

Subject: Skilled Nursing Facilities

Objective:

- I. To ensure that Tuality Health Alliance (THA) members are appropriately placed in skilled nursing facilities (SNF's) according to national criteria, accepted standards of care, specific health plan criteria, and state or federal administrative regulations and statutes.

Policy:

- I. **SNF Admission**
 - a. THA Nurse Case Managers will collaborate with a member's primary care provider or attending physician to determine whether a SNF level of care is medically necessary.
 - b. SNF stays require prior authorization (PA); the THA Nurse Case Managers and THA Medical Director make SNF authorization decisions according to specific health plan criteria, McKesson InterQual, Medicare/Medicaid Criteria (Quality Improvement System for Managed Care and Division of Medical Assistance Program) and applicable state/federal regulations and statutes.
 - c. Member must be transferred to a SNF within thirty (30) days of a qualifying inpatient hospitalization.
 - d. SNF treatment must be provided for the condition that was treated in the qualifying hospital stay.
 - e. THA Oregon Health Plan members have a twenty (20) day SNF benefit. If a longer stay in a SNF is required, the Department of Human Services (DHS) assumes coverage and a DHS Pre-Admission Screening and Resident Review must be completed.
 - f. Moreover, skilled care is covered in a SNF when all of the following four factors are met:
 1. The patient requires skilled nursing services or skilled rehabilitation services and is ordered by a physician.
 2. The patient requires the skilled services on a daily basis.
 3. The daily skilled services can be provided only as an inpatient in a SNF.
 4. The services must be reasonable and necessary for the treatment illness or injury, and must meet accepted standards of medical practice, and must be reasonable in terms of duration and quantity.
 - g. The THA Nurse Case Managers and THA Medical Director determine SNF denials based on medical appropriateness; members and providers have the

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right to appeal SNF denial decisions. All appeals or requests for reconsideration of the denial must be routed to THA.

- II. **SNF Admission for Supervision and Management of a Complicated or Extensive Plan of Care**
 - a. Average length of SNF stay for a Complicated or Extensive Plan of Care is between three (3) and twenty one (21) days.
 - b. There must be a significantly high probability that complications would arise without skilled supervision of the treatment plan by a licensed nurse.
 - c. Care plans must include realistic nursing goals and objectives for the patient, discharge plans, and the planned interventions by the nursing staff to meet those goals and objectives. Updated care plans must document the outcome of the planned interventions.
 - d. There must be daily documentation of the patient's progress and/or complications.
 - e. The need for skilled management should be re-evaluated at least every seven days.

- III. **Observation, Assessment, and Monitoring**
 - i. The unstable condition of the patient must require the skills of a licensed nurse in order to detect and evaluate the need for modification of the treatment plan.
 - ii. There must be a high probability of complications or further acute episodes.
 - iii. Daily nursing notes must give evidence of the patient's condition and indicate the results of monitoring.
 - iv. Documentation must indicate the patient's condition and the results of monitoring.
 - v. The need for skilled observation should be re-evaluated at least every seven days.

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- IV. **Complex Teaching Services to the Patient and/or Caregiver Requiring Twenty-four (24) Hour SNF Confinement vs. Intermittent Home Health Visits**
- a. The teaching by a licensed care professional to a member and/or caregiver is a covered benefit/ skilled service. However, the member and/or caregiver's performance of that taught skill may or may not be considered a covered benefit/skilled service.
 - b. Documentation should include the reasons why the teaching was not completed in the hospital, as well as the patient's or caregiver's capability of compliance.
 - c. Admissions for complex teaching may be approved for five (5) days. Extensions beyond five (5) days may be granted if the patient and/or caregiver are making significant progress towards learning goals and if learning barriers are documented.
- V. **Insulin Injections**
- a. The patient must be receiving multiple daily doses of regular insulin based on a sliding scale.
 - b. There must be documentation that a sliding scale is medically necessary, as evidence by fluctuating, unstable blood sugars and/or hypoglycemic reactions.
 - c. There must be a documented plan to progress the patient to a long-acting insulin regimen.
 - d. Admissions should be reviewed every seven (7) days.
- VI. **Unstable Parenteral Pain Management**
- a. Medication must be ordered and given parenterally every four to six hours or as a continuous infusion. The patient's pain status must be unstable as evidenced by adjustment of pain medications at least daily.
 - b. Admissions may be approved for seven (7) days. There must be documentation of continued medical necessity for parenteral medication beyond seven (7) days.
- VII. **Complex Medication Regimen**
- a. The patient must have a complex range of new medications (including oral medications) following a hospitalization where there is a high probability of

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adverse reactions and/or a need for changes in the dosage or type of medication.

- b. Admissions may be approved for up to seven (7) days. Extensions beyond this require documentation of the patient's unstable condition, medication changes, and continuing probability of complications.
- VIII. **New Tube Feedings (Nasogastric, Jejunostomy, Gastrostomy)**
Admissions for new feeding tubes may only be approved for seven (7) days. Extensions beyond seven (7) days may be considered based on submitted documentation.
- IX. **Enteral Feedings**
Enteral feedings that comprise at least twenty-six (26) percent of daily calorie requirements and provide at least 501 milliliters of fluid per day qualify as skilled care per CMS Guidelines.
- X. **Endotracheal Suctioning**
- a. Deep tracheal suctioning must be required at least every four hours. Suctioning daily or less frequently than every four hours is not considered skilled treatment.
 - b. Admissions for patients requiring suctioning may be approved at seven to fourteen (7-14) day intervals. Extensions may be granted based only on clear documentation that the patient is being suctioned at least every four hours.
- XI. **Ventilator-Dependent Patients**
- a. These patients are considered skilled due to their complex care.
 - b. Admissions for ventilator dependent patients may be approved at thirty (30) day intervals up to their benefit maximum of twenty one (21) days.
- XII. **Wound Care (Including Decubitus Ulcers)**
Wound Care alone rarely requires a SNF setting. SNF treatment may be necessary when all of the following criteria are met:
- i. A physician must order the wound care.
 - ii. The patient must require extensive wound care (e.g., packing, debridement, and/or irrigation) that cannot be accomplished by the patient, caregiver, or home health services.
 - iii. Treatment of extensive decubitus ulcers or other widespread skin disorder is considered.

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- iv. Skilled observation and assessment of a wound must be documented daily and should reflect any changes in wound status to support the medical necessity for continued observation.
 - v. Continuing admissions may be approved at seven (7) day intervals up to twenty-one (21) days.
- XIII. **SNF Admission for Skilled Rehabilitative Services: Physical Therapy**
SNF admissions when physical therapy (PT) is the anchor therapy may be medically necessary as long as the criteria defined below are met. Supporting disciplines may include occupational or speech therapy. Requests for SNF admission when PT is not the anchor therapy may be reviewed on an individual basis. Average length of stay for therapies is seven (7) to twenty-one (21) days.
- a. The patient must have a loss of function resulting from an acute event or an exacerbation of a chronic condition.
 - b. The expectation for improvement is reasonable, and the planned discharge setting is an inpatient rehabilitation program or a home setting.
 - c. There must be clear documentation of the patient's rehabilitative and restorative functional potential. In addition, there must be documentation of the treatment plan, PT goals (including the approximate dates the goals will be met), as well as the anticipated length of treatment and discharge plan.
 - d. PT must relate to the restoration of lost function (e.g., gait, transfer, or stair training or bed mobility).
 - e. Unless a gait disturbance is present the following are not considered skilled PT: progressive ambulation, repetitive exercises to improve ambulation and maintain strength and endurance, and assisted walking of 100 feet or more
 - f. There must be documentation of the patient's active participation in PT sessions at least five (5) days per week.
 - g. The continuation of PT services is acceptable as long as the documentation indicates objective evidence that the patient is making significant functional improvement and the services continue to require the skills of a licensed therapist.

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- h. Admissions for skilled PT services may be approved at seven (7) or fourteen (14) day intervals
- XIV. **SNF Admission for Skilled Rehabilitative Services: Respiratory Therapy**
The need for respiratory therapy (RT), either by a nurse or by a respiratory therapist, does not alone qualify a patient for SNF care.
- a. Skilled observation may be required during these treatments for patients with a high probability of complications during their admission. Refer to the above criteria for observation and assessment.
 - b. Physician-prescribed respiratory therapy services may be required for the management of patients with acute respiratory diseases or acute exacerbations of chronic respiratory diseases. Services performed by a respiratory therapist may not duplicate those services that can be performed by an RN. The frequency, duration and modality of RT services must be reasonable and consistent with the nature and severity of the patient's medical condition, and services must be generally accepted by the professional medical community as being safe and effective for the purpose used. The need for RT should decrease as the patient's condition improves. In general, RT services may be approved for the following:
 - i. Establishment and maintenance of artificial airways, including tracheostomy tube changes;
 - ii. Ventilator therapy and other means of airway pressure manipulation.
 - iii. Precise delivery of oxygen concentration (e.g., titration of O₂ for Ventimasks) – oxygen delivery by nasal cannula is not eligible for RT visits;
 - iv. Chest physiotherapy, IPPB, postural drainage;
 - v. Nasotracheal suctioning when performed in conjunction with RT services;
 - vi. Diagnostic tests for evaluation by a physician (e.g., pulmonary function tests, blood gas analyses, Spirometry); or
 - vii. Periodic assessment, as warranted by changes in the patient's condition, to evaluate the need for or effectiveness of RT services.
- XV. **SNF Admission Is NOT Considered Medically Necessary for the Following Services:**
- a. Routine or Maintenance Medication Administration
SNF admissions solely for the administration of routine or maintenance medications, including daily IV, IM, and SQ medications, are not considered skilled. Parenteral medication administration in medically

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stable patients is most often managed in the home setting by a home health or home infusion therapy provider.

b. Urinary Catheters

The presence of a stable indwelling or suprapubic catheter, the need for routine intermittent straight catheterization, catheter replacement, or routine catheter irrigation does not qualify a patient for SNF placement unless other skilled needs exist.

c. Heat Treatment - Wet or Dry

- Whirlpool baths, paraffin baths, or heat lamp treatments do not qualify a patient for care in a SNF.
- There may be a rare instance when a severely compromised patient with desensitizing neuropathies or severe burns requires skilled observation during the above treatments. These cases are to be reviewed on an individual basis. Documentation must support the medical necessity for such observation.

References:

42 CFR 409.31
Medicare/Medicaid Quality Improvement System for Managed Care
Oregon Division of Medical Assistance Programs
OAR 410-120-1210
OAR 411-70
McKesson InterQual

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