Subject: Inpatient Rehabilitation/Long-Term Acute Care

Background:
Prior authorization is required for inpatient rehabilitation facility (IRF) and long-term acute care (LTAC) admissions for members enrolled in Harvard Pilgrim StrideSM Medicare Advantage (HMO & POS) products. A preadmission evaluation of the patient’s condition and need for IRF or LTAC level of care must document ALL the following:

• Baseline level of function, and summary of medical history that has led to the need for IRF or LTAC level of care;
• Medical treatment needs (e.g., physical therapy, occupational therapy, speech-language pathology, telemetry, vent weaning, specialized nursing care), including expected frequency and duration of treatment, and other information relevant to the individual member’s care needs;
• Prognosis including expected level of improvement, and anticipated length of stay necessary to achieve that level of improvement.

Policy and Coverage Criteria:
Harvard Pilgrim StrideSM (HMO & POS) policies are based on medical science and relevant information including current Medicare benefit coverage (including Medicare Benefit Policy Manual, National and Local Coverage Determinations for the jurisdiction in which the care is rendered), and Harvard Pilgrim StrideSM (HMO & POS) Medicare Advantage Plan materials. Harvard Pilgrim Health Care (HPHC) also utilizes the current editions of Change Health Care InterQual® Level of Care criteria: Long Term Acute Care (LTAC) and InterQual® Level of Care: Acute Rehab in reviewing the appropriateness of admissions to LTAC and inpatient rehab facilities. InterQual® Criteria is available as part of the prior authorization and concurrent review process for Inpatient Rehabilitation and Long-Term Acute Care coverage.

Change Healthcare InterQual® Criteria are nationally recognized medical necessity criteria developed by a clinical research staff, which includes physicians, registered nurses, and other health care professionals. The clinical content of the criteria is annually reviewed, updated, and validated by a national panel of clinicians and medical experts, including those in community and academic practice settings, as well as within the managed care industry throughout the United States.

Please complete Extended Care Facility (ECF) Prior Authorization Form and submit via secure fax to 617-509-4207. For details see the Stride Medicare Advantage Authorization and Notification Policy in our Provider Manual. In some cases, clinical documentation may be required to complete a medical necessity review. Please submit required documentation via secure fax 617-509-4207.
To Obtain InterQual® Criteria
Providers may contact the Medicare Advantage Provider Service Center at 1-888-609-0692 to request a copy of the criteria.

Background and Disclaimer
InterQual® are Medical Necessity Guidelines developed to determine coverage for benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. Harvard Pilgrim Health Care will make coverage decisions using Medicare benefit coverage (including the Medicare Benefit Policy Manual, National and Local Coverage Determinations for the jurisdiction in which the care is rendered), InterQual® guidelines, along with the Member’s benefit document, and in coordination with the Member’s physician(s) on a case-by-case basis considering the individual Member's health care needs.

Medical Necessity Guidelines are developed for selected therapeutic or diagnostic services found to be safe and proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the HPHC service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations.

We revise and update Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revision.

Medical Necessity Guidelines apply to Harvard Pilgrim Stride SM (HMO) Medicare Advantage Plans when Harvard Pilgrim Healthcare conducts utilization review unless otherwise noted in this guideline or in the Member’s benefit documentation. Coverage may vary depending on the terms of the benefit documentation. If a discrepancy exists between a Medical Necessity Guideline and the member’s benefit document, the provisions of the benefit document will govern.

Treating providers are solely responsible for the medical advice and treatment of members. The use of this guideline is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to eligibility and benefits on the date of service, coordination of benefits, referral/authorization, utilization management guidelines when applicable, and adherence to plan policies, plan procedures and claims editing logic.

Summary of Changes:

<table>
<thead>
<tr>
<th>Date</th>
<th>Changes</th>
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<tbody>
<tr>
<td>7/21</td>
<td>Annual review of IQ criteria</td>
</tr>
<tr>
<td>10/20</td>
<td>Annual review; added version of IQ criteria. Clarified language on when criteria is used. Added instructions for submitting requests and requesting a copy of criteria.</td>
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Approved by Medical Policy Committee: 7/20/21
Approved by Clinical Policy Operational Committee: 12/20; 7/21
Policy Effective Date: 10/1/21
Initiated: 10/19