naviHealth	MEDICAL POLICY MPC.01.001 – Skilled Nursing Facility Coverage Guidelines		
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I. Purpose

To provide clinical coverage guidelines for admission and continued care in a skilled nursing facility (SNF). Coverage guidelines are to be used with the member's eligibility and benefits as established by the health plan.

II. Definitions

- Skilled Nursing Facility (SNF) - A facility (which meets specific regulatory certification requirements) that primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital (CMS.gov).
- Skilled Nursing Facility Care - nursing care provided by registered professional nurses, bed and board, physical therapy, occupational therapy, speech therapy, social services, medications, supplies, equipment, and other services necessary to the health of the patient. (medicareadvocacy.org)
- Custodial Care - services supporting a member in activities of daily living (ADLs), as defined in Medicare Benefit Policy Manual Chapter 16

III. Applicable Lines of Business

- Medicare
- Commercial

IV. Coverage Criteria

All health plans managed by naviHealth require prior authorization for inpatient skilled nursing facility. Eligibility and health plan benefits and requirements also apply, which may supersede clinical medical necessity determination.

In addition to the CMS policies, National Coverage Determinations (NCD) and Local Coverage Determinations/Articles (LCD/LCA), identified through the Medicare Coverage Database, provide coverage guidelines, as applicable by the service request or location.

For Medicare Members –

- The original Medicare requirement of three (3) consecutive calendar hospital day stay before transferring to a SNF is waived for Medicare Advantage members.
- naviHealth will use Medicare Benefit Policy Manual Chapter 8 Section 30 for review of all inpatient skilled nursing facility requests as well as for the management of continued stay.

- As directed by the health plan, naviHealth will utilize InterQual® in addition to the Medicare Benefit Policy Manual Chapter 8 Section 30 for review of inpatient skilled nursing facility requests.
    - To receive information regarding a specific health plan's requirement for the use of InterQual®, providers can contact their naviHealth Provider Relations representative or contact naviHealth's Pre-Service department.

For Commercial Members –

- naviHealth will utilize InterQual® for review of all inpatient skilled nursing facility requests as well as for the management of continued stay.

V. Covered Services (Medicare Benefit Policy Manual Chapter 8, Section 30)

Care in a SNF is covered if all of the following four factors are met:

- The patient requires skilled nursing services or skilled rehabilitation services, i.e., services that must be performed by or under the supervision of professional or technical personnel (see §§30.2 - 30.4); are ordered by a physician and the services are rendered for a condition for which the patient received inpatient hospital services or for a condition that arose while receiving care in a SNF for a condition for which he received inpatient hospital services;
- The patient requires these skilled services on a daily basis (see §30.6); and
- As a practical matter, considering economy and efficiency, the daily skilled services can be provided only on an inpatient basis in a SNF (See §30.7.)
- The services delivered are reasonable and necessary for the treatment of a patient's illness or injury, i.e., are consistent with the nature and severity of the individual's illness or injury, the individual's particular medical needs, and accepted standards of medical practice. The services must also be reasonable in terms of duration and quantity.

Direct Skilled Nursing to Patients (42CFR §409.32 and §409.33)

Direct Skilled Nursing to Patients Nursing services are considered skilled when they are so inherently complex that they can be safely and effectively performed only by, or under the supervision of, a registered nurse or, when provided by regulation, a licensed practical (vocational) nurse. If all other requirements for coverage under the SNF benefit are met, skilled nursing services are covered when an individualized assessment of the patient's clinical condition demonstrates that the specialized judgment, knowledge, and skills of a registered nurse or, when provided by regulation, a licensed practical (vocational) nurse are necessary. Skilled nursing services would be covered where such skilled nursing services are necessary to maintain the patient's current condition or prevent or slow further deterioration so long as the patient requires skilled care for the services to be safely and effectively provided, and all other requirements for coverage under the SNF benefit are met. Coverage does not turn on the presence or absence of an individual's potential for improvement from nursing care, but rather on the patient's need for skilled care.

Examples of services that qualify as skilled nursing services:

- Intravenous or intramuscular injections and intravenous feeding;
- Enteral feeding that comprises at least 26 percent of daily calorie requirements and provides at least 501 milliliters of fluid per day;
- Naso-pharyngeal and tracheotomy aspiration;
- Insertion, sterile irrigation, and replacement of suprapubic catheters;

- Application of dressings involving prescription medications and aseptic techniques (see §30.5 for exception);
- Treatment of decubitus ulcers, of a severity rated at Stage 3 or worse, or a widespread skin disorder (see §30.5 for exception);
- Heat treatments which have been specifically ordered by a physician as part of active treatment and which require observation by skilled nursing personnel to evaluate the patient's progress adequately (see §30.5 for exception);
- Rehabilitation nursing procedures, including the related teaching and adaptive aspects of nursing, that are part of active treatment and require the presence of skilled nursing personnel; e.g., the institution and supervision of bowel and bladder training programs;
- Initial phases of a regimen involving administration of medical gases such as bronchodilator therapy;
- Care of a colostomy during the early post-operative period in the presence of associated complications. The need for skilled nursing care during this period must be justified and documented in the patient's medical record.

Direct Skilled Therapy Services (42CFR §409.32)
Coverage for direct skilled therapy services to patients, including skilled physical therapy, occupational therapy, and speech/language pathology therapy, does not turn on the presence or absence of a patient's potential for improvement from therapy services, but rather on the patient's need for skilled care. Therapy services are considered skilled when they are so inherently complex that they can be safely and effectively performed only by, or under the supervision of, a qualified therapist. These skilled services may be necessary to improve the patient's current condition, to maintain the patient's current condition, or to prevent or slow further deterioration of the patient's condition. If all other requirements for coverage under the SNF benefit are met, such skilled therapy services are covered when an individualized assessment of the patient's clinical condition demonstrates that the specialized judgment, knowledge, and skills of a qualified therapist are necessary for the performance of the rehabilitation services.

- Skilled therapy services must meet all of the following conditions (Medicare Benefit Policy Manual Chapter 8 Section 30.4.1.1):
  - The services must be directly and specifically related to an active written treatment plan that is based upon an initial evaluation performed by a qualified physical therapist after admission to the SNF and prior to the start of physical therapy services in the SNF that is approved by the physician after any needed consultation with the qualified physical therapist. In those cases where a beneficiary is discharged during the SNF stay and later readmitted, an initial evaluation must be performed upon readmission to the SNF, prior to the start of physical therapy services in the SNF;
  - The services must be of a level of complexity and sophistication, or the condition of the patient must be of a nature that requires the judgment, knowledge, and skills of a qualified physical therapist;
  - The services must be provided with the expectation, based on the assessment made by the physician of the patient's restoration potential, that the condition of the patient will improve materially in a reasonable and generally predictable period of time; or, the services must be necessary for the establishment of a safe and effective maintenance program; or, the services must require the skills of a qualified therapist for the performance of a safe and effective

maintenance program. The services must be considered under accepted standards of medical practice to be specific and effective treatment for the patient's condition; and,
    - The services must be reasonable and necessary for the treatment of the patient's condition; this includes the requirement that the amount, frequency, and duration of the services must be reasonable.

- Teaching and Training Activities (Medicare Benefit Policy Manual Chapter 8 Section 30.2.3.3)
    - Teaching and training activities, which require skilled nursing or skilled rehabilitation personnel to teach a patient how to manage their treatment regimen, would constitute skilled services.

For more detailed guidelines and examples of skilled nursing and skilled therapy services, refer to Medicare Benefit Policy Manual Chapter 8 - Coverage of Extended Care (SNF) Services Under Hospital Insurance

Services not covered

Skilled nursing facility care is considered not medically necessary under any of the following circumstances:

- The member requires Custodial Care
    - Custodial Care serves to assist an individual with activities of daily living but does not require daily, continuous attention by trained medical personnel

  Refer to Medicare Benefit Policy Manual Chapter 16 - General Exclusions From Coverage
- The member has not completed his/her acute course of care and is not anticipated to complete care within 48 hours –or—is pending test results which may impact the outcome of the members discharge plan
- The member's needs can be reasonably met with intermittent skilled services (see Medicare Benefit Policy Manual Chapter 8 Section 30.6 for definition of daily skilled services and Section 30.7 for Services Provided on an Inpatient Basis as a "Practical Matter")
- Stage I or II wound/pressure ulcer care (staging defined by the National Pressure Injury Advisory Panel) in the absence of any other daily skilled needs (Medicare Benefit Policy Manual Chapter 8 Section 30.3)
- The member's SNF benefits have exhausted (Medicare Benefit Policy Manual Chapter 3 Section 20 or per Health Plan specific guidelines)
- The member is utilizing their Medicare Hospice benefit (refer to member's Part A benefits)
- The member's condition precludes them from participation in daily therapy (e.g., refusal or cognitive function)
- Maintenance program whereby the performance does not require the skills of a therapist because it could safely and effectively be accomplished by the patient or with the assistance of non-therapists, including unskilled caregivers (Medicare Benefit Policy Manual Chapter 8 Section 30.4.1.2)

VI. Documentation

Initial Review for Prior Authorization (§30.2.2.1)

Medical record documentation is required to support the medical necessity decision of the initial authorization. Documentation should be recent. This includes (as applicable to the member's skilled need and circumstance):

- Recent History and Physical
    - Acute Inpatient setting
    - PCP or specialist office
    - Assisted living facility
    - Other non-acute settings
- Recent Medical Progress Notes
- Recent Therapy Evaluation (including baseline functional status, goals, progress to goals, and any barriers to progress)
- Recent Therapy Documentation, describing current functional status
- Current Medication List including any Injectable medications, TPN or infusion
- Relevant Labs and other diagnostic evaluations
- Wound Notes with measurements, stagging and treatment
- Case Management Notes (Social Work, Discharge Planning) indicating member's usual living situation and support

Continued Stay

Facility medical record documentation is required to support the medical necessity continued stay review. Documentation should be recent. This includes (as applicable to the member's skilled need):

- Therapy Evaluation from inpatient skilled nursing facility
- Recent Therapy Documentation that includes:
    - Barriers to progress
    - Training of caregivers
    - Rationale for skilled services
    - Skilled interventions
- Recent Medical Notes
    - Continuation of Infusion with end date
    - Any weaning attempts related to TPN, ventilator, or tracheostomy
- Medication List
- Documentation which includes:
    - The rationale for skilled services
    - Skilled interventions being delivered
- Wound notes which include:
    - Measurements
    - Changes to treatment
    - Goal of treatment
    - Training of caregiver
- Case Management Notes (Social Work, Discharge Planning)

VII. Responsibility

This policy will be reviewed annually by the Utilization Management Committee

VIII. References

- Medicare Benefit Policy Manual Chapter 8 - Coverage of Extended care (SNF) Services Under Hospital Insurance)
- Medicare Benefit Policy Manual Chapter 16 - General Exclusions From Coverage
- Medicare Benefit Policy Manual Chapter 3 – Duration of Covered Inpatient Services
- InterQual® Level of Care Subacute & Skilled Nursing Facility Criteria
- Department of Health and Human Services and Centers for Medicare and Medicaid Services Transmittal 378: Medicare Skilled Nursing Facility Manual
- Code of Federal Regulations Title 42
- European Pressure Ulcer Advisory Panel, National Pressure Injury Advisory Panel and Pan Pacific Pressure Injury Alliance. Prevention and Treatment of Pressure Ulcers/Injuries: Quick Reference Guide. Emily Haesler (Ed.). EPUAP/NPIAP/PPPIA: 2019.
- Medicare National Coverage Determinations and Local Coverage Determinations (CMS Medicare Coverage Database)

IX. Approval/Maintenance

This policy is approved by the UM Committee. Maintenance of this policy is the responsibility of the UM Committee.

Documentation of Approval:

Utilization Management Committee, 08/29/2023