Skilled Nursing Facility (SNF) Care and Exhaustion of SNF Benefits

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Instructions for Use

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Related Policies
None

Coverage Guidelines

Inpatient skilled nursing facility care (up to 100 days per benefit period) including room and board, skilled nursing care and other customarily provided services in a Medicare certified skilled nursing facility bed are covered when coverage factors are met.

COVID-19 Public Health Emergency Waivers & Flexibilities: In response to the COVID-19 Public Health Emergency, CMS has updated some guidance for certain skilled nursing facility services. For a comprehensive list of Coronavirus Waivers & Flexibilities, refer to https://www.cms.gov/about-cms/emergency-preparedness-response-operations/current-emergencies/coronavirus-waivers. (Accessed April 12, 2021)

Skilled Nursing Facility (SNF) Care

Coverage Factors

Care in a skilled nursing facility (SNF) is covered if all of the following four factors are met:

- The patient requires skilled nursing services or skilled rehabilitation services, i.e., services that must be performed by or under the supervision of professional or technical personnel; are ordered by a physician and the services are rendered for a condition for which the patient received inpatient hospital services or for a condition that arose while receiving care in a SNF for a condition for which he received inpatient hospital services.
- These skilled services are required on a daily basis.
- As a practical matter, considering economy and efficiency, the daily skilled services can be provided only on an inpatient basis in a SNF.

- The services delivered are reasonable and necessary for the treatment of a patient's illness or injury, i.e., are consistent with the nature and severity of the individual's illness or injury, the individual's particular medical needs, and accepted standards of medical practice. The services must also be reasonable in terms of duration and quantity.

For more detailed guideline and examples, refer to the Medicare Benefit Policy Manual, Chapter 8, §30 - Skilled Nursing Facility Level of Care – General. (Accessed April 12, 2021)

Principles for Determining Whether a Service is Skilled

- If the inherent complexity of a service prescribed for a patient is such that it can be performed safely and/or effectively only by or under the general supervision of skilled nursing or skilled rehabilitation personnel, the service is a skilled service; e.g., the administration of intravenous feedings and intramuscular injections; the insertion of suprapubic catheters; and ultrasound, shortwave, and microwave therapy treatments.
- The Health Plan considers the nature of the service and the skills required for safe and effective delivery of that service in deciding whether a service is a skilled service. While a patient's particular medical condition is a valid factor in deciding if skilled services are needed, a patient's diagnosis or prognosis should never be the sole factor in deciding that a service is not skilled.

For specific examples, refer to the Medicare Benefit Policy Manual, Chapter 8, §30.2.2 – Principles for Determining Whether a Service is Skilled. (Accessed April 12, 2021)

Documentation to Support Skilled Care Determinations

Claims for skilled care coverage need to include sufficient documentation to enable a reviewer to determine whether:

- Skilled involvement is required in order for the services in question to be furnished safely and effectively; and
- The services themselves are, in fact, reasonable and necessary for the treatment of a patient's illness or injury, i.e., are consistent with the nature and severity of the individual's illness or injury, the individual's particular medical needs, and accepted standards of medical practice. The documentation must also show that the services are appropriate in terms of duration and quantity, and that the services promote the documented therapeutic goals.

For more detailed guideline, refer to the Medicare Benefit Policy Manual, Chapter 8, §30.2.2.1 – Documentation to Support Skilled Care Determinations. (Accessed April 12, 2021)

Specific Examples of Some Skilled Nursing or Skilled Rehabilitation Services

Management and Evaluation of a Patient Care Plan

The development, management, and evaluation of a patient care plan, based on the physician's orders and supporting documentation, constitute skilled nursing services when, in terms of the patient's physical or mental condition, these services require the involvement of skilled nursing personnel to meet the patient's medical needs, promote recovery, and ensure medical safety. However, the planning and management of a treatment plan that does not involve the furnishing of skilled services may not require skilled nursing personnel; e.g., a care plan for a patient with organic brain syndrome who requires only oral medication and a protective environment. The sum total of non-skilled services would only add up to the need for skilled management and evaluation when the condition of the patient is such that there is an expectation that a change in condition is likely without that intervention.

The patient's clinical record may not always specifically identify "skilled planning and management activities" as such. Therefore, in this limited context, if the documentation of the patient's overall condition substantiates a finding that the patient's medical needs and safety can be addressed only if the total care, skilled or not, is planned and managed by skilled nursing personnel, it is appropriate to infer that skilled management is being provided, but only if the record as a whole clearly establishes that there was a likely potential for serious complications without skilled management.

For specific examples, refer to the Medicare Benefit Policy Manual, Chapter 8, §30.2.3.1 – Management and Evaluation of a Patient Care Plan. (Accessed April 12, 2021)

Observation and Assessment of Patient's Condition

Observation and assessment are skilled services when the likelihood of change in a patient's condition requires skilled nursing or skilled rehabilitation personnel to identify and evaluate the patient's need for possible modification of treatment or initiation of additional medical procedures, until the patient's condition is essentially stabilized.

For specific examples, refer to the Medicare Benefit Policy Manual, Chapter 8, §30.2.3.2 – Observation and Assessment of Patient's Condition. (Accessed April 12, 2021)

Teaching and Training Activities

Teaching and training activities, which require skilled nursing or skilled rehabilitation personnel to teach a patient how to manage their treatment regimen, would constitute skilled services.

For specific examples, refer to the Medicare Benefit Policy Manual, Chapter 8, §30.2.3.3 – Teaching and Training Activities. (Accessed April 12, 2021)

Direct Skilled Nursing to Patients

Nursing services are considered skilled when they are so inherently complex that they can be safely and effectively performed only by, or under the supervision of, a registered nurse or, when provided by regulation, a licensed practical (vocational) nurse. (See 42CFR §409.32) If all other requirements for coverage under the SNF benefit are met, skilled nursing services are covered when an individualized assessment of the patient's clinical condition demonstrates that the specialized judgment, knowledge, and skills of a registered nurse or, when provided by regulation, a licensed practical (vocational) nurse are necessary. Skilled nursing services would be covered where such skilled nursing services are necessary to maintain the patient's current condition or prevent or slow further deterioration so long as the patient requires skilled care for the services to be safely and effectively provided, and all other requirements for coverage under the SNF benefit are met. Coverage does not turn on the presence or absence of an individual's potential for improvement from nursing care, but rather on the patient's need for skilled care.

For more detailed guideline, refer to the Medicare Benefit Policy Manual, Chapter 8, §30.3 – Direct Skilled Nursing Services to patients. (Accessed April 12, 2021)

Direct Skilled Therapy Services

Coverage for direct skilled therapy services to patients, including skilled physical therapy, occupational therapy, and speech/language pathology therapy, does not turn on the presence or absence of a patient's potential for improvement from therapy services, but rather on the b patient's need for skilled care. Therapy services are considered skilled when they are so inherently complex that they can be safely and effectively performed only by, or under the supervision of, a qualified therapist. (See 42CFR §409.32) These skilled services may be necessary to improve the patient's current condition, to maintain the patient's current condition, or to prevent or slow further deterioration of the patient's condition.

If all other requirements for coverage under the SNF benefit are met, such skilled therapy services are covered when an individualized assessment of the patient's clinical condition demonstrates that the specialized judgment, knowledge, and skills of a qualified therapist are necessary for the performance of the rehabilitation services.

For more detailed guideline, refer to the Medicare Benefit Policy Manual, Chapter 8, §30.4 – Direct Skilled Therapy Services to Patients. (Accessed April 12, 2021)

Three-Day Prior Hospitalization

The original Medicare requirement of three (3) consecutive calendar hospital day stay before transferring to a SNF is waived for UnitedHealthcare Medicare Advantage members.

For Medicare's requirement information, refer to the Medicare Benefit Policy Manual, Chapter 8, §20.1 – Three-Day Prior Hospitalization. (Accessed April 12, 2021)

Benefit Period (Spell of Illness)

- Inpatient skilled care and services are covered for up to 100 days per benefit period. Benefit period (spell of illness) is the period of time for measuring the use of hospital insurance benefits. A benefit period begins with the first day (not included in a previous benefit period) on which a patient is furnished inpatient hospital or skilled nursing facility services by a qualified provider. The benefit period ends with the close of a period of 60 consecutive days during which the patient was neither an inpatient of a hospital nor an inpatient of a SNF. To determine the 60-consecutive-day period, begin counting with the day on which the individual was discharged.
- If a member's coverage begins while in a SNF, any SNF days used in that benefit period prior to the member's effective date will apply toward the 100-day benefit.
- While an inpatient in a SNF, should the member be admitted to an acute care hospital for an illness related to the original problem or a new diagnosis, the consecutive days will stop temporarily until the member is transferred back to the SNF.
- If a member is discharged from a SNF and within 60 days requires readmission to the SNF, the member must use the existing benefit period.
- It is important to note that a benefit period (spell of illness) cannot end while a patient is an inpatient of a hospital, even if the hospital does not meet all of the requirements that are necessary for starting a benefit period. Similarly, a benefit period cannot end while a patient is an inpatient of a SNF (meaning a new benefit period cannot be started).
- To end a benefit period, a patient cannot have been an inpatient of a hospital nor a SNF for at least 60 consecutive days; where SNF is defined as a facility which is primarily engaged in providing skilled nursing care and related services to residents who require medical or nursing care, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons.
- An individual may be discharged from and readmitted to a hospital or SNF several times during a benefit period and still be in the same benefit period of 60 consecutive days have not elapsed between discharge and readmission. The stays need not be for related physical or mental conditions.

For more detailed guideline, refer to the Medicare General Information, Eligibility and Entitlement Manual, Chapter 3, §10.4 - Benefit Period (Spell of Illness). (Accessed April 12, 2021)

Note: When a member changes membership (i.e., from one MA plan to a UHC MA plan, or from one UHC MA plan to another UHC MA plan) while in the middle of SNF admission, the member does not automatically get a new 100-day benefit. The member continues on with the benefit period started with the previous plan and the member must meet all the SNF coverage criteria and requirements to begin a new benefit period.

Medicare SNF Coverage Guidelines Under PPS - Covered Services Under Part A

Under SNF PPS, covered SNF services include post-hospital SNF services for which benefits are provided under Part A (the hospital insurance program) and all items and services which, prior to July 1, 1998, had been paid under Part B (the supplementary medical insurance program) but furnished to SNF residents during a Part A covered stay other than the following:

- Physician services, physician assistant services, nurse practitioner and clinical nurse specialist services, certified mid-wife services, qualified psychologist services, certified registered nurse anesthetist services;
- Certain dialysis-related services;
- Erythropoietin (EPO) for certain dialysis patients;
- Hospice care related to a terminal condition;
- Ambulance trips that convey a member to the SNF for admission or from the SNF following discharge;
- Ambulance transportation related to dialysis services;
- Certain services involving chemotherapy and its administration;
- Radioisotope services;
- Certain customized prosthetic devices; and
- Services furnished during 1998 only, the transportation costs of electrocardiogram equipment for electrocardiogram test services.

Note: These services can be considered for payment separately under Part B during a covered Part A SNF stay since the items listed above are excluded from the PPS consolidated billing methodology.
For information regarding hospice coverage, refer to the Coverage Summary titled Hospice Services.

Refer to the Medicare Benefit Policy Manual, Chapter 8, §10.2 – Medicare SNF Coverage Guidelines Under PPS. (Accessed April 12, 2021)

Part B Services Covered for Members with Exhausted SNF Benefits

Members who exhaust their SNF benefits while inpatient or in a skilled nursing facility (SNF) are entitled to coverage of certain services under Part B. These services and supplies would continue to be covered until a new benefit period begins or they are no longer considered to be medically necessary or reasonably necessary for the diagnosis and treatment of the member's illness/injury. Examples include, but are not limited to:

- Diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests
- X-ray, radium, and radioactive isotope therapy, including materials and services of technicians
- Prosthetic devices (other than dental) which replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices
  Example: Accessories and supplies used directly with an enteral or parenteral device (e.g., catheters, filters, extension tubing, infusion bags, pumps, IV poles, needles, syringes, dressings, tape, flushing solutions, volumetric monitors, and parenteral and enteral nutrient solutions
- Leg, arm, back, and neck braces, trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition;
- Outpatient physical therapy, outpatient speech language pathology services, and outpatient occupational therapy
  Note: Therapy services are payable under the Physician Fee Schedule when furnished by 1) a provider to its outpatients in the patient's home; 2) a provider to patients who come to the facility's outpatient department; 3) a provider to inpatients of other institutions, or 4) a supplier to patients in the office or in the patient's home. Coverage includes therapy services furnished by participating hospitals and SNFs to their inpatients who have exhausted Part A inpatient benefits or who are otherwise not eligible for Part A benefits. Providers of therapy services that have inpatient facilities, other than participating hospitals and SNFs, may not furnish covered therapy services to their own inpatients. However, since the inpatients of one institution may be considered the outpatients of another institution, all providers of therapy services may furnish such services to inpatients of another health facility. Refer to the Medicare Benefit Policy Manual, Chapter 15, §220.1.4 - Requirement That Services Be Furnished on an Outpatient Basis. (Accessed April 12, 2021)
- Surgical dressings, splints and casts, and other devices used for reduction of fractures and dislocations;
- Physician, Physician Nurse Practitioner or Clinical Nurse Specialist services (usually billed to part B)
- Screening mammography services
- Screening pap smears and pelvic exams;
- Influenza, pneumococcal pneumonia, and hepatitis B vaccines
- Some colorectal screening
- Diabetes self-management (e.g., diabetic supplies and equipment including blood glucose monitors, strips and lancets)
- Prostate screening; also see the Coverage Summary for Preventive Health Services and Procedures
- Ambulance services
- Hemophilia clotting factors
- Epoetin Alfa (EPO) for ESRD beneficiaries when given in conjunction with dialysis.

Refer to the:

- Medicare Benefit Policy Manual, Chapter 15, §250 – Medical and Other Health Services Furnished to Inpatients of Hospitals and Skilled Nursing Facilities.
- Medicare Benefit Policy Manual, Chapter 8, §70 – Medical and Other Health Services Furnished to SNF Patients. (Accessed April 12, 2021)

Non-Covered Services for Member with Exhausted SNF Benefit

The following are services not covered when member has exhausted the SNF benefit:

- SNF fees (room and board)
- DME is not covered after a member exhausts the 100-day benefit (per spell of illness), or is determined to be at a custodial level of care and resides in an institution or distinct part of an institution that is an acute hospital or skilled nursing facility. Some examples of DME items are oxygen, front-wheeled walkers, standard wheelchairs and hospital beds.
  Exception: The UnitedHealthcare Nursing Home Plan makes separate payment for certain DME while a member is on a Part A benefit and reimburses for certain DME items under Part B when a member is not receiving skilled care. All items

must meet Medicare coverage criteria in order to be covered. Contact the Customer Service Department to determine if member is enrolled in the UnitedHealthcare Nursing Home Plan.
Note: For purposes of rental and purchase of DME a member's home may be his/her own dwelling, an apartment, a relative's home, a home for the aged, or some other type of institution. However, an institution may not be considered a member's home if it:

- Meets at least the basic requirement in the definition of a hospital, i.e., it is primarily engaged in providing by or under the supervision of physicians, to inpatients, diagnostic and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, and sick persons, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons; or
- Meets at least the basic requirement in the definition of a skilled nursing facility, i.e., it is primarily engaged in providing to inpatients skilled nursing care and related services for patients who require medical or nursing care, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons.

Therefore, if a member is a patient in an institution or distinct part of an institution which provides the services described in the bullets above, the individual is not entitled to have separate Part B payment made for rental or purchase of DME because such an institution may not be considered the member's individual's home.
Refer to the:

- Medicare Benefit Policy Manual, Chapter 6, §80 - Rental or Purchase of Durable Medical Equipment.
- Medicare Benefit Policy Manual, Chapter 15, §110 – Durable Medical Equipment. (Accessed April 12, 2021)

Custodial Care

Custodial care is excluded from coverage. Custodial care serves to assist an individual in the activities of daily living, such as assistance in walking, getting in and out of bed, bathing, dressing, feeding, and using the toilet, preparation of special diets, and supervision of medication that usually can be self-administered. Custodial care does not require the continuing attention of trained medical or paramedical personnel.

Refer to the:

- Medicare Benefit Policy Manual, Chapter 16, §110 – Custodial Care
- Medicare Benefit Policy Manual, Chapter 16, §110 – Custodial Care. (Accessed April 12, 2021)

Private Duty Nurse or Private Duty Attendant

Services of a private-duty nurse or other private-duty attendant are not covered. Private duty nursing services are services provided by a private-duty nurse or other private-duty attendant. Private-duty nurses or private-duty attendants are registered nurses, licensed practical nurses, or any other trained attendant whose services ordinarily are rendered to, and restricted to, a particular patient by arrangement between the patient and the private-duty nurse or attendant. Such persons are engaged or paid by an individual patient or by someone acting on their behalf, including a hospital that initially incurs the costs and looks to the patient for reimbursement for such non-covered services.

Refer to the Medicare Benefit Policy Manual, Chapter 1, §20 – Nursing and Other Services. (Accessed April 12, 2021)

Bed-Hold Charge

Charges to the member for admission or readmission to a Skilled Nursing Facility (SNF) are not allowed by Medicare, and will not be covered by UnitedHealthcare Medicare Advantage. However, when temporarily leaving a SNF, a resident member can choose to make bed-hold payments to the SNF. Bed-hold payments are the financial responsibility of the member, and will not be reimbursed or paid by the health plan.

For more specific information, refer to the Medicare Claims Processing Manual, Chapter 1, §30.1.1 – Provider Charges to Beneficiaries and §30.1.1.1 – Charges to Hold a Bed During SNF Absence. (Accessed April 12, 2021)

Home Skilled Nursing Facility

An MA plan must provide coverage through a home SNF (defined at 42 CFR § 422.133 (b)) of post-hospital extended care services to members who resided in a nursing facility prior to the hospitalization, provided:

- The member elects to receive the coverage through the home SNF; and
- The home SNF either has a contract with the MA plan or agrees to accept substantially similar payment under the same terms and conditions that apply to similar nursing facilities that contract with the MA plan.

This requirement also applies if the MA plan offers SNF care without requiring a prior qualifying hospital stay.

The post-hospital extended care scope of services, cost-sharing, and access to coverage provided by the home SNF must be no less favorable to the member than post-hospital extended care services coverage that would be provided to the member by a SNF that would be otherwise covered under the MA plan (42 CFR § 422.133 (c). In particular, in a PPO, in-network cost-sharing applies.

Refer to the Medicare Managed Care Manual, Chapter 4, §10.9 – Return to Enrollee's Home Skilled Nursing Facility (SNF). (Accessed April 12, 2021)

Note: Effective immediately, in accordance with the Supreme Court's ruling in United States v. Windsor, Medicare Advantage (MA) organizations must cover services in a skilled nursing facility (SNF) in which a validly married same sex spouse resides to the extent that they would be required to cover the services if an opposite sex spouse resided in the SNF.

Refer to the CMS Memorandum: Impact of United States v. Windsor on Skilled Nursing Facility Benefits for Medicare Advantage Enrollees – Immediate Action Required dated August 29, 2013. (Accessed April 12, 2021)

Religious Non-Medical Health Care Institution (RNHCI) Services

refer to the Coverage Summary titled Hospital Services (Inpatient and Outpatient) for coverage guideline.

Definitions

Hospital: As defined in Sec. 1861(e) of the Social Security Act, the term "hospital" means an institution which: (1) is primarily engaged in providing, by or under the supervision of physicians, to inpatients (A) diagnostic services and therapeutic services for medical diagnosis, treatment, and care of injured, disabled or sick persons, or (B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons; (2) maintains clinical records on all patients; (3) has bylaws in effect with respect to its staff of physicians; (4) requires every patient to be under the care of a physician; (5) provides 24-hour nursing services rendered or supervised by a registered professional nurse, and has a licensed practical nurse or registered professional nurse on duty at all times; (6)(A) has in effect a hospital utilization review plan that meets the requirements of the law [§1861(k) of the Act], and (B) has in place a discharge planning process that meets the requirements of the law [§1861(ee) of the Act].
(Accessed April 12, 2021)

Skilled Nursing Facility: As defined in Section 1819(a) of the Social Security Act, the term "skilled nursing facility" means an institution (or a distinct part of an institution) which (1) is primarily engaged in providing to residents-(A) skilled nursing care and related services for residents who require medical or nursing care, or (B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons, and is not primarily for the care and treatment of mental diseases; (2) has in effect a transfer agreement (meeting the requirements of section 1861(l) with one or more hospitals having agreements in effect under section 1866; and (3) meets the requirements for a skilled nursing facility described in subsections (b), (c), and (d) of this section.
(Accessed April 12, 2021)

Policy History/Revision Information

Date	Summary of Changes
04/20/2021	Template Update • Reformatted policy; transferred content to new template • Routine review; no change to coverage guidelines

Instructions for Use

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information in making health care decisions. Physicians and patients must exercise their independent clinical discretion and judgment in determining care. Each benefit plan contains its own specific provisions for coverage, limitations, and exclusions as stated in the Member's Evidence of Coverage (EOC)/Summary of Benefits (SB). If there is a discrepancy between this policy and the member's EOC/SB, the member's EOC/SB provision will govern. The information contained in this document is believed to be current as of the date noted.

The benefit information in this Coverage Summary is based on existing national coverage policy; however, Local Coverage Determinations (LCDs) may exist and compliance with these policies are required where applicable.

There are instances where this document may direct readers to a UnitedHealthcare Commercial Medical Policy, Medical Benefit Drug Policy, and/or Coverage Determination Guideline (CDG). In the absence of a Medicare National Coverage Determination (NCD), Local Coverage Determination (LCD), or other Medicare coverage guidance, CMS allows a Medicare Advantage Organization (MAO) to create its own coverage determinations, using objective evidence-based rationale relying on authoritative evidence (Medicare IOM Pub. No. 100-16, Ch. 4, §90.5).