To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after implementation, please contact your PHP.

Table of Contents

Related Clinical Coverage Policies

Refer to https://medicaid.ncdhhs.gov/ for the related coverage policies listed below:
2A-1, Acute Care Inpatient Hospital Services

1.0 Description of the Procedure, Product, or Service

A Medicare recognized Long term Care Hospital (LTCH) is a hospital that provides inpatient diagnostic and medical treatment or rehabilitation services to beneficiaries in a general hospital inpatient setting to patients who have clinically complex medical needs, and who typically suffer from multiple acute or chronic conditions. LTCH services often include comprehensive rehabilitation services, respiratory therapy, cancer treatment, head trauma treatment, and pain management services, and the average length of stay is greater than 25 calendar days.

The Facility must meet all of the requirements that pertain to Long Term Care Hospitals by regulation, in **42 CFR 412.23 (e) (1) -(e)(8)** as well as in **Social Security Act section 1886(d)(1)(B)(iv)(I)**. They must also meet all other requirements as specified in Federal and Division of Health Service Regulation (DHSR) rules and regulations that pertain to LTCHs, and be recognized as an LTCH by Medicare.

An LTCH must meet the Utilization guidelines as found in the NC Medicaid clinical coverage policy, 2A-1, *Acute Care Inpatient Hospital Services,* **Appendix D** at*:* https://medicaid.ncdhhs.gov/.

1.1 Definitions

None Apply.

2.0 Eligibility Requirements

2.1 Provisions

2.1.1 General

(*The term "General" found throughout this policy applies to all Medicaid policies*)

a. An eligible beneficiary shall be enrolled in the NC Medicaid Program *(Medicaid is NC Medicaid program, unless context clearly indicates otherwise*);
b. Provider(s) shall verify each Medicaid beneficiary's eligibility each time a service is rendered.
c. The Medicaid beneficiary may have service restrictions due to their eligibility category that would make them ineligible for this service.

2.1.2 Specific

(***The term "Specific" found throughout this policy only applies to this policy***)

a. <u>Medicaid</u>
None Apply.

2.2 Special Provisions

2.2.1 EPSDT Special Provision: Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age

a. **42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]**

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid beneficiary under 21 years of age **if** the service is **medically necessary health care** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed practitioner).

This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his or her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the beneficiary's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the beneficiary's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product or procedure:

1. that is unsafe, ineffective, or experimental or investigational.
2. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure meets all EPSDT criteria, including to correct or improve or maintain the beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

b. **EPSDT and Prior Approval Requirements**

1. If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does **NOT** eliminate the requirement for prior approval.
2. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *NCTracks Provider Claims and*

Billing Assistance Guide, and on the EPSDT provider page. The Web addresses are specified below.

NCTracks Provider Claims and Billing Assistance Guide: https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html

EPSDT provider page: https://medicaid.ncdhhs.gov/

3.0 When the Procedure, Product, or Service Is Covered

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

3.1 General Criteria Covered

Medicaid shall cover the procedure, product, or service related to this policy when medically necessary, and:

a. the procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the beneficiary's needs;
b. the procedure, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide; and
c. the procedure, product, or service is furnished in a manner not primarily intended for the convenience of the beneficiary, the beneficiary's caretaker, or the provider.

3.2 Specific Criteria Covered

3.2.1 Specific criteria covered by Medicaid

None Apply.

3.2.2 Medicaid Additional Criteria Covered

Medicaid covers Medicare recognized LTCH services when the beneficiary:

a. Has one or more than one chronic disease or complex medical condition as listed in **Subsection 3.3** below that have stabilized, but still requires acute medical care;
b. Requires safety monitoring of drug therapy, continuous use of a respirator or ventilator, or requires suctioning or nasopharyngeal aspiration at least once per nursing shift;
c. Requires a registered nurse to be present and provide specific treatments on a 24-hour-per-day basis;
d. Requires at least one of the following treatments at the specified frequency:
    1. Extensive dressings for deep decubiti, surgical wounds, or vascular ulcers daily;
    2. Isolation for infectious disease 24-hours-per-day;
    3. Suctioning at least three times per day;
    4. Oxygen daily;
    5. Traction or extensive cast care;
    6. Catheter or wound irrigation daily; or
    7. Burn care, including extensive dressing and hydrotherapy; and
e. Requires a high acuity level of specialized or restorative therapy services at the specified frequency that include:

1. Occupational, physical, or speech therapy at least five times per week;
2. Respiratory therapy at least three times per week; or
3. Special ostomy care daily.

3.2.3 Medicare Recognized LTCH Services

Medicaid covers Medicare recognized LTCH services for beneficiaries who have one or more chronic disease(s) or complex medical condition(s), including:

a. Ventilator Dependent Respiratory Failure;
b. Chronic Obstructive Pulmonary Disease;
c. Tracheotomy;
d. Burns;
e. Infectious Disease;
f. Cardiac Disease;
g. Neurological injury or illness;
h. Complex medical disease;
i. Gastrointestinal disease;
j. Pressure wounds;
k. Multisystem failure;
l. Traumatic Brain Disorder;
m. Mental Diseases and disorder;
n. Renal disease including dialysis;
o. Infectious diseases;
p. Complex wound involvement;
q. Complex orthopedic conditions;
r. Spinal cord injury;
s. Major trauma; or
t. Other conditions covered by Medicare in an LTCH setting.

4.0 When the Procedure, Product, or Service Is Not Covered

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

4.1 General Criteria Not Covered

Medicaid shall not cover the procedure, product, or service related to this policy when:

a. the beneficiary does not meet the eligibility requirements listed in **Section 2.0;**
b. the beneficiary does not meet the criteria listed in **Section 3.0;**
c. the procedure, product, or service duplicates another provider's procedure, product, or service; or
d. the procedure, product, or service is experimental, investigational, or part of a clinical trial.

4.2 Specific Criteria Not Covered

4.2.1 Specific Criteria Not Covered by Medicaid

None Apply.

4.2.2 Medicaid Additional Criteria Not Covered

None Apply.

5.0 Requirements for and Limitations on Coverage

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for Medicaid Beneficiaries under 21 Years of Age.

5.1 Prior Approval

Prior approval is **Not** required for a Medicaid beneficiary's admission to a LTCH.

5.2 Prior Approval Requirements

5.2.1 General

None Apply.

5.2.2 Specific

None Apply.

5.3 Utilization and Quality Management

The Medicare recognized LTCH must comply with all Medicaid utilization management and review programs, including any requirements implemented for appropriateness of admissions, continued stay reviews, retrospective medical necessity reviews, and claim audits.

NC Medicaid's designee validates all diagnostic and procedural codes and related information.

The Medicare recognized LTCH must provide the following when requested by NC Medicaid:

a. Evidence to support the medical necessity, reasonableness, and appropriateness of the admission including:
   1. Medication records;
   2. Discharge summary;
   3. Diagnostic tests and medical procedures provided during the beneficiary's hospital confinement; and
b. Evidence that appropriate activities designed to continuously monitor, evaluate, and improve the quality of care and services provided to beneficiaries have been implemented**.**

6.0 Provider(s) Eligible to Bill for the Procedure, Product, or Service

To be eligible to bill for the procedure, product, or service related to this policy, the provider(s) shall:

a. meet Medicaid qualifications for participation;
b. have a current and signed Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement; and
c. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

6.1 Provider Qualifications and Occupational Licensing Entity Regulations

Hospitals may bill for Long Term Care services when the hospital:

a. Is designated by Medicare as a Long-Term Care Hospital.
b. Meets Medicaid qualifications for participation as an acute care hospital to provide hospital-based services; and
c. Medicare recognized LTCHs are enrolled as Specialty Hospitals.

6.2 Provider Certifications

The LTCH is certified under Medicare as an acute care hospital and has an average inpatient length of stay greater than 25 calendar days.

7.0 Additional Requirements

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

7.1 Compliance

Provider(s) shall comply with the following in effect at the time the service is rendered:

a. All applicable agreements, federal, state and local laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements; and
b. All NC Medicaid's clinical (medical) coverage policies, guidelines, policies, provider manuals, implementation updates, and bulletins published by the Centers for Medicare and Medicaid Services (CMS), DHHS, DHHS division(s) or fiscal contractor(s).

The Medicare recognized LTCH must:

a. Maintain all admission and discharge records for Long Term Care Hospital beneficiaries separately from the records of beneficiaries receiving services through other units of the hospital;
b. Maintain a signed certificate of need by the attending physician along with the recertification of need at 60 calendar days. Refer to clinical coverage policy, 2A-1, Acute *Care Inpatient Hospital Services* at: https://medicaid.ncdhhs.gov/

8.0 Policy Implementation/Revision Information

Original Effective Date: March 1, 2013

Revision Information:

Date	Section Revised	Change
03/01/2013	All sections and attachment(s)	Initial promulgation of policy for LTCH services which were previously called Specialty Hospitals Services
10/01/2015	All Sections and Attachments	Updated policy template language and added ICD-10 codes to comply with federally mandated 10/1/2015 implementation where applicable.
03/15/2019	Table of Contents	Added, "To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after November 1, 2019, please contact your PHP."
03/15/2019	All Sections and Attachments	Updated policy template language.
01/03/2020	Table of Contents	Updated policy template language, "To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after implementation, please contact your PHP."
01/03/2020	Attachment A	Added, "Unless directed otherwise, Institutional Claims must be billed according to the National Uniform Billing Guidelines. All claims must comply with National Coding Guidelines".
06/01/2023	All Sections and Attachments	Updated policy template language due to North Carolina Health Choice Program's move to Medicaid. Policy posted 6/1/2023 with an effective date of 4/1/2023.

Attachment A: Claims-Related Information

Provider(s) shall comply with the, *NCTracks Provider Claims and Billing Assistance Guide*, Medicaid bulletins, fee schedules, NC Medicaid's clinical coverage policies and any other relevant documents for specific coverage and reimbursement for Medicaid:

A. Claim Type

Institutional (UB-04/837I transaction)

Unless directed otherwise, Institutional Claims must be billed according to the National Uniform Billing Guidelines. All claims must comply with National Coding Guidelines.

B. International Classification of Diseases and Related Health Problems, Tenth Revisions, Clinical Modification (ICD-10-CM) and Procedural Coding System (PCS)

Provider(s) shall report the ICD-10-CM and Procedural Coding System (PCS) to the highest level of specificity that supports medical necessity. Provider(s) shall use the current ICD-10 edition and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for code description, as it is no longer documented in the policy.

C. Code(s)

Provider(s) shall report the most specific billing code that accurately and completely describes the procedure, product or service provided. Provider(s) shall use the Current Procedural Terminology (CPT), Health Care Procedure Coding System (HCPCS), and UB-04 Data Specifications Manual (for a complete listing of valid revenue codes) and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for the code description, as it is no longer documented in the policy.

If no such specific CPT or HCPCS code exists, then the provider(s) shall report the procedure, product or service using the appropriate unlisted procedure or service code.

Unlisted Procedure or Service

CPT: The provider(s) shall refer to and comply with the Instructions for Use of the CPT Codebook, Unlisted Procedure or Service, and Special Report as documented in the current CPT in effect at the time of service.

HCPCS: The provider(s) shall refer to and comply with the Instructions For Use of HCPCS National Level II codes, Unlisted Procedure or Service and Special Report as documented in the current HCPCS edition in effect at the time of service.

D. Modifiers

Provider(s) shall follow applicable modifier guidelines.

E. Billing Units

Provider(s) shall report the appropriate code(s) used which determines the billing unit(s).

F. Place of Service

Inpatient

G. Co-payments

For Medicaid refer to Medicaid State Plan:
https://medicaid.ncdhhs.gov/meetings-notices/medicaid-state-plan-public-notices

H. Reimbursement

Provider(s) shall bill their usual and customary charges.
For a schedule of rates, refer to: https://medicaid.ncdhhs.gov/

Reimbursed at the Rehabilitation per diem rate is defined in the North Carolina State Plan Amendment 4.19A.