Medicare Advantage Skilled Nursing Facility Coverage Criteria

Medical Policy

Utilization Management

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I. DEFINITION:

Skilled nursing facility (SNF) care is a level of care ordered by a doctor that must be given or supervised by licensed health care professionals. It may be skilled nursing care, or skilled rehabilitation services, or both. Skilled nursing care includes services that require the skills of a licensed nurse to perform or supervise. Skilled rehabilitative services are physical therapy, speech therapy, and occupational therapy. Physical therapy includes exercise to improve the movement and strength of an area of the body, and training on how to use special equipment such as how to use a walker or get in and out of a wheelchair. Speech therapy includes exercise to regain and strengthen speech and/or swallowing skills. Occupational therapy provides assistance with learning how to do usual daily activities such a eating and dressing.

A stay is considered an admission to a skilled nursing facility to receive skilled care. When skilled care ends for any length of time a Notice of Medicare Non-coverage (NOMNC) will be provided. A new stay would begin upon receipt of skilled care again, regardless of discharge from the nursing home. More than one skilled nursing stay per 100 day benefit period can occur.

Custodial care is care for personal needs rather than medically necessary needs. Custodial care is care that can be provided by people who do not have professional skills or training. This care includes help with walking, dressing, bathing, eating, preparation of special diets, and taking medications. Medicare Advantage does not cover custodial care unless it is provided as other

care that is received in addition to the daily skilled nursing care, and/or skilled rehabilitation services.

Benefit period is used to determine coverage for inpatient stays in hospitals and skilled nursing facilities. A benefit period begins on the first day of admission to a Medicare Advantage covered inpatient hospital or a SNF. The benefit period ends when there has not been an inpatient stay at any hospital, swing bed, or SNF for 60 days in a row. If admitted to the hospital or SNF after one benefit period ends, a new benefit period begins. There is not a limit to the number of benefit periods a member can have.
The type of care that is covered depends on whether the member is considered an inpatient for hospital or SNF stays. The member is an inpatient in a SNF only if care in the SNF meets certain standards for skilled levels of care. Specifically, in order to be an inpatient in a SNF, the member must need daily skilled nursing or skilled rehabilitation care, or both.
Inpatient skilled nursing facility coverage is limited to 100 days each benefit period.
If a member has been free of confinement or not receiving skilled care in a SNF, swing bed, or inpatient hospital stay for a 60 day timeframe a new benefit period would begin.

Maintenance care is services provided to a member after the acute phase of an illness or injury has passed and maximum therapeutic benefit has occurred. Such care promotes optimal function in the absence of significant symptoms.

Supportive care services are provided to a patient whose recovery has plateaued, slowed, or ceased entirely and only minimal rehabilitative gains can be demonstrated with continued care. The determination of what constitutes maintenance or supportive care is made after review of a patient case history and treatment plan submitted by a health care provider.

Medicare Benefit Policy Manual (MBPM), Internet Only Manual

II. CLINICAL AUTHORIZATION CRITERIA:

Prior authorization is required.
Submit request through the MyAdvocate Medicare Advantage provider portal: provider.myadvocatema.com.
Prior Authorization Request form

Providers can also contact MyAdvocate Medicare Advantage at (715) 221-9212 to request prior authorization or fax information to (715) 221-9215.

A. MyAdvocate Medicare Advantage does not require a 3 day hospital stay to access the SNF benefit. Member must meet all other Medicare criteria for skilled nursing home coverage.

B. Approvals are provided in terms of a day. An eligible day is defined as a member occupying a bed in the SNF from 12:00am or later through 11:59pm of the same day. If these criteria are not met, the day is considered a leave of absence or a discharge day if the member is discharged from the facility. Leave of absence days and discharge days will not be reimbursed.

C. Medicare Advantage (MA) organizations must cover services in a skilled nursing facility (SNF) in which a validly married same sex spouse resides to the extent that they would be required to cover the services if an opposite sex spouse resided in the SNF.

Under section 1852(I) of the Social Security Act, an MA organization is required to provide an MA plan enrollee Medicare-covered SNF services in a particular SNF if (1) the enrollee elects coverage in that SNF; (2) the SNF either contracts with the MA organization, or agrees to accept payment under the same terms and conditions that apply to similarly situated contracting SNFs; and (3) the SNF meets the definition of a "home skilled nursing facility." One of the ways that a SNF can qualify as a "home" SNF is that it is the SNF "in which the spouse of the enrollee is can't residing at the time of [the enrollee's] discharge from [a] hospital" after a qualifying 3 day hospital stay entitling the enrollee to Medicare coverage of SNF services. Section 1852(l)(4)(A)(iii) (emphasis added). Note: MyAdvocate Medicare Advantage does not require a 3 day hospital stay to access the SNF benefit.

D. Guidelines for determining the need for skilled nursing facility care are as follows:
   1. In all cases, history of treatment prior to a nursing home admission must be considered. *(MBPM, Chapter 8, Section 30 and 30.2)* MBPM Chapter 8 .
   2. Skilled Nursing facility services are medically necessary when **all** of the following are met per Medicare guidelines:
      a. The patient requires skilled nursing or skilled rehabilitation services that must be performed by, or under the supervision of, professional or technical personal.
      b. The patient requires skilled nursing or skilled rehabilitation services on a daily basis; (note: if skilled rehabilitation services are not available on a 7 day a week basis, an individual whose inpatient stay is based, solely on the need for skilled rehabilitation services would meet the 'daily basis" requirement when he/she needs and received those services at least 5 days a week).
      c. As a practical matter, considering economy and efficiency the daily skilled services can be provided only on an impatient basis in a skilled nursing facility. Is this the least restrictive environment for the member to receive these services?
      d. SNF services must be furnished pursuant to a physician's orders and be reasonable and necessary for the treatment and severity of the individual's illness or injury, his particular medical needs and accepted standard of medical practice. The services must be reasonable in terms of duration and quantity.

E. Admission to a skilled nursing facility for skilled nursing services and/or rehabilitation services must include **all** development, management, and evaluation of a plan of care as follows:
   1. The involvement of skilled nursing or skilled rehabilitation personnel is required to meet the individual's medical needs, promote recovery, and ensure medical safety and to achieve the medically desired results (in terms of the individual's physical or medical condition).
   2. There must be significant probability that complications would arise without skilled supervision of the treatment plan by a licensed nurse or skilled rehabilitation personnel.
   3. Care plans must include realistic nursing goals and objectives for the individual, discharge plans, and the planned interventions by the nursing staff to meet these goals and objectives.
   4. Updated care plans must document the outcomes of the planned interventions.
   5. There must be daily documentation of the individual's progress and/or complications.

F. In addition to the general requirements above, the individual condition must require **one or more** of the following defined settings below on a daily basis:
   1. Observation, Monitoring and Assessment of Patient's Condition *(MBPM, Chapter 8, Section 30.2.3.2)* MBPM Chapter 8*; or*
   2. Complex teaching services to an individual and/or caregiver requiring 24-hour SNF setting vs. intermittent home health setting. *(MBPM, Chapter 8, Section 30.2.3.3)* MBPM Chapter 8*; or*
   3. Complex medication Regimen; or
   4. Initiation of tube feedings; *or*
   5. Active weaning of ventilator dependent individuals; *or*
   6. Direct Skilled Nursing Services to Patient *(MBPM, Chapter 8, Section 30.3)* MBPM Chapter 8*; or*
   7. Direct Skilled Rehabilitation Services *(MBPM , Chapter 8, Section 30.4.1)* MBPM Chapter 8*; or*
   8. Skilled Physical Therapy *(MBPM , Chapter 8, Section 30.4.1*) MBPM Chapter 8. Some of the more common skilled physical therapy modalities and procedures are:
      a. Evaluation
      b. Therapeutic Exercises
      c. Gait Training
      d. Range of motion
      e. Maintenance Therapy
      f. Ultrasound, Shortwave, and Microwave Diathermy Treatments
      g. Hot packs, Infra-Red Treatments, Paraffin Baths, and Whirlpool Baths; *or*
   9. Speech-Language Pathology (MSNFM., Section 230.3, Subsection C) MSNFM Chapter 15
      a. Evaluation
      b. Restorative Therapy
      c. Maintenance Program

d. Types of Services
   i. Diagnostic and Evaluation Services
   ii. Therapeutic Services; *or*

10. Occupational Therapy *(MSNFM Section 230.3, Subsection C)* MSNFM Chapter 15
    a. Evaluation
    b. Task-Oriented Therapeutic Activities
    c. Therapeutic Activity Programs
    d. Tasks and Activities to Restore Sensory-Integrative Function
    e. Teaching Compensatory Technique
    f. Fitting of Orthotic and self-help Devices
    g. Vocational Assessment and Trainings.

III. LIMITATIONS/EXCLUSIONS:

A skilled nursing facility setting is **not** considered medically necessary when any **one** of the following is present:

A. Services do not meet the medically necessary criteria above; *or*
B. The individual's condition has changed such that skilled medical or rehabilitative care is no longer needed; *or*
C. Physical medicine and rehabilitation services in which there is not a practical improvement in the level of functioning within a reasonable period of time; *or*
D. Services that are solely performed to preserve the present level of function or prevent regression of functions for an illness, injury, or condition that is resolved or stable; *or*
E. The individual refused to participate in the recommended treatment plan; *or*
F. Care has become custodial; *or*
G. A family member or another non-medical person provides the services. When the service can be safely and effectively performed (or self-administered) by the average non-medical person without the direct supervision of a nurse, the service cannot be regarded as a skilled service.
H. For services that do not require the skills of a licensed nurse or rehabilitation personnel and are therefore considered to be not medically necessary in the skilled nursing facility setting unless there is documentation of comorbidities and complications that require individual consideration. This is not an all-inclusive list. Please refer to the following reference: MBPM, Chapter 8, Section 30.5 MBPM Chapter 8
I. Refer to Skilled Nursing Facility Consolidated Billing rules to determine services that are separately payable during a Member's Part A stay in a skilled nursing home. Skilled Nursing Facility Consolidated Billing
J. Contessa Post-Acute Care episode days do not apply to the 100 day benefit period.

IV. REFERENCES:

The criteria included in this policy are based on Center for Medicare and Medicaid Services current published criteria.

Medicare Benefit Policy Manual Chapter 8 - Coverage of Extended Care (SNF) Services Under Hospital Insurance

Medicare Benefit Policy Manual Chapter 15 - Covered Medical and Other Health Services

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