical supplies
  - Medications
  - Diagnostic testing
  - Dialysis
  - Total parenteral nutrition (TPN)
  - Wound vacuum
  - Bed enclosure
  - Non-customized orthotic and prosthetic devices
  - Telemetry
  - Overlay air mattress
  - PAP therapy devices (e.g., C-PAP/BiPAP)
  - Bariatric equipment
  - Modified barium swallow

Exclusions
Per diem exclusions may require referral and/or prior authorization. Refer to the Referral, Prior Authorization, and Notification Policy for more information:

- Physician coverage
- Ambulance transportation
- Customized orthotic and prosthetic devices
- Psychological/neuropsychological evaluation
- Botox
- IV chemotherapy
- Radiation therapy

Examples of Diagnoses, Surgeries and/or Procedures
Acute spinal cord injuries, young stroke, ventilator member with expectations for weaning, complex burns, traumatic brain injury

LEVEL C1 - LONG TERM ACUTE CARE (LTAC) REVENUE CODE 120

Daily medical management and monitoring and skilled rehab services, pulmonologist available daily, Daily MD/NP/PA sees member daily, average length of stay is 25 days

Skilled Nursing Services (with Complex Specialized Medical Equipment)

- Rehab Nursing available 24 hours/day Nursing interventions/treatments greater than 6.5 hours per day, which include but may not be limited to:
  - Patient/caregiver teaching /education (e.g., medication adherence, ADLs, chronic) disease management)
  - IV fluids, antibiotics and heparin
  - Physical assessment requiring functions, which include but may not be limited to: bowel and bladder management
  - Minimum of three IV meds

Skilled Rehabilitation Services
Must include one of the following:

- Skilled rehabilitation services one to three hours/day, greater than or equal to 5 days/week; or
- one to two disciplines; or
- Respiratory therapy greater than three times a day for complex respiratory diagnosis or vent member and restorative nursing program

Combined Services
Combined nursing and rehab 7.5-9.5 hours/day

Inclusions
Per diems include, but are not limited to:

- Room and board (private or semi-private room)
- All DME, including specialized DME (e.g., Clinitron Bed, CPM)
- All ancillary services, such as:
  - Laboratory Services
  - Medical/Surgical Supplies
  - Medications
  - Diagnostic Testing
  - Dialysis
  - TPN
  - Wound Vacuum
  - Non-custom orthotic and prosthetic Devices
  - Telemetry
  - Overlay air mattress
  - C-PAP
  - Bariatric equipment
  - Bed enclosure

Exclusions
Per diem exclusions may require referral and/or prior authorization. Refer to the Referral, Prior Authorization, and Notification Policy for more information:

- Physician coverage
- Ambulance transportation
- Customized orthotic and prosthetic devices
- Psychological/neuropsychological evaluation
- Botox
- IV chemotherapy
- Radiation therapy

Examples of Diagnoses, Surgeries and/or Procedures
Vent management and weaning, complex wound management with significant co-morbidities

OTHER REQUIREMENTS

- All items and services must be related to the member's diagnosis and treatment and ordered by the PCP.
- LOC is determined by the CM/DCM and is based on the aggregate medical needs of the member, reflecting the needed intensity of nursing services, rehabilitation and pharmacy administration.
- The CM/DCM must have access to and knowledge of weekly meetings and family meetings, the opportunity to participate in care planning, review of cases with interdisciplinary team, and discharge planning goals, including collaboration on the need for home visits, and the opportunity to develop systems that identify and report changes of condition of subacute and custodial members within 24 hours, or by the following business day.
- At the point of member discharge, the provider must send a copy of the discharge summary to the CM/DCM and the member's PCP within **seven days** of discharge (or the member's post-discharge visit with the PCP, whichever is sooner).
- For Tufts Medicare Preferred HMO members, the facility will deliver a valid Notice of Medicare Non-Coverage (NOMNC) no later than 2 days prior to the last covered day, as required by the CMS. All completed NOMNCs must be forwarded to Tufts Health Plan within 7 days of valid delivery.
- PT, OT, ST will be routinely provided 5 or more days per week and available 7 days per week, as necessary and in accordance with the terms of the provider's health services agreement.

AUDIT AND DISCLAIMER INFORMATION

Tufts Health Plan reserves the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in this payment policy. If such an audit determines that a provider/facility did not comply with this payment policy, Tufts Health Plan will expect the provider/facility to refund all payments related to noncompliance. For more information about Tufts Health Plan's audit policies, refer to the Provider website.

This policy provides information on Tufts Health Plan claims adjudication processes. As every claim is unique, this policy is neither a guarantee of payment, nor a final indication of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management requirements (when applicable), adherence to plan policies and procedures, and claims editing logic. An authorization is not a guarantee of payment. Claims for services subject to authorization may be reviewed for accuracy and compliance with payment policies.

This policy applies to the Tufts Health Plan products, as identified in the checkboxes on the first page, and to CareLink℠ for providers in Massachusetts and Rhode Island service areas. Providers in the New Hampshire service area are subject to Cigna's provider agreements with respect to CareLink members. This policy does not apply to the Private Health Care Systems (PHCS) network (also known as Multiplan). Tufts Health Plan reserves the right to amend a payment policy at its discretion.