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Northwest Utilization Review

UR 7 Skilled Nursing Facility Medical Necessity Criteria

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MEDICAL NECESSITY CRITERIA AND OTHER REQUIREMENTS FOR SKILLED NURSING FACILITY CARE FOR COMMERCIAL, MEDICAID, AND MEDICARE BUSINESS-see Special Group Considerations for Medicare and Washington Medicaid specific information

DEFINITIONS

Definitions of Skilled Nursing Facility

1. An institution or distinct part of an institution that is primarily engaged in providing skilled nursing care and related services for the rehabilitation of injured, disabled or sick persons, and meets the requirements for participation in # 1819 of the Social Security Act and in regulations 42CFR part 483.
2. For Medicare purposes, the term SNF does not include any institutions that are primarily for the care of mental disease or tuberculosis.

Definition of Benefit for Skilled Services

1. Post-hospital extended care services furnished to inpatients of a skilled nursing facility are covered under the Part A hospital insurance program, commercial plans, and under Oregon and Washington Medicaid benefits.
2. Patients with hospital insurance coverage are entitled to have payment made on their behalf for the reasonable cost of covered extended care services furnished by a skilled nursing facility, or by a hospital with which the facility has a transfer agreement.
3. Part A covers up to 100 days of skilled nursing facility services per each benefit period. Oregon Medicaid Health Plan (OHP) covers up to 20 days of skilled nursing services per each benefit period. Commercial plans have various benefit periods. A benefit period begins with the first day of a Medicare covered inpatient skilled nursing stay, and ends with the close of a period of 60 consecutive days during which the member was neither an inpatient of a hospital or a SNF. As long as the beneficiary continues to be entitled to Part A, or OHP, there is no limit on the number of benefit period(s) he/she may have. There is no limit to the amount of skilled benefit days for Washington Medicaid members as long as they meet medical necessity criteria.
4. Beginning the benefit period: A benefit period begins upon admission to a qualified SNF for skilled care, even though payment for the services cannot be made because the prior hospitalization or transfer requirement has not been met.

5. See Waiver of a Three Day Stay Admission Criteria below for details on the waiver of a three-day qualifying stay.
6. Prolonging a benefit period: Beneficiaries who continue to require skilled care after exhausting their 100 days of covered Part A coverage until the close of a period of 60 consecutive days during which the beneficiary was neither an inpatient of a hospital or a SNF at a skilled level of care.

Covered Services in a Skilled Nursing Facility

1. Skilled nursing care.
2. Bed and board.
3. Physical Therapy (PT), Occupational Therapy (OT), Speech Therapy (ST).
4. Respiratory services (RT).
5. Medical/Social Services
6. Drugs and biologicals. (See below)
7. Medical services of interns and residents (see regulations for details).
8. Other health services necessary to the health of patients as are generally provided by SNFs (e.g., labs, x-ray, routine personal hygiene items and services).
9. Medical equipment, both standard and complex.
10. Medically necessary ambulance services.

Covered Drugs and Biologicals

1. During a covered skilled stay, prescribed drugs and biologicals that are ordinarily furnished by the facility are covered. Three requirements for coverage are:
   a. Must represent a cost to the institution, AND
   b. Must be included in the US Pharmacopoeia, the National Formulary, or the US Homeopathic Pharmacopoeia; or, except for those unfavorably evaluated, in AMA Drug Evaluations Accepted, AND
   c. Must be reasonable and necessary.
2. Drugs not included in the compendia are nevertheless covered if such a drug:
   a. Was furnished during the patient's prior hospitalization, AND
   b. Was approved by the hospital's drug therapeutic committee, AND
   c. Is required for the continued treatment in the SNF.
3. Drugs used outside the facility:
   a. If the drug or biological is deemed medically necessary to permit the patient's departure from the facility, and a supply is required until he/she can obtain a continuous supply, the drugs or biologicals would be covered as an extended care service of the SNF.

CRITERIA

Extenuating circumstances around pre-authorization and admission notification is based on the Best Practice Recommendations (BPR) put forth by the Washington Healthcare Forum operated by OneHealthPort but are applicable to all lines of business in Oregon and Washington. Please see associated Regional UM Policy:

UR 70: Extenuating Circumstances Policy at http://internal.or.kp.org/utilization/.

Pre-Admission Qualifying Criteria (Medicare Part A and Commercial)

A. Entitlement to Part A Medicare or Commercial Kaiser Permanente Health Plan (KPHP) coverage.
B. SNF day(s) available.
C. Care is reasonable and necessary.
D. The need for skilled services is certified/re-certified by a physician (MD), nurse practitioner (NP) or Clinical Nurse Specialist (CNS) (see Timing of Certifications and Re-certifications for frequency).
E. Prior hospitalization: Part A - The patient must have been an inpatient of a hospital for a medically necessary stay of at least three consecutive days. (See Waiver of a Three Day Stay Admission Criteria regarding waiver of this and associated requirements).
F. In addition, the patient must have been either:
   a. transferred to a participating SNF within 30 days after discharge from the hospital (the day of discharge is not counted); or
   b. if period of more than 30 days has elapsed, and the patient's condition makes it medically inappropriate to begin and achieve a course of treatment within 30 days after hospital discharge AND it is medically predictable at the time of hospital discharge that such care will be required within a pre-determinable time period.
G. The care is related to prior hospitalization (NOTE: "related to" means the condition requiring skilled care was treated during the hospitalization), or
H. The patient has been evaluated by a physician within the last 7 days in a clinic, emergency room, or in Home Health and skilled care is required to prevent hospitalization.
I. Skilled services (nursing or rehabilitation) must be needed and provided on a "daily basis" i.e., on essentially a 7-day-a-week basis, a patient whose inpatient stay is based solely on the need for skilled rehabilitation services would meet the daily basis requirement when services are needed and received on at least 5 days per week.

Waiver of Three Day Stay Admission Criteria (Medicare Part A)

A. A number of Kaiser Foundation Health Plans have elected to waive the 3-day qualifying stay requirement allowing patients to be directly admitted to a SNF when medically appropriate.
B. This waiver means that a SNF stay not preceded by a qualifying stay for the 1876 Cost member must be billed to KFHP not Medicare.
C. Medicare Advantage member admissions are always billed to KFHP.
D. If the Kaiser Permanente (KP) SNF benefit waives the qualifying stay, the 30-day transfer rule and the requirement for the SNF care to be related to the preceding hospital care is also waived.

Pre-Admission Qualifying Criteria (Washington Medicaid)

A. Entitlement with Medicaid managed care organization (MCO).
B. Washington Medicaid covers costs when the patient is not covered by Medicare, another primary insurance, or third party insurance. Medicaid is the payor of last resort.

C. All members are required to have a Preadmission Screening and Resident Review Level I screening (PASRR). This screening looks for indicators of an intellectual disability or a serious mental illness.

D. Care is reasonable and necessary. Covered when the Plan determines that nursing facility care is more appropriate that acute hospital care.

E. The need for skilled services is certified/re-certified by a physician (MD), nurse practitioner (NP) or Clinical Nurse Specialist (CNS) (see Timing of Certifications and Re-certifications for frequency).

F. Skilled services (nursing or rehabilitation) must be needed and provided on a "daily basis" i.e., on essentially a 7-day-a-week basis, a patient whose inpatient stay is based solely on the need for skilled rehabilitation services would meet the daily basis requirement when services are needed and received on at least 5 days per week.

G. Services are not covered by DSHS Aging and Long Term Supports Administration.

H. Services are not covered if it is determined to not be medically necessary for rehabilitation.

I. The Plan shall coordinate with the Skilled Nursing facility to provide prescription medications, durable medical equipment, therapies, intravenous medications, and any other medically necessary service or product.

Pre-Admission Qualifying Criteria (Oregon Medicaid)

A. The post hospital extended care benefit must be authorized by pre-admission screening for individuals not enrolled in managed care.

B. SNF days available.

C. Must be receiving Oregon Health Plan benefits and not Medicare eligible.

D. Have a medically necessary, qualifying hospital stay, not including a hold bed, observation bed, or emergency room bed. The stay must consist of three or more consecutive days, not counting the day of discharge.

E. Transfer to a nursing facility within 30 days of discharge from the hospital.

F. Need skilled nursing or rehabilitation services on a daily basis meeting Medicare skilled criteria that may be provided only in a nursing facility.

G. All members are required to have a Preadmission Screening and Resident Review Level I screening (PASRR). This screening looks for indicators of an intellectual disability or a serious mental illness.

Criteria for Skilled Care under Medicare Part A, Commercial and Oregon and Washington Medicaid

A. Skilled means:

1. The patient requires skilled nursing or skilled rehabilitation services (PT, OT, ST) and meets medical necessity criteria.
2. These services require the skills of technical or professional personnel and are furnished directly by, or under the supervision of such personnel.
3. These services are required on a daily basis (skilled nursing 7 days per week; skilled therapies at least 5 days per week).
4. As a practical matter, considering economy and efficiency, the daily skilled services can only be provided on an inpatient basis in a SNF.

5. The services delivered are reasonable and necessary for the treatment of the patient's illness or injury. The services must also be reasonable in terms of duration and quantity.

B. Specific categories of skilled services are:
    1. Direct care.
    2. Management and evaluation of a patient's care plan.
    3. Observation and assessment of a patient's condition.
    4. Teaching and training services.

OTHER CLINICAL REQUIREMENTS

Physician Services in SNF

A. A physician must approve, in writing, a recommendation that an individual be admitted to a facility.
B. Each resident must remain under the care of the physician.
C. Visits: Physician must:
    1. Review the total program of care at each visit.
    2. Write, sign and date progress notes at each visit.
    3. Sign and date all orders.
    4. Frequency: Beneficiary must be seen once every 30 days for the first 90 days after admission and at least once every 60 days thereafter. The visits must be timely which means the visit occurs no later than 10 days after the required visit date.
D. The physician must make the initial visit. Thereafter he/she may elect to alternate between personal visits and visits by a Physician Assistant (PA), Nurse Practitioner (NP), or Clinical Nurse Specialist (CNS) as permitted by State Law.
E. Physician must be available for emergency care.
F. Physician must certify and/or re-certify to the skilled level of care (also see Physician Delegation below).

Physician Delegation of Tasks in SNF

All required physician visits must be made by the physician personally except at the option of the State, the physician may delegate these tasks/visits to a NP, CNS, or PA who is not an employee of the facility, but who is working in collaboration/association with the physician, and is acting within their scope of practice.

Note: A Physician Assistant is not permitted to sign certifications/re-certifications.

Discharge Planning

1. The resident must have a discharge summary that includes a post-discharge plan of care that is developed with the participation of the resident and his/her family, and that will assist the resident to adjust to his or her new living environment.
2. DME may be delivered to a facility that does not qualify as the patient's home, up to 2 days prior to discharge for the purposes of fitting or training. However, suppliers may only bill from date of discharge.

OTHER ADMINISTRATIVE REQUIREMENTS

Certification General Requirements

A. A physician must approve in writing a recommendation that an individual be admitted to a facility.
B. Each resident must remain under the care of a physician.
C. Certification: A physician must certify in writing that:
    1. The beneficiary needs daily skilled nursing or rehabilitation services which can only be provided in a SNF on an inpatient basis for either the condition for which he/she received inpatient hospital services, or for a condition which arose after transfer while in the SNF for treatment of a condition for which he/she received inpatient hospital services, OR
    2. The individual has been correctly assigned to one of the RUGs designated as representing the required level of care (Part A).

Re-Certification General Requirements

A. Re-certification: The physician must recertify to:
    1. The reasons for the continued need for post-hospital SNF care.
    2. The estimated time the individual will need to remain in the SNF.
    3. Plan for home care, if any.
    4. If appropriate, that continued services are needed for a condition that arose after admission to the SNF and while the individual was still under treatment for the condition for which he/she had received inpatient hospital services.

B. There is no requirement for a specific procedure or form as long as the approach permits verification that the certification and re-certification requirement is met. They may be entered in forms, notes, or other records that a physician normally signs in caring for the patient, or on a separate form.

Certification and Re-certification:

A. The attending physician or a physician on the staff who has knowledge of the case signs certifications and re-certifications.
B. The physician may delegate certification/re-certification to a nurse practitioner or clinical nurse specialist who does not have a direct or indirect employment relationship with the facility, but is working in collaboration with the physician.

Note: Per regulation, Physician Assistants may not sign certifications/re-certifications.

Timing of Certifications and Re-certifications

A. Certification: First certification must be made at the time of admission or as soon thereafter as is reasonable and practical.
B. Re-certifications: No later than the 14th day of post-hospital SNF care. Subsequent recertification must be made at intervals not exceeding 30 days.

Change From Skilled to Custodial Level or Exhausted Benefit

A. Beneficiaries who are in a skilled Medicare Part A covered SNF stay, whose physician determines that they no longer require skilled care must be notified in writing via a Medicare Notice of Non-Coverage (NOMNC) prior to discharge to the non-skilled level (Form CMS 10123-NOMNC).
B. Beneficiaries who exhaust their Medicare Part A 100-day benefit and continue to require skilled care are not considered custodial, and must receive a Medicare Notice of Denial of Payment (CMS-10003-NDMCP).

C. Beneficiaries who are in a skilled commercial covered SNF stay, whose physician determines that they no longer require skilled care and the beneficiary disagrees, or who have exhausted their benefit must be notified in writing via a Concurrent Care Claim Denial Notice.

D. Beneficiaries who are in a Washington Medicaid skilled covered SNF stay, whose physician determines that they no longer meet medical necessity criteria for skilled care, must be notified in writing via a Notice of Denial of Services (Notice 17-2921) if the patient does not agree with the discharge.

E. Beneficiaries who are in an Oregon Medicaid skilled covered SNF stay, whose physician determines that they no longer require skilled care or have exhausted their 20-day benefit, must be notified in writing via a Notice of Action.

Minimum Data Set (MDS)/Resident Assessment (Part A)

A. In October 2019, the Patient Driven Payment Model (PDPM) was established by CMS. Under the PDPM model, each patient is classified into a group for each of five case-mix adjusted components: PT, OT, Speech, Nursing and a comorbidity score. SNFs are paid a case mix based upon the components in a covered Part A stay. Under PDPM, an adjustment factor is applied and changes the per diem rate over the course of the stay.
B. The SNF is required to complete an assessment that is both scheduled and unscheduled, with a variety of rules that govern timing, interaction among assessments and combining assessments. The assessments are entered into the Minimum Data Set (MDS) system according to Medicare assessment schedule if they are billing Medicare directly. If the SNF is billing Kaiser Foundation Health Plan, Inc., the first MDS is not due until the 14th day of SNF stay.

Billing Rules (Medicare Part A)

A. Care must be ordered and directed by a physician, AND
B. The care must be furnished for a condition for which the beneficiary received inpatient hospital care, or which arose while receiving inpatient hospital care (see Waiver of Three Day Stay).
C. Under the PDPM System, when the SNF bills Medicare directly, the clinical criteria for covered skilled care must include documentation per the Minimum Data Set assessment and assignment to a payable PDPM classification.
D. Patients assigned to one of the five case-mix categories are PRESUMED to be receiving daily skilled services.
E. Services which are not included in the SNF PPS and for which separate Part B payment must be made:
    1. Cardiac catheterization
    2. CT (computerized tomography)
    3. MRI (magnetic resonance imaging)
    4. Ambulatory surgery
    5. Emergency services
    6. Radiation therapy
    7. Angioplasty
    8. Lymphedema and venous insufficiency
    9. Physician services
F. Medicare Advantage Contract billing requirements:
    1. SNFs bill KFHP
    2. Payment based on contract terms
    3. MDS not required until the 14th day
G. #1876 Cost Contract billing requirements:
    1. SNFs bill Medicare directly

2. SNFs must abide by Medicare PPS and consolidated billing rules, i.e., MDS assessment schedule and RUG assignment.

Contracts (Medicare Part A and Commercial) KFHP must use a Medicare-certified provider. The SNF must have an active state license.

(Oregon and Washington Medicaid) KFHP must use a Medicaid-certified provider.

SPECIAL GROUP CONSIDERATIONS, WHEN GROUP HAS A SNF BENEFIT

Commercial, FEDs, Oregon Medicaid: these criteria apply;

Medicare: January 2014 revisions to the Medicare Benefit Policy Manual related to Skilled Nursing facility, Home Health and Outpatient skilled care clarified that a beneficiary's lack of restoration potential cannot serve as the basis for denying coverage in this context. Rather, such coverage depends upon an individualized assessment of the beneficiary's medical condition and the reasonableness and necessity of the treatment, care, or services in question. Moreover, when the individualized assessment demonstrates that skilled care is, in fact, needed in order to safely and effectively maintain the beneficiary at his or her maximum practicable level of function, such care is covered (assuming all other applicable requirements are met). Conversely, coverage in this context would not be available in a situation where the beneficiary's maintenance care needs can be addressed safely and effectively through the use of *nonskilled* personnel.

Washington Medicaid: Skilled Nursing care is covered for members that meet Milliman Care Guidelines (MCG) for skilled nursing care instead of Medicare criteria. There is no limit to the number of days in a benefit period. The coverage of skilled care will continue as long as the care is medically necessary.

REFERENCES

MEDICARE

Criteria are based on Medicare Benefit Policy Manual, Chapter 8, Coverage of Extended Care (SNF) Services (Rev. 10/5/23).

Note: Kaiser Foundation Health Plan (KFHP) of the Northwest does not require a 3-day hospital stay prior to admission to a Skilled Nursing Facility (SNF).