

Skilled Nursing Facility Benefits

Policy Number: IN0600

Active policy, not scheduled for routine review.

Definition:

A skilled nursing facility (SNF) is an institution licensed under applicable state laws and engaged primarily in providing to inpatients, under the supervision of a doctor and a registered professional nurse, skilled nursing care on a 24-hour basis and an inpatient level of rehabilitative services. A hospital inpatient level of care would be required if a SNF were not available, and other alternative levels of care, such as office, outpatient, home, or lesser-than-SNF level of care (i.e., an intermediate care facility [ICF] or rest home) are unable to provide the frequency and/or intensity of services needed.

Coverage:

Charges made to patients for services received in a skilled nursing facility (SNF) basically fall into two distinct categories - routine and ancillary. In providing benefits for services received in an SNF, distinction is made between routine and ancillary charges for purposes for reimbursement. Regardless of the manner in which the services are billed, routine services are not paid as items separate from accommodation charges. However, ancillary charges, if covered, are paid apart from the charge for room accommodation:

1. Routine services which should be included in the accommodation charge include:
 - a. Medical social services
 - b. All general nursing services, including administration of oxygen and related medications, handfeeding, incontinency care, tray service, enemas
 - c. Items furnished routinely and relatively uniformly to all patients; e.g., patient gowns, paper tissues, water pitchers, bedpans, deodorant, mouthwash
 - d. Items stocked at the nursing station or on the floor in large quantity and distributed individually in small amounts; e.g., alcohol, applicators, cotton balls, Band-aids, Maalox, aspirin (and other non-legend drugs ordinarily kept on hand), suppositories, tongue depressors
 - e. Items which are utilized by individual patients but which are reusable and expected to be available in an institution providing a skilled level of care; e.g., ice bags, bedrails, canes, crutches, walkers, wheelchairs, IV poles and pumps, traction equipment, and other durable medical equipment
 - f. Special dietary supplements used for tube feeding or oral feeding, such as elemental high nitrogen diet, even if written as prescription items by a physician
2. To be considered as ancillary charges payable as separate items when billed by an SNF, services must be:
 - a. Directly identifiable services provided to an individual at the direction of a physician because of a specific medical need; e.g., physical therapy, speech therapy
 - b. Not reusable; e.g. legend drugs, irrigation solutions, IV fluids, oxygen (including medications), disposable catheters; or represent a cost for each use; e.g. sterilization and set-up of reusable catheters
3. The following are covered in a skilled nursing facility:
 - a. Daily charges for room and board, up to the semi-private room rate, as outlined above
 - b. Ancillary charges and other services ordinarily covered in a general hospital, as outlined above

Approval Procedures:

1. A letter of medical necessity and plan of treatment signed and dated by the physician must be submitted to the Medical Review section prior to rendering the service.

2. Documentation must include:
 - a. Member identification number
 - b. Patient's mailing address
 - c. Medical diagnosis, including patient's physical and mental status and the necessity for skilled care
 - d. Admission history and physical and discharge summary of the qualifying acute-care facility admission
 - e. Specific skilled services required on a continuing daily basis
 - f. Expected duration of admission
3. Providers will be notified of approval and providers and members will be notified of denial.
4. The Medical Review section will use the following criteria in determining whether the service is covered:
 - a. Benefits are provided for post-hospital skilled nursing facility care when all of the following conditions are met:
 - i. The patient requires medically necessary skilled care on a continuing daily basis as evidenced by the need for the constant nearby presence, on-site availability, and supervision of a skilled (registered or licensed practical) nurse for the purpose of either monitoring and evaluation of the patient for an unstable medical condition or for the provision or administration of services or procedures that can only be provided by a skilled nurse.
 - ii. The patient receives skilled care for any of the conditions for which he received medically-necessary inpatient hospital care, or for a condition which arose while he was in a skilled nursing facility receiving care for such a condition
 - iii. Such services are medically required to be given on an inpatient basis as evidenced by documentation that the services are being provided and are needed in a frequency (a minimum of every 8 hours) and/or an intensity that cannot be provided in the home setting through intermittent Home Health skilled nursing visits and custodial support and assistance.
 - iv. The patient is referred by and remains under the continual care of an attending physician who should evaluate the patient through an on-site visit at least once a month.
 - b. In determining whether services rendered in a SNF constitute covered care, it is necessary to determine whether the individual services provided are skilled, and whether skilled management of the services provided is needed, and whether the services planned are needed, whether provided or not. Skilled services are medically necessary services that must be rendered by licensed health care professionals in accordance with state law or regulation. The ability to provide skilled services requires the specialized skills of licensed medical personnel. Covered care includes the skills of teaching, restoring, retraining, and intensive skilled nursing procedures as provided by licensed health care professionals. It connotes an active regimen with short and/or long term goals, and requires skilled services for a period of time. Where the inherent complexity of a service prescribed for a patient is such that it can be safely and/or effectively performed only by or under the direct supervision of licensed health care professionals, the service constitutes a skilled service.
 - c. A noninclusive list of services that are not considered skilled follows:
 - i. Assistance with activities of daily living, to include bathing, assistance with walking, dressing, feeding, preparation of special diets, eating, continence, toileting, transferring, skin care, enemas, and taking patient to the doctor's office.
 - ii. Administration of routine oral medications, eye drops, and ointments
 - iii. Routine care of indwelling bladder catheters
 - iv. Routine care of an established colostomy/ileostomy
 - v. Routine care of incontinent patient
 - vi. Established gastrostomy tube feedings
 - vii. Established oxygen therapy
 - viii. Care of decubitus ulcers that are not infected or extensive (Stage I/II)
 - ix. Passive range of motion exercises
 - x. Care of the confused or disoriented patient who is no longer receiving active treatment but is under an established medication regimen, if required.
 - xi. Observation and monitoring of patients receiving routine care for the above listed nonskilled services.
 - xii. Superficial oropharyngeal or nasotracheal suctioning.

- xiii. Tracheostomy site care for established tracheostomy.
- xiv. Routine measurement of vital signs.

- d. The importance of a particular service to an individual patient does not necessarily make it a skilled service. For example, a primary need of a non-ambulatory patient may be frequent changes of position to avoid development of decubiti. If changing a patient's position is the only regular and frequent service provided, it is not a skilled service.
- e. The need for, and length of stay in, a skilled nursing facility depends upon the patient's medical condition and the type, amount, and frequency of skilled nursing services provided.
 - i. The patient must require continuous skilled nursing services daily. The fact that a person may require periodic or occasional skilled services would not in itself make a skilled nursing facility admission an eligible benefit.
 - ii. Skilled services rendered primarily to sustain life or to aid in essentials of daily living such as tube feeding or Foley catheter care may constitute custodial care when the patient is not under specific treatment to restore his condition to the extent necessary to live outside an institution.
 - iii. Skilled paramedical services (such as physical therapy, occupational therapy, and speech therapy) which can be, and generally are, rendered on an outpatient basis do not qualify an admission for benefits unless the patient is also receiving one or more other types of skilled care.
- f. Covered care includes the skills of teaching, observation, restoring, retraining, and intensive skilled nursing procedures. It connotes an active regimen with short-and/or long-term goals, and requires skilled services for a period of time. Services for an individual who lacks rehabilitation potential are not necessarily non-covered. For example, a terminal cancer patient whose life expectancy is a few months may require skilled services which are covered care.
- g. At a point in time, a patient may no longer need skilled nursing services. The primary purpose of the care being furnished the individual may be to assist with the activities of daily living. Care which assists the individual in meeting his activities of daily living by doing for' or 'assisting with' such activities as bathing, dressing, eating, walking, or taking medication on a regular schedule is non-covered. Assistance needed by the patient during a period of teaching, of either the patient or his caretaker, or retraining is covered.
- h. Intramuscular or intravenous medications are generally considered to be skilled services. In general, subcutaneous medications are self-administered or administered by properly instructed family members.
 - i. Intramuscular injections administered over a prolonged period of time must be related to a specific illness, and the need documented by medical and clinical evidence.
 - ii. Injections which can usually be self-administered do not require skilled care; e.g., the well-regulated diabetic who receives daily insulin does not require skilled care for the purpose of receiving his injection.
 - iii. Injections to the brittle diabetic who requires monitoring of blood glucose, observations, and regulation of insulin dosage every 8 hours or more frequently, are skilled services. A "sliding scale insulin" regimen that is stable and unchanging can be administered by the patient or by a trained family member and is thus not considered skilled services.
- i. Oral medications which may result in hazardous side effects or reactions, should be administered to the patient and observed by licensed nurses, and thus constitutes a skilled service until the patient has demonstrated good and reliable tolerance to the medication.
- j. Where a prolonged regimen of potentially hazardous oral drug therapy is instituted, the need for skilled care can only be presumed during the period in which the routine is being established, when changes in dosage or skilled observation may be required.
- k. Insertion, replacement, or sterile irrigation of a catheter is a skilled service. Routine servicing of indwelling bladder catheters, such as emptying containers, etc., is not a skilled service.
- l. Skilled services may be required during the immediate post-operative colostomy care 'teaching period' following a newly-created or revised opening. General maintenance of this condition can then usually be performed by the patient or by a person without professional training, and would not require skilled services.

- m. Dressings or soaks involving sterile technique which cannot be performed by non-medical personnel are considered skilled services. Changing dressings of non-infected post-operative or chronic conditions is not a skilled service.
- n. Without other medical conditions requiring skilled care, incontinence being treated by the use of methods such as diapers does not require skilled services. An active regimen such as bladder and/or bowel training requires skilled services only while it is being initiated.
- o. The care of a confused or disoriented patient who is receiving active medical treatment for his mental status may require skilled services during the treatment period. Care of a confused or disoriented patient who no longer receives 'active' treatment but is controlled by medications, and who has no other medical conditions requiring skilled services, is non-covered care.
- p. A patient's mobility status alone would not determine whether care is covered or non-covered. The level of care required by the medical condition of the patient and the need for skilled services determines if the care is covered.
- q. The initial regimen of oxygen therapy often must be performed under medical supervision and is covered care. There are instances where oxygen therapy is non-covered. For example, care of a patient with emphysema who can be taught to manage oxygen therapy (intermittent positive pressure) would be non-covered after the 'teaching period' had ended.
- r. Restorative nursing procedures constitute skilled services when designed to restore functions lost or reduced by illness or injury, and are a type requiring the presence of nurses; for example, an intensive regimen of physical therapy. When a patient attains his restoration potential, the services required to maintain him at this level are not skilled services. General supervision of exercises is not a skilled service.
- s. Treatment of extensive decubiti (stage III or higher) or other widespread skin disorders necessitates skilled care. Routine prophylactic and palliative skin care such as bathing, application of lotions, etc., is not a skilled service.
- t. The therapeutic use of sunlamps, infra-red lamps, whirlpool, diathermy, and similar equipment is covered when the service is specifically ordered by a physician as a part of an active treatment regimen and observation by skilled personnel is required to evaluate the results of treatment. Routine use of such equipment for palliative and comfort purposes is not covered.
- u. Physical therapy constitutes skilled care for the purpose of rehabilitation and/or restoration of function of the patient when the services:
 - i. Are directly and specifically related to an active written treatment regimen designed by the physician (in consultation with a qualified physical therapist).
 - ii. Require the judgment, knowledge, and skills of a qualified physical therapist.
 - iii. Are provided with the expectation that the patient will improve significantly in a reasonable and generally predictable period of time, or establish a safe and effective maintenance program in connection with a specific disease state.
 - iv. Are considered by accepted standards of medical practice to be a specific and effective treatment for the patient's condition.
 - v. The provision of physical therapy does not in itself constitute a covered level of care. The patient must regularly receive one or more other types of skilled care. Also, an inpatient intensity and duration of rehabilitative services should be provided as evidenced by at least two hours or more of a combination of physical therapy and one other rehabilitative modality, either occupational therapy or speech therapy. If only physical therapy (or occupational therapy or speech therapy) is provided, skilled nursing services of a continuous nature must also be provided to qualify for SNF benefits.
- v. Hot packs, hydrocollator, infra-red treatments and whirlpool bath treatments do not ordinarily require a qualified physical therapist, except where the patient's condition is complicated by circulatory deficiency, open wounds, etc. If such treatment is prerequisite for physical therapy, it is considered a part of that physical therapy.
- w. Gait training and training for a patient whose ability to walk has been impaired by neurological, muscular, or skeletal

abnormality, require the services of a qualified physical therapist. Repetitive exercises to improve gait, maintain strength and endurance, or assist the feeble or unstable patient do not require the skills of a qualified physical therapist.

- x. Ultrasound, shortwave, and microwave diathermy treatments should always be carried out by, or under the supervision of a qualified physical therapist.
- y. Only a qualified physical therapist may perform range of motion tests. Range of motion exercises require a qualified physical therapist only when they are a part of active treatment of a loss or restriction of mobility and such exercises may be performed safely only by a qualified physical therapist because of their nature or the condition of the patient. Passive range of motion exercises not related to the restoration of specific loss of function can ordinarily be provided safely by aides or nursing personnel.
- z. The repetitive services required to maintain function, rather than to restore it, do not involve the use of complex and sophisticated physical therapy procedures and do not require the skills of a qualified physical therapist. A qualified physical therapist may be required to establish a maintenance program.

Limitations and Exclusions:

1. The patient must have incurred a prior admission to an acute-care facility of not less than three (3) days to qualify for benefits in a skilled nursing facility.
2. The admission to the skilled nursing facility must occur within 14 calendar days of discharge from the acute-care facility.
3. Skilled nursing facilities not certified to deliver services as outlined in Title XVIII of the Social Security Act (Medicare) may not bill the member or the Plan for charges that would otherwise be covered by Medicare.
4. Coverage is limited to the period in which the patient requires skilled nursing or rehabilitative services on a continuing daily basis. (up to a maximum of 100 days per fiscal year for the same reason.)
5. Any admission that began prior to the member's date of coverage with the Plan is not covered.
6. If the patient is subject to a 12-month waiting period for pre-existing conditions and remains continuously confined in a skilled nursing facility during that time, there would be no coverage for the confinement at the end of the 12-month waiting period without discharge from the skilled nursing facility, admission to an acute-care facility, and subsequent readmission to the skilled nursing facility as outlined in (1) and (2) above.
7. Intermediate care, custodial care, or domiciliary care (rest home) is not covered.
8. Patients requiring chronic ventilation use (minimum 8 hours a day) are not subject to the 100 days a year limit, as long as they continue to receive and require continuous daily skilled nursing care as defined by policy requirements above.

Authority:

- G.S. 135-42(b)
- G.S. 108A-70.21(b)
- G.S. 135-40.1(18) (statute effective through 06/30/2008 for Predecessor Plan)
- G.S. 135-40.6(3) (statute effective through 06/30/2008 for Predecessor Plan)
- G.S. 135-40.6A(b)(1) (statute effective through 06/30/2008 for Predecessor Plan)
- G.S. 135-40.1(17a) (statute effective through 06/30/2008 for Predecessor Plan)
- G.S. 135-40.7(2) (statute effective through 06/30/2008 for Predecessor Plan)
- G.S. 135.40.7(22) (statute effective through 06/30/2008 for Predecessor Plan)

Complete Review of Policy:

December 1989
March 2005

Revised:

December 1995

June 1998

September 2000

March 2002

December 2008