Clinical Policy: Long Term Care Placement

Reference Number: CP.MP.71
Date of Last Review: 01/25

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description
Nursing home care includes both long term residential care and short-term post-acute or rehabilitative care. This policy addresses long term care (LTC) placement ranging from basic custodial care to more intense care needed due to dementia or other complex medical needs. Skilled services require the skills of qualified technical or professional health personnel such as registered nurses, licensed vocational nurses, physical therapists, occupational therapists, speech pathologists, or audiologists.

Policy/Criteria
I. It is the policy of health plans affiliated with Centene Corporation® that long term care placement is **medically necessary** for the following indications:

A. **Custodial/Non-Skilled Care**
Care that does not meet the criteria for skilled nursing, skilled rehabilitation, or the specialized care services included later in this policy is considered custodial care, or non-skilled care. Custodial care can be maintenance care provided by family members, health aides or other unlicensed individuals when an individual has reached the maximum level of physical or mental function and still requires assistance.

Custodial care is primarily for those who need hands on help and/or supervision with activities of daily living (ADLs) or supervision for safety or behavior management. Areas of ADLs include bathing, dressing, toileting, transferring, and eating. These are generally personal needs rather than medical and are not specific to an illness or injury. Other factors that should be considered when determining need for custodial care include ability to communicate, cognitive status, behavior, and ability to self-administer medications.

1. Placement Criteria: In determining whether an individual needs to receive custodial care, factors to consider are the level of care and medical supervision required. The decision is not based on diagnosis, type of condition, degree of functional limitation or rehabilitation potential. If multiple levels of custodial care are available at a facility, the level of need should be evaluated to determine which level of care is appropriate. Examples of different levels of care *could include*:

a. Intermediate-Light Care
Member/enrollee needs help with or is dependent for **up to two** activities of daily living, intermittent supervision and/or occasional behavior management.
b. Intermediate-Moderate Care
Member/enrollee needs help with or is dependent for **three or four** activities of daily living, frequent supervision and/or behavior management.
c. Intermediate-Heavy Care
The resident needs help with or is dependent for all **five** areas of daily living listed above, constant supervision and/or behavior management.

2. Discharge Criteria
   a. Member/enrollee is independent or requires only limited assistance with ADLs which could be provided by a home caregiver on an intermittent basis;
   b. Patient or caregiver is able and willing to meet care needs including:
      i. Managing medication regimen;
      ii. Transfers and ambulation;
      iii. Home exercise program and/or prescribed therapy program;
   c. Home environment is safe and accessible;
   d. Appropriate equipment/devices are prearranged.

B. **Dementia/Wandering Care**
Service Goal: To ensure the provision of residential care for demented member/enrollee in need of a protective environment for wandering behavior.

1. Placement Criteria: the member/enrollee must meet the following admission criteria:
   a. The member/enrollee has a diagnosis of dementia (includes Alzheimer's disease), organic brain syndrome, or other diagnoses affecting their cognitive ability such as traumatic brain injury; and
   b. Member/enrollee has failed to adequately improve with appropriate psychiatric evaluation and treatment attempts; and c or d
   c. In a *residential setting*, there is documentation that the member/enrollee exhibits problematic wandering behavior which endangers the member/enrollee or other residents and is characterized by one or more of the following:
      i. Repeatedly exits through outside doors;
      ii. Frequently wanders into off-limit areas such as the kitchen, laundry, storage, maintenance, resident rooms and other off-limit areas without responding to redirection;
      iii. Is unable to find their way back to their own room after a wandering episode;
   d. In *home and community based services* (HCBS) setting, there is documentation that the member/enrollee exhibits problematic wandering behavior characterized by one or more of the following:
      i. Repeatedly wanders away from home, requiring local police, or others to return them because of confusion about which house in the neighborhood is theirs;
      ii. Requires the family or other caregiver to lock the member/enrollee in the house when leaving the member/enrollee unattended to prevent them from

getting out and lost;
iii. Unsafe driving despite actions taken by family, caregiver, or authorities.

2. Intensity of Service: the member/enrollee must be provided with all of the following:
   a. Secure living area indoors and outdoors by means of locks and/or electronically controlled access;
   b. Activities appropriate for persons with dementia;
   c. All services, medications, supplies and equipment necessary to manage the needs of the member/enrollee.

3. Discharge Criteria
   a. Member/enrollee no longer meets placement criteria, and b or c;
   b. Member/enrollee is able to be safely managed in a lower level of care, or
   c. Member/enrollee requires higher level of care than what is able to be provided.

C. **Dementia with Behaviors Care**
Service Goal: To ensure the provision of residential care for members/enrollees with cognitive impairments in need of a protective environment for significant behaviors.

1. Placement Criteria: the member/enrollee must meet all of the following admission criteria:
   a. The member/enrollee has a diagnosis of dementia (includes Alzheimer's disease), organic brain syndrome, or other diagnoses affecting their cognitive ability such as traumatic brain injury; and
   b. The member/enrollee has failed to adequately improve with appropriate psychiatric evaluation and treatment attempts; and
   c. Documentation that the member/enrollee exhibits problematic behavior on a daily basis which endangers the member/enrollee, or other residents, that cannot be managed in a traditional nursing facility or in an HCBS setting as characterized by one or more of the following:
      i. Repeated attempts to exit through an outside door, repeatedly banging on locked door (unable to redirect);
      ii. Physical aggression toward other residents;
      iii. Suicide attempts or other self-injurious behaviors;
      iv. Throwing things in an uncontrolled manner and unable to redirect;
      v. Yelling continuously for several hours during the day or night despite treatments for pain and non-pharmacological interventions;
      vi. Repeatedly throwing self out of a wheelchair or out of bed, or throwing self to floor, requiring increased staffing for safety concerns;
      vii. Displaying sexualized behaviors, including attempts to inappropriately touch other residents;
      viii. Misuse/abuse of medications, alcohol, and/or drugs;
      ix. Mental disorders such as psychosis or depression, not manageable at a lower level of care;
      x. Two documented attempts to step member/enrollee down from dementia/wandering unit have been attempted and failed causing an

exacerbation of symptoms and increased behaviors.

2. Intensity of Service: the member/enrollee must be provided with all of the following:
   a. Secure living area indoors and outdoors by means of locks and/or electronically controlled access that is separate from the areas of other facility residents, and
   b. Staff ability to directly observe and supervise the member/enrollee at all times, and
   c. Psychiatric nursing care services with observation and assessment of member's/enrollee's changing condition, and
   d. Activities appropriate for persons with dementia, and
   e. All services, medications, supplies and equipment necessary to manage the needs of the member/enrollee.

3. Discharge Criteria
   a. Member/enrollee no longer meets placement criteria, and b or c;
   b. Member/enrollee is able to be safely managed in a lower level of care, or
   c. Member/enrollee requires higher level of care than what is able to be provided.

D. **Dialysis Care**
Service Goal: To provide skilled nursing, residential care, and supervision for members/enrollees with high acuity and specialized dialysis needs.

1. Placement Criteria: the member/enrollee must meet the following admission criteria:
   a. Member/enrollee requires dialysis and is unable to receive it in an outpatient setting due to a medical condition such as pericarditis, pneumonia or other infection, gastrointestinal bleeding, confusion or dementia, or hemodynamic instability; and
   b. Member/enrollee is unable to sit up for four hours at a time and one of the following:
      i. The member/enrollee has a wound that prohibits outpatient dialysis, or
      ii. The member/enrollee has to use a Hoyer lift for transfers.

2. Intensity of Service: the member/enrollee must be provided with:
   a. Dialysis treatment as prescribed by a nephrologist, and
   b. Evaluation and monitoring of member's/enrollee's condition on an on-going basis, and
   c. Relevant diagnostic studies and reporting of results to ordering physician on a timely basis, and
   d. All services, medications, supplies and equipment necessary to manage the needs of the member/enrollee.

3. Discharge Criteria
   a. Member/enrollee no longer meets placement criteria, and b or c;
   b. Member/enrollee is able to be safely managed in a lower level of care, or
   c. Member/enrollee requires higher level of care than what is able to be provided.

E. **Respiratory Care**
Service Goal: To provide skilled nursing, residential care, and supervision for members/enrollees requiring respiratory care who need nursing services on a 24-hour basis, but who do not require hospital care under the daily direction of a physician.

1. Placement Criteria: the member/enrollee must meet the following admission criteria:
   a. The member/enrollee requires three or more of the following in a 24-hour period performed by the facility licensed staff:
      i. Tracheostomy care twice a day and as needed;
      ii. Tracheal suctioning every four hours and as needed;
      iii. Aerosol therapy, cool mist fraction of inspired oxygen (FIO2) 28% or greater;
      iv. Chest physical therapies, such as percussion and postural drainage;
      v. Continuous positive airway pressure CPAP/bilevel positive airway pressure (BIPAP) continuous or during sleep;
      vi. CPAP or pressure support ventilation (PSV) setting on a ventilator;
      vii. Mechanical ventilation < six hours in a calendar day, without weaning in progress.

2. Intensity of Service: the member/enrollee must be provided with:
   a. Respiratory therapy needs as prescribed by member's/enrollee's physician, and
   b. Evaluation and monitoring of member/enrollee's condition on an ongoing basis, and
   c. Relevant diagnostic studies and reporting of results to ordering physician on a timely basis, and
   d. All services, medications, supplies and equipment necessary to manage the needs of the member/enrollee.

3. Discharge Criteria
   a. Member/enrollee no longer meets placement criteria, and b or c;
   b. Member/enrollee is able to be safely managed in a lower level of care, or
   c. Member/enrollee requires higher level of care than what is able to be provided.

F. **Ventilator Care**
Service Goal: To provide skilled nursing care, residential care, and supervision for members/enrollees who are dependent on mechanical ventilation to sustain life and who need nursing services on a 24-hour basis, but do not require hospital care under the daily direction of a physician.

1. Placement Criteria: the member/enrollee must meet the following admission criteria:
   a. Requires mechanical ventilation for ≥ six hours per day to sustain life. Acceptable setting modes for ventilator care include:
      i. Assist control (AC), or
      ii. Spontaneous intermittent mandatory ventilation (SIMV); OR
   b. The member/enrollee requires < six hours of mechanical ventilation and weaning from the ventilator is in progress.

2. Intensity of Service: the member/enrollee must be provided with:
   a. Mechanical ventilation needs as prescribed by member's/enrollee's physician, and
   b. Evaluation and monitoring of member's/enrollee's condition on an on-going basis, and
   c. Relevant diagnostic studies and reporting of results to ordering physician on a timely basis, and
   d. All services, medications, supplies and equipment necessary to manage the needs of the member/enrollee.

3. Discharge Criteria
   a. Member/enrollee no longer meets placement criteria, and b or c;
   b. Member/enrollee is able to be safely managed in a lower level of care, or
   c. Member/enrollee requires higher level of care than what is able to be provided.

G. **Bariatric Care**
Service Goal: To provide skilled nursing care, residential care, and supervision for member/enrollee with high acuity and specialized care due to extreme obesity.

1. Placement Criteria: the member/enrollee must meet both of the following:
   a. BMI $\geq$ 50 kg/m^2, and
   b. Member/enrollee is unable to change position, ambulate, or transfer without hands-on assistance from three or more caregivers.

2. Intensity of Service: the member/enrollee must be provided with all of the following:
   a. Nutritional counseling to assist with appropriate caloric needs
   b. Physical, occupational or restorative therapies tailored to the member/enrollee
   c. An ongoing, multidisciplinary approach to weight loss
   d. All services, medications, supplies and bariatric equipment necessary to manage the needs of the member/enrollee.

3. Discharge Criteria
   a. Member/enrollee no longer meets placement criteria, and b or c;
   b. Member/enrollee is able to be safely managed in a lower level of care, or
   c. Member/enrollee requires higher level of care than what is able to be provided.

Background
Nursing home care accounts for a substantial portion of health care costs for older individuals. For individuals who reside in these facilities, room and board costs are generally paid for by Medicaid, long term care insurance, or out-of-pocket by individuals and their families. Short stay nursing home care, such as after an acute inpatient admit for rehabilitation, is generally paid by the skilled nursing facility benefit, most often through Medicare.

Per Medicare, a patient whose inpatient stay is based solely on the need for skilled rehabilitation services would meet the daily basis requirement when they need and receive those services, even if these therapy services are offered just five or six days a week, as long as they need and get the therapy services each day they're offered.

The need for basic custodial care is not based on the medical need of an individual, rather the need for assistance with ADLs, or supervision for safety or behavior management. However, when there are complex medical needs or the need for more intense supervision, different levels of care within a nursing home facility exist.

Many states have obtained waivers from the Center for Medicare and Medicaid Services to provide community-based long term custodial care to consumers who are eligible for nursing facility care but chose to and can be safely managed in community settings.

A comprehensive geriatric assessment evaluates the individual's functional, physical, cognitive, emotional, and psychosocial status. The Omnibus Reconciliation Act of 1987 (OBRA) requires that nursing homes complete a comprehensive assessment at the time of admission in order to develop a comprehensive treatment plan. Information from this assessment and treatment plan will help determine the level of care that the individual requires upon admission.

Ongoing assessment of an individual's status is required to ensure the appropriate level of care is maintained to ensure patient needs are met. An individual's status changes can be observed by both facility staff and the family/friends of the individual. Family meetings are an important component of care to serve as a means of learning and sharing information. Medical decision making and advanced care planning should be shared by the facility and medical staff as well as the family. Changes in an individual's status should also be shared with the Health Plan Case Manager to ensure proper placement.

Definitions
Custodial care provides services that assist a member/enrollee with ADLs such as assistance with walking, bathing, dressing, feeding, toileting, and supervision of medication that can normally be self-administered. Services can be provided by someone who is not a trained medical or paramedical personnel.

Coding Implications
This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2024, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up to date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT® Codes	Description
90960	End-stage renal disease (ESRD) related services monthly, for patients 20 years of age or older, with four or more face to face visits by a physician or other qualified health care professional per month

CPT® Codes	Description
90961	End-stage renal disease (ESRD) related services monthly, for patients 20 years of age or older, with two to three face to face visits by a physician or other qualified health care professional per month
90962	End-stage renal disease (ESRD) related services monthly, for patients 20 years of age or older, with one face to face visit by a physician or other qualified health care professional per month
94004	Ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing, nursing facility, per day

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Policy developed and reviewed by specialist.		05/14
Minor wording changes for clarity. References reviewed and updated.	04/18	04/18
References reviewed and updated. Codes updated. Specialist Reviewed.	04/19	04/19
Deleted the following codes as informational only: 94660, E0470, E0471, E0472	05/19	
Annual review completed. Coding reviewed and updated. New ICD-10 codes of E66.01 and Z68.43 through Z68.45 added; G30.1 changed to G30.0.	04/20	04/20
Replaced all instances of "member" with "member/enrollee." References reviewed and updated.	04/21	04/21
Annual review. References reviewed and updated. Changed, "review date," in the header to, "date of last revision," and, "date," in the revision log header to, "revision date." ICD-10 codes deleted. Definition edited for custodial care in I.A and A.1.a. through c. Background info added on state waivers. Reviewed by specialist.	04/22	04/22
Annual review. References reviewed and updated.	04/23	04/23
Annual review. Edit to description for 94004. References reviewed and updated. Reviewed by external specialist.	02/24	02/24
Annual review. References reviewed and updated.	01/25	01/25

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Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care and are solely responsible for the medical advice and treatment of member/enrollees. This clinical policy is not intended to recommend treatment for member/enrollees. Member/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, member/enrollees and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, member/enrollees and their representatives agree to be bound by such terms and conditions by providing services to member/enrollees and/or submitting claims for payment for such services.

Note: For Medicaid member/enrollees, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare member/enrollees, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.