

## Medical Necessity Guidelines Pediatric Extended Care Facility

**Policy Number: 022**

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### Overview

The purpose of this document is to describe the guidelines Mass General Brigham Health Plan utilizes to determine the most clinically appropriate level of care for pediatric members who require treatment in an extended care facility.

Mass General Brigham Health Plan covers admissions and continued stays in a pediatric extended care facility when care meets medical necessity criteria and is within the member’s benefit coverage. Members must require and receive the care authorized for their condition and approved level of care. Members not receiving the services approved under the level of care are evaluated for a more appropriate level of care, facility transfer, and/or discharge. The treating provider must request prior authorization for the specific level of care.

Failure to obtain the required prior authorization or to provide the required notification may result in an administrative denial of payment to the facility.

In order to make a medical necessity determination, Mass General Brigham Health Plan requires certain documentation to be provided, including but not limited to: the member’s prior level of function, current medical condition, current functional capacity, current ability to participate in any requested rehabilitation plan, the treatment plan, expected level of improvement, and anticipated length of stay necessary to achieve these goals.

Care managers initiate discharge planning as expeditiously as possible on admission to the extended care facility and throughout the concurrent review process. Care managers coordinate post-discharge care, as appropriate, with the treating facility’s discharge planners/care managers, treating providers, PCP, community agencies, and specialty providers for members with special needs for managed care organization (MCO)-covered and MCO non-covered services.

### Medicare Advantage

Prior Authorization Required	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
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Mass General Brigham Health Plan uses guidance from the Centers for Medicare and Medicaid Services (CMS) for medical necessity determinations for its Medicare Advantage plan members. National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Local Coverage Articles (LCAs), and documentation included in the Medicare manuals are the basis for medical necessity determinations. When there is no guidance from CMS for the requested service, Mass General Brigham Health Plan’s medical policies are used for medical necessity determinations. **At the time of Mass General Brigham Health Plan’s most recent policy review, CMS did not have medical necessity guidance for pediatric long-term acute care (LTAC) or pediatric nursing homes.**

### Mass General Brigham ACO

Prior Authorization Required	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
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Mass General Brigham Health Plan uses guidance from MassHealth for medical necessity determinations for its Mass General Brigham ACO members. When there is no guidance from MassHealth for the requested service, Mass General Brigham Health Plan’s medical policies are used for medical necessity determinations. **At the time of Mass General Brigham Health Plan’s most recent policy review, MassHealth did not have medical necessity guidance for Pediatric LTAC.**

The Department of Public Health’s [Medical Review Team](#) is charged with assessing patients for pediatric nursing homes.

### One Care and Senior Care Options (SCO)

Prior Authorization Required	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
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Mass General Brigham Health Plan uses guidance from CMS for medical necessity determinations for its One Care and SCO plan members. NCDs, LCDs, LCAs, and documentation included in the Medicare manuals are the basis for medical necessity determinations. When there is no guidance from CMS for the requested service, or the member does not meet all of the medical necessity criteria for the requested service, Mass General Brigham Health Plan uses medical necessity guidelines from MassHealth. **See Medicare Advantage criteria and exclusions above. If Medicare Advantage criteria are not met, then MassHealth criteria are applied.**

### Commercial and Qualified Health Plans

Prior Authorization Required	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
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Not all plans cover all of these services, please check plan’s benefit package to verify coverage and limits.

#### Pediatric Nursing Homes

All members less than 22 years of age must first be screened by the Department of Public Health’s [Medical Review Team](#) and approved for admission into a pediatric nursing home. Medical necessity for nursing homes is established when the following criteria are met:

1. The Department of Public Health [Medical Review Team](#) has approved admission into the pediatric nursing home.
2. The member meets the InterQual®-recognized covered level of care.

#### Pediatric LTAC

The member must be less than 22 years of age and meet at least one of the following two criteria for admission to or continued stay in a pediatric long-term acute care facility:

1. The member must require services that:



- a. can be provided safely and effectively at the long-term acute care level. Such services must be ordered by physician and documented in member's record; and
  - b. include at least daily physician intervention or 24-hour availability of medical services and equipment available only in the hospital setting; or
2. The member's medical condition and treatment needs are such that no effective, less costly alternative placement is available to the member.

A member is considered appropriate for LTAC placement only when medical need exists for an intensive program that includes a multidisciplinary approach to improve the member's ability to function to his or her maximum potential. Factors present in the member's condition indicate potential for functional movement or freedom from pain. A member who requires therapy solely to maintain function is not an appropriate LTAC patient.

## Definitions

**Daily:** For services rendered by a physical therapist, occupational therapist, or speech language pathologist, daily means five days a week. For nursing services, daily means seven days a week.

**Long-Term Care Hospital (LTCH):** LTCHs are certified as acute care hospitals, but LTCHs focus on patients who, on average, stay more than 25 days. Many of the patients in LTCHs are transferred there from an intensive or critical care unit. LTCHs specialize in treating patients who may have more than one serious condition; but who may improve with time and care and return home. Services provided in LTCHs typically include comprehensive rehabilitation, respiratory therapy, head trauma treatment, and pain management. Patients typically have multiple complex medical conditions that require daily physician evaluations, skilled nursing of at least 6.5 hours a day, and equipment found in a hospital setting.

## Effective Dates

May 2026: Annual review. Reformatted policy. Clarified criteria hierarchy in One Care and SCO section. Streamlined policy to focus on pediatric members. Changed title.

January 2026: Ad hoc review. Updated prior authorization table and added variation for One Care and SCO members. Fixed formatting. Added MassHealth variation.

July 2025: Annual review. Simplified policy sections where InterQual® criteria are used. Medicare Variation language updated. Nursing Facility criteria updated. Pediatric LTAC criteria added. References updated.

June 2024: Annual review.

June 2023: Annual review. Added Medicare Advantage to table. Added Medicare variation language.

June 2022: Annual review.

May 2021: Annual review.

June 2020: Annual review.

June 2019: Annual review. Minor edit to footnote under table on page 1. References updated.

November 2018: Annual review.

April 2017: Annual review. Changes reflect the addition of InterQual® LTCH criteria.

April 2016: Annual review.

April 2015: Ad hoc review. Amend coverage guideline statement for clarity

February 2015: Annual review.

January 2014: Annual review. Reorganized criteria and changed title.

September 2012: Annual review.

September 2011: Annual review.

September 2010: Annual review.

September 2009: Annual review.



September 2008: Annual review.  
December 2007: Annual review.  
October 2006: Annual review.  
April 2005: Annual review.  
June 2003: Annual review.  
January 2002: Effective date.

## References

Centers for Medicare & Medicaid Services (CMS). Manuals. Publication # 100-02. Medicare Benefit Policy Manual, Chapter 8 – Coverage of Extended Care (SNF) Services Under Hospital Insurance

Commonwealth of Massachusetts, Massachusetts Executive Office of Health and Human Services, Notice of Final Agency Action, MassHealth: Payment for Pediatric Chronic Disease and Rehabilitation Hospitals, effective October 1, 2024.

Commonwealth of Massachusetts, Division of Medical Assistance, Provider Manual Series: Nursing Facility Manual (130 CMR 456.000)

Commonwealth of Massachusetts, Division of Medical Assistance, Provider Manual Series: Chronic Disease and Rehabilitation Inpatient Manual (130 CMR 435.000)

The Health Strategies Consultancy LLC, Long-Term Acute Care Hospitals: *“Revised Certification Criteria Could Improve Medicare Provider Category”*

Change Healthcare LLC, InterQual<sup>®</sup> Level of Care criteria, Acute Care Adult, Acute Care Pediatric, Rehabilitation Adult and Pediatric, Sub acute and Skilled Nursing Facilities Adult and Pediatric.

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