

FEP Utilization Management Guideline 002: Inpatient Skilled Nursing Facility Services

Effective Date: April 1, 2021

Related Guidelines: NA

Inpatient Skilled Nursing Facility Services

DEFINITION

FEP defines a Skilled Nursing Facility (SNF) as a free standing institution or a distinct part of a hospital which customarily bills insurance as a skilled nursing facility and meets the following criteria:

- Is Medicare Certified as a Skilled Nursing Facility;
- Is licensed in accordance with State or local law or is approved by the State or local licensing agency as meeting the licensing standards (where State or local law provides for the licensing of such agencies or organizations);
- Has a transfer agreement in effect with one or more Preferred hospitals; and
- Is primarily engaged in providing skilled nursing care and related services for individuals who require medical or nursing care; or rehabilitation services for the rehabilitation of injured, disabled, or sick persons.

The term skilled nursing facility does not include any institution which is primarily for the care and treatment of mental diseases. A Preferred hospital is a hospital with a Preferred agreement with the Local Plan to limit what they bill our members.¹

As defined by the Centers for Medicare and Medicaid Services (CMS), a skilled nursing facility is an institution or a distinct part of an institution, such as a skilled nursing home or rehabilitation center, which has a transfer agreement in effect with one or more participating hospitals and which:

1. Is primarily engaged in providing skilled nursing care and related services for residents who require medical or nursing care; or rehabilitation services for the rehabilitation of injured, disabled, or sick persons, and
2. Meets the requirements for participation in 1819(a) through 1819 (d) as amended by 4201 of OBRA 1987 of the Social Security Act and in regulations at 42 CFR 483, B.

A qualified SNF is one that meets all the requirements in the preceding definition. For Medicare purposes, the term SNF does not include any institution which is primarily for the care and treatment of mental diseases.²

A Skilled Nursing Facility or Nursing Facility may be:

- An entire facility for skilled nursing facility or nursing facility care;
- A distinct part of a rehabilitation center;
- A distinct part of a hospital, such as a wing or a section;
- A distinct part of a skilled nursing facility or nursing facility (see §2762.B³); or
- A religious nonmedical health care institution operated or listed and certified by the First Church of Christ, Scientist, Boston, Massachusetts.

"To qualify for participation in the program as a distinct part SNF and of an institution, it must be physically separate from the rest of the institution, i.e., it must represent an entire physically identifiable unit consisting of all beds within that unit, such as a separate building, floor, wing, or ward...it need not be confined to a single location within the institution's physical plant"^{2,3}

In the absence of an available bed meeting the FEP definition of SNF above, Plans may approve admission to a Medicare designated "swing bed". "The Social Security Act (the Act) permits certain small, rural hospitals to enter into a swing bed agreement, under which the hospital can use its beds, as needed, to provide either acute or SNF care. As defined in the regulations, a swing bed hospital is a hospital or critical access hospital (CAH) participating in Medicare that has CMS approval to provide post-hospital SNF care and meets certain requirements."⁴

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UM GUIDELINE

1. For Members enrolled in Basic Option and Federal Employee Program (FEP®) Blue Focus:
Benefits are not available for inpatient Skilled Nursing Facility (SNF) care for individuals enrolled in Basic Option.

2. For Members enrolled in Standard Option and in Medicare Part A primary:
FEP Benefits are available for inpatient SNF care for individuals enrolled in Standard Option and in Medicare Part A primary. Benefits are provided when Medicare has made a payment and are limited to coverage of the first through 30th day of confinement for each benefit period as defined by Medicare. Medical necessity is considered met when Medicare Part A has made a payment for the stay.

3. For Members enrolled in Standard Option:
FEP benefits are available for inpatient SNF care for individuals enrolled in Standard Option and who are not enrolled in Medicare Part A primary for a **maximum of 30-days, annually**, when the following criteria are met:
 - a. Patient can be expected to benefit from the short term SNF services with a goal of returning home.
 - b. Patient is enrolled in case management prior to admission to the SNF.
 - i. Member is enrolled in case management prior to admission to the SNF (signed consent required).
 - ii. Patient and/or proxy must participate in case management prior to and during the patient's admission to the SNF.
 - c. Precertification is obtained prior to admission (including overseas admissions).
 - d. The preliminary treatment plan is approved prior to admission.
 - i. Treatment plan must include proposed therapies and need for daily inpatient SNF care.
 - ii. Assessment of functional status and development of preliminary SNF plan of care must be performed prior to admission to the SNF and must address any issues/conditions in the items below:
 1. Neurological and cognitive status;
 2. Musculoskeletal status and functional mobility;
 3. Cardiopulmonary status;
 4. Integumentary assessment (noting the absence of impairments or if present, providing details, including staging, measurements, etc. of impaired integrity);
 5. Medications and therapies;
 6. Renal status;
 7. Mental Health status;
 8. Nutritional and gastrointestinal status, including ability to swallow and digest; and the need for special diets;
 9. Psychosocial assessment; and
 10. Educational needs.

Assessment may be performed by providers where patient is receiving treatment prior to proposed transfer to the SNF (i.e., hospital RN and PT caring for the patient).
 - iii. Medication reconciliation must occur between the transferring facility, receiving SNF, and Plan case manager prior to admission to the SNF.

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- iv. Treatment plan includes: documentation of need for daily inpatient care, estimated length of stay; medical and rehabilitation therapies (including frequency) to be provided during the stay; preliminary short and long-term goals; and plan for discharge (including services and location).
- e. Patient participates in all treatment and care planning activities, including discharge planning/transition to home.

Note: The 30 day/calendar year SNF benefit available to members enrolled in Standard Option who are not enrolled in Medicare Part A primary does not require a minimum inpatient hospital stay.

Benefits are not available for inpatient SNF care solely for management of tube feedings, for home level dialysis treatment, as an interim transition to long-term care placement, etc., or for any non-covered services. Benefits are not available for court ordered placement in a skilled nursing facility.

- 4. The SNF must be able to provide the nursing, rehabilitative, respiratory, nutritional, educational, pharmacological, and behavioral health services indicated for the individual patient in a manner consistent with standards of care.

Note: The above reference to behavioral health services does not imply SNF admission is appropriate for management of behavioral health conditions. It is intended to convey the expectation that a facility must have the resources available for assessment and management of an individual patient with behavioral health needs related to their physical illnesses (i.e., depression due to alteration in functional status).

- 5. The SNF must be able to provide the Local Plan with regular reports of the patient's progress towards goals and the status of the discharge plan at the intervals determined by the local Plan.
 - a. Reports must be provided no less than weekly and must include:
 - i. The progress note(s) from the physician, nurse practitioner, or physician's assistant coordinating care for the patient in the SNF (as defined by regulations and respective practice acts). For patients on ventilators or admitted for tracheostomy weaning, this must also include the weekly note(s) from the pulmonologist.
 - ii. Medication reconciliation, including current medications and patient education related to medications.
 - iii. Rehabilitation therapy activities: therapy frequency (treatment logs), patient participation, functional status, etc.
 - iv. Wound care activities (if applicable): treatment, frequency, wound assessment (measurements, stage, etc.), patient/family education, etc.
- 6. Skilled nursing facility (SNF) services for members not enrolled in Medicare Part A primary are **medically necessary** when ALL the criteria in item 3 above are met; **ALL** of the following criteria in Section A are met; **and** one or more of the subsections (care categories) in Section B are met:

Section A:

- 1. Inpatient SNF care is ordered by a physician and provided under the supervision of a physician.
 - a. Attending physician's admission orders, documentation the patient requires covered SNF care on a daily basis, and review of preliminary treatment plan must occur within 72 hours of the patient's admission to the SNF.
 - b. Patient is seen at least weekly by the supervising physician, nurse practitioner, and/or physician's assistant (as defined by regulations and respective practice acts).
 - i. If the patient is admitted on a ventilator or for tracheostomy weaning, the patient must be seen at least weekly by the pulmonologist directing the patient's respiratory care.
 - 2. Care delivery requires an interdisciplinary clinical team.
 - 3. Patient does not reside in a nursing home or similar facility as a long-term care resident.
 - 4. Prior to admission to the SNF, the admission is determined by the Local Plan to be medically necessary for the treatment of the individual's illness or injury (i.e., be consistent with the nature and severity of the individual's illness or injury, the particular medical needs and accepted standards of medical practice); and the inpatient admission is considered reasonable in terms of duration and quantity.
 - 5. Patient/proxy agrees with the proposed treatment plan, short and long term goals, and discharge plan.
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6. If hospitalized, patient is not projected to be at a home care, outpatient, or intermediate, long-term care, or residential level of care within the next 48-72 hours.
7. In the absence of an approved SNF admission, it would be medically necessary for the patient to remain in the acute inpatient care setting for more than 48-72 hours and/or if discharged from the hospital, **the member is at high risk of readmission within 30 days of the hospital stay immediately preceding SNF admission.**
8. Patient is medically stable.
9. For patients whose primary SNF need is rehabilitation, patient does not have an infectious disease requiring isolation in a private room that limits patient participation in rehabilitative therapies.
10. Patient requires skilled nursing and/or skilled rehabilitation services that must be performed on an inpatient basis by professional health personnel (RN, LPN, PT, OT, or SLP); the services must require the judgment of a qualified and appropriately licensed provider; and
 - a. Patient requires these skilled services on a daily basis, 7 days/week. (See section B)
 - b. SNF admissions solely for physical rehabilitation meet the daily basis requirement when:
 - i. Skilled rehabilitation services (physical and occupational therapy from a licensed therapist are received at least 5 days/week for a minimum combined total of one (1) hour/day, and
 - ii. Patient also requires skilled nursing care (i.e., medication management, patient teaching, monitoring of condition, wound care, etc.).
 - c. Admissions that are not primarily for rehabilitation must meet the following requirements:
 - i. Patient requires multiple skilled treatments daily (at least three times/day, see Section B).
11. Patient is able to follow commands and to participate in rehabilitation therapies and patient teaching activities regarding care.
12. The inpatient SNF services are expected to result in significant, continuous, and measurable improvement in the patient's medical condition or functional capabilities within a reasonable and defined period of time.
13. The services needed are not such that a person not medically skilled could perform them safely and reasonably with training, or that mainly assist the individual with daily living activities, such as:
 - a. Personal care, including help in walking, getting in and out of bed, bathing, eating (by spoon, tube, or gastrostomy), exercising, or dressing;
 - b. Homemaking, such as preparing meals or special diets;
 - c. Moving the individual;
 - d. Acting as companion or sitter;
 - e. Supervising medication administration; or
 - f. Treatment or services that any person can perform with minimal instruction, such as recording pulse, temperature, and respiration; simple wound care; or administration and monitoring of feeding systems
14. During the inpatient SNF admission, patient participates as expected in the treatment plan.

Section B: (Medical records must provide evidence the patient meets criteria in at least one of the subsections below)

- A. Rehabilitative Care
 1. Therapy is intended to treat a documented decline in functional status due to recent illness, injury, disease, or surgical procedure(s).
 2. Patient is able to actively participate in one or more therapy disciplines (Physical and/or Occupational Therapy) at least 1 hour/day, at least five days/week. Active participation includes evidence the patient's ability to respond to verbal or visual stimuli and the ability to follow commands.
 - A. During the inpatient SNF stay, the patient must receive and actively participate in individualized (1:1) medically necessary physical and/or occupational therapy by a licensed therapist (PT, OT) or therapy assistant (PTA, OTA) for a minimum combined total of one (1) hour/day at least five days/week; and
 - B. If clinically indicated, patient is able to participate in and receives individualized, medically necessary speech therapy by a licensed therapist at least 3 days/week.
 3. Patient requires more than light physical assistance for mobility **and** basic activities of daily living (i.e., bathing, dressing, eating, and toileting that can be managed by Home Health care).
 4. Patient requires minimum or greater level of assistance with mobility in more than one area of physical function (i.e., ambulation and transfers).
 5. Within twenty four (24) hours of admission to the SNF, the patient receives a physical therapy evaluation; a therapy treatment plan is developed and implemented; and short and long term
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functional goals are developed and agreed to by the patient (or patient proxy if patient is unable to give consent).

B. Daily Nursing Care and Management

1. Inpatient skilled nursing care is required for ongoing assessment and management of unstable or complex medical conditions, including need for treatment modifications until the patient's condition is stabilized (i.e., septicemia, uncontrolled pain, severe respiratory disease, etc.); and
2. Complex teaching and training with the individual or caregiver requiring 24-hour inpatient skilled setting (i.e., new ostomy, administration of multiple newly ordered infused and/or injected medications, wound care for a Stage 3 and/or Stage 4 wound or multiple Stage 2 wounds).

C. Injections and infusions

1. Medically necessary administration of multiple intravenous (IV), intramuscular (IM) and/or subcutaneous (SQ) medications for new and/or complex needs
 - A. At least one of the medications is administered every 8 hours or more frequently**Note:** Inpatient SNF care is considered not medically necessary for routine medication administration, such as insulin, or previously established infusions.

D. Ventilator and/or tracheostomy

1. Active weaning of the ventilator and/or tracheostomy or patient/caregiver education to prepare for patient return to a home setting (other than long-term care) with ventilator and/or tracheostomy; and
2. Patient care requires availability of a respiratory therapist on site in the SNF 24 hours/day; and
3. Respiratory management is directed by a pulmonologist who evaluates patient within 12 hours of admission and at least weekly thereafter.

E. Respiratory Treatment other than tracheostomy or ventilator

1. Patient care requires respiratory therapy available on site in the SNF 24 hours/day; and
2. Chest Physiotherapy (PT) at least three (3) times/day;
3. New respiratory treatments to stabilize new medical conditions, including new use of oxygen and respiratory nebulization therapies more than three (3) times/day;
4. Nasopharyngeal or tracheal suctioning on a frequent basis (i.e., at least every four hours).

F. Ostomy Care

1. Management of and patient/caregiver education regarding a new colostomy or ileostomy during the early post-operative period and/or related to complications to prepare patient for home.
 - A. Management and teaching must be at a level that cannot be performed in an alternative care setting, such as the patient's home, long-term care facility, outpatient, etc.

G. Complex Wound Care

1. Extensive treatment (i.e., packing, debridement, irrigation) of Stage 3, Stage 4 or multiple Stage 2 decubitus ulcers or other complicated wounds;
2. Complex treatment of wounds requiring multiple dressing changes within a 24 hr. period (at least every 8 hours) and the treatment cannot be safely performed in the outpatient, home, or long-term care facility setting; or
3. Complex treatment of extensive skin disorders, requiring frequent treatment (at least every 8 hours) and skilled observation and assessment.

Skilled observation and assessment of each wound must be documented daily and reflect any changes in the wound status.

Note: Benefits are not available for admissions for training and management of enteral feedings, TPN/PPN, home level dialysis treatment, and similar care.

Not Medically Necessary

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

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1. Services do not meet the criteria above;
2. Patient is not participating in the treatment plan (i.e., not participating in rehabilitation therapies, patient education, etc.);
3. Patient's family, proxy, and/or caregiver is not participating as provided in the treatment plan;
4. Patient has not demonstrated practical improvement in the level of functioning within a reasonable period of time;
5. Patient is ambulatory/mobile for household distances (70 feet or more) with less than minimal assistance, and is capable of performing activities of daily living with less than minimal assistance;
6. Services are provided to preserve the present level of function or prevent regression of functions for an illness, injury or condition that is resolved or stable;
7. Care is primarily for routine services directed toward the prevention of injury or illness;
8. Routine or maintenance medication administration, such as insulin, oral medications, eye drops, nebulization treatments, and oxygen;
9. Medication administration and treatments in medically stable individuals that could be managed in the home setting, including wound care, physical therapy; IV medications administered by a home health or home infusion therapy provider, even though the home setting is not available, a caregiver is not present, etc.;
10. Care solely for the administration of oxygen, intermittent positive pressure breathing (IPPB) treatments and/or nebulizer treatments for stable respiratory conditions;
11. Routine enteral feedings and/or TPN/PPN;
12. Routine colostomy care;
13. Custodial care, including custodial care performed by a licensed practical nurse (LPN) or registered nurse (RN);
14. Nasotracheal or nasopharynx suctioning less frequently than every four hours when infection is not present and there are no other conditions meeting the medically necessary criteria (i.e., active ventilator weaning);
15. Medically stable ventilator care that can be safely provided in an alternative setting, such as the home or long-term care facility, even though the home setting is not available, a caregiver is not present, etc.;
16. The presence of a stable indwelling or suprapubic catheter, the need for routine intermittent straight catheterization or ongoing intermittent straight catheterization for a chronic condition, catheter replacement or routine catheter irrigation when there are no other conditions meeting the medically necessary criteria.
17. Wound care requiring daily dressing changes that can safely be performed in the outpatient setting.

Benefit Limitations: Skilled nursing facility benefits are only available for covered services listed under the benefit provision in the Service Benefit Plan brochure. Benefits are not available for custodial care, maintenance care, or other services listed as general exclusions under the contract. SNF benefits are not available for members enrolled in Standard Option who are not enrolled in Medicare Part A primary when any of the following are present:

1. Precertification is not obtained prior to admission;
2. The patient declines Case Management enrollment and/or ongoing collaboration with the Plan case manager;
3. The member/proxy has not signed the consent for case management after reasonable attempt by the case manager to obtain the written consent;
4. The patient and/or family refuse to participate in the recommended treatment plan;
5. Care is initially or has become custodial;
6. The care can be safely provided by a non-medical person (i.e., service can be safely and effectively self-administered or performed by the average non-medical person without the direct supervision of a nurse, even though a nurse may perform the care).
7. Home setting is not available, home setting is not suitable, caregiver is not available, etc.;
8. Patient is not in the SNF for the date of service billed (i.e., "bed hold" for therapeutic leave, hospitalization, etc.) **NOTE:** Precertification approvals will be revised to reflect non-covered days.

Special Considerations:

A. Case Management

- Case Management enrollment is required for member support with education, coordination of services, and for assistance in identifying resources available within regular benefits, local care management programs and community resources to support a safe discharge.
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- Case Managers also collaborate frequently with the patient/proxy, facility care manager, and treating physician(s)/nurse practitioner(s) to monitor care received by the patient.

B. Required Documentation

Initial and ongoing approval of covered inpatient skilled nursing facility care requires at least the following be submitted to the Local Plan:

- a. Initial documentation
 - i. Transferring facility/provider (i.e. hospital) admission assessment; therapy assessment;
 - ii. Documentation listed in 3.d above
- b. Post SNF admission documentation at a frequency determined by the Local Plan case manager. May be in the form of clinical notes and/or treatment logs, as requested by the Plan case manager.
 - i. Clinical and rehabilitation status;
 - ii. Treatment received, including frequency and length of treatment period each day;
 - iii. Patient participation and progress toward clinical and rehabilitation goals;
 - iv. Patient/caregiver training progress toward goals;
 - v. Patient/caregiver participation in discharge planning; and
 - vi. Status of the discharge plan, including targeted site, date, and skilled needs (i.e., RN, PT, DME, etc.)

C. Preadmission Screening and Resident Review (PASRR) Requirements⁸

"Preadmission Screening and Resident Review (PASRR) is a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long term care. PASRR requires that

- 1) all applicants to a Medicaid-certified nursing facility be evaluated for serious mental illness (SMI) and/or intellectual disability (ID);
- 2) be offered the most appropriate setting for their needs (in the community, a nursing facility, or acute care settings); and
- 3) receive the services they need in those settings

PASRR is an important tool for states to use in rebalancing services away from institutions and towards supporting people in their homes, and to comply with the Supreme Court decision, *Olmstead vs L.C.* (1999), under the Americans with Disabilities Act, individuals with disabilities cannot be required to be institutionalized to receive public benefits that could be furnished in community-based settings. PASRR can also advance person-centered care planning by assuring that psychological, psychiatric, and functional needs are considered along with personal goals and preferences in planning long term care.

In brief, the PASRR process requires that all applicants to Medicaid-certified Nursing Facilities be given a preliminary assessment to determine whether they might have SMI or ID. This is called a "Level I screen." Those individuals who test positive at Level I are then evaluated in depth, called "Level II" PASRR. The results of this evaluation result in a determination of need, determination of appropriate setting, and a set of recommendations for services to inform the individual's plan of care." (www.Medicaid.gov)⁹

REFERENCES

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9. Preadmission Screening and Resident Review (PASRR). Accessed September 7, 2017 from: <https://www.medicaid.gov/medicaid/ltss/institutional/pasrr/index.html>

HISTORY

Date	Action	Description
December 2017	New	New UM Guideline
March 2018	Replace Policy	Clarification- for Medicare A
March 2019	Replace Policy	Policy reviewed. No changes
March 2020	Replace Policy	No changes to guideline. References updated
December 2020	Replace Policy	UM Guideline Criteria: Section A: Section A: 1, a: Review of treatment plan changed from 24 hours to 72 hours; Section. A.10, b, i: and Section B. 2. A.- physical rehab daily requirement changed from two (2) hours/day to one hour/day; Section B, 4: moderate changed to minimum; Section B. 5: Time from admission to PT evaluation changed from 16 to 24 hours. References: Removed archived Anthem Clinical Guideline; Updated BCBS Service Benefit Plan brochure to 2021, and Centers for Medicare and Medicaid Services resources.
January 2021	Policy updates	Added FEP Blue Focus to UM guideline 1; updated brochure year to 2021; Guidelines unchanged.