HEALTH PLAN POLICY		
Policy Title: : Skilled Nursing Facility Utilization Review		**Policy Number:** MUM04 **Revision:** D
Department: Medical Management	**Sub-Department:** Utilization Management	
Applies to Product Lines: ☐Medicaid ☐Children's Health Insurance Plan ☒Health Insurance Exchange ☒Medicare ☒USFHP ☒Commercial Insured ☒Non Insured Business		
Origination/Effective Date: 12/09/2014		
Reviewed Date(s):	**Revision Date(s):** 03/04/216, 06/01/2017, 09/20/2018, 04/29/2020	

SCOPE:

This purpose of this policy is to provide written guidelines for skilled nursing facility admission, return following a hospitalization, and continued stays review.

DEFINITIONS AND ACRONYMS:

- **Return to Enrollee's Home Skilled Nursing Facility (SNF)** – member returns to the same SNF they were at prior to a re-hospitalization.
- **Skilled Nursing Facility (SNF) -** A nursing facility with the staff and equipment to give skilled nursing care and, in most cases, skilled rehabilitative services and other related health services.

POLICY:

A. Skilled nursing facility level of care:

The skilled nursing level of care is covered if all the following criteria are met:

- The patient requires skilled nursing services or skilled rehabilitation services. The services must be performed by professional or technical personnel and are ordered by a physician.
- The patient requires these skilled services on a daily basis.
- The daily skilled services can be provided only on an inpatient basis in a SNF and cannot be provided at alternate level of care.
- The services delivered are reasonable and necessary for the treatment of a patient's illness or injury. The services must also be reasonable in their duration and quantity.

If any of these four factors are not met, a stay in SNF, even though it might include delivery of skilled services may not be covered.

A member who resided in a nursing facility prior to the hospitalization may elect to receive post-discharge coverage through the home SNF if the home SNF is contracted with the Plan and agrees to accept substantially similar payment under the same terms and conditions that apply to similar nursing facilities that contract with the Plan.

B. Skilled nursing services:

Nursing services are considered skilled when they are so inherently complex that they can be safely performed only by or under the supervision of a registered nurse or a licensed practical (vocational) nurse. A service is not a skilled nurse service merely because it is performed by or under the direct supervision of nurse. If a service can be safely and effectively performed (or self-administered) by an

unskilled person, the service cannot be regarded as skilled nursing service although the nurse actually provides the service.

The skilled nursing services must meet the following criteria:

- Services can be provided by skilled registered nurse, licensed vocational nurse or licensed practical nurse.
- Similar services cannot be provided at an alternate level of care such as home setting.
- Services are required on a continual daily basis under the supervision of a skilled nurse for an unstable condition, or to prevent deterioration of current medical condition.
- All services must be provided under the guidance and supervision of an attending physician.

Some examples of skilled nursing services are:

- Intravenous or intramuscular injections and intravenous feeding,
- Nasopharyngeal and tracheostomy aspiration,
- Insertion, sterile irrigation or replacement of suprapubic catheter,
- Application of dressings involving prescription medications and aseptic techniques,
- Decubitus ulcer care of stage 3 or worse.
- Colostomy care during the early post-operative period in the presence of associated complications.
- Teaching and training of patient or caregiver about the rehabilitation nursing procedures that require the presence of skilled nursing personnel; e.g. institution and supervision of bowel or bladder training programs.

C. Skilled rehabilitation services:

These include physical therapy, occupational therapy and speech or language therapy. Therapy services are considered skilled rehab services when they are so inherently complex that they can be safely and effectively performed only by or under the supervision of a qualified therapist.

The skilled rehabilitation services must meet the following criteria:

- 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.
- Skilled rehab services are provided to the patient at least five (5) days per week for at least one hour per day.
- The services are intended to treat the documented decline in the functional status due to recent surgical procedure, illness or disease state.
- For continuation of a SNF stay there should be documentation of measurable progress in the patient's condition.
- All services must be provided under the guidance and supervision of an attending physician.

D. **Documentation required for determining appropriateness of SNF stay:**

The SNF facility should provide the following documentation to the utilization management nurse to determine medical necessity.

- History and physical exam pertinent to patient care (including the response or changes in behavior to previously administered skilled services).
- The skilled services provided.
- The patient's response to skilled services.
- Plan of future care based on the rationale of prior results.
- A detailed rationale that explains the need for the skilled service in the light of patient's overall medical condition and experiences.
- Any other pertinent clinical information.
- For continued SNF stay, provide weekly progress notes, weekly objective documentation of functional status and measured progress toward goal.

The utilization management nurse reviews the applicable clinical criteria and, if the patient does not meet criteria, refers the case to the chief medical officer or designee for review. The medical director or designee will be available to perform a timely review and render a decision regarding services that do not clearly meet clinical criteria.

Prior to termination of SNF services, the provider must deliver a valid written notice to the member of the decision to terminate covered services no later than two days before the proposed end of the services. The Plan is financially liable for continued services until two days after the member receives valid notice. If the member's services are expected to be fewer than two days duration, the provider should notify the member at the time of admission to the provider. A member who receives advance notice and agrees with the termination of services earlier than two days hence may waive continuation of services.

REFERENCES:

- Medicare Benefit Policy Manual, 42 CFR, 422.133(b), 42 CFR, 422.133(c)
- www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bpl102c08.pdf
- TRICARE Policy Manual 6010.57-M, February 1, 2008, Chapter 2, Section 3.1

RELATED DOCUMENTS:

None

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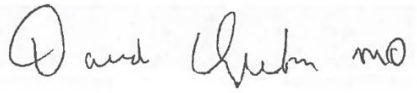
Chief Executive Officer Health Plans



David Engleking, M.D.
Medical Director

REVISION HISTORY:

Revision	Date	Description of Change	Committee
New	12/09/2014	Initial Release	Board of Directors
A	03/04/2016	Yearly review – updated to current template. Made minor edits to grammar.	Board of Directors
B	06/01/2017	Annual Review. Changed from chief medical officer to medical director. Changed signatory from Anita Leal, Executive Director to Nancy Horstmann, CEO.	Board of Directors
C	09/20/2018	Annual review - product lines updated	Executive Leadership
D	04/29/2020	Annual review. Updated Definitions and Acronyms, References, and verbiage throughout policy.	Executive Leadership