## Coverage Summary

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

| Approved by: | UnitedHealthcare Medicare Benefit Interpretation Committee | Last Review Date: | 04/16/2019 |

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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 is 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).

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I. COVERAGE

Coverage Statement: 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.

Guidelines/Notes:

1. Skilled Nursing Facility (SNF) Care
   a. Coverage Factors - Care in a Skilled Nursing Facility (SNF) is covered if all of the following four (4) factors are met:
      1) 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.
      2) These skilled services are required on a daily basis.
      3) As a practical matter, considering economy and efficiency, the daily skilled services can be provided only on an inpatient basis in a SNF.
      4) 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, see the Medicare Benefit Policy Manual, Chapter 8, §30 - Skilled Nursing Facility Level of Care - General. (Accessed April 1, 2019)

   b. 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, see the Medicare Benefit Policy Manual, Chapter 8, §30.2.2 - Principles for Determining Whether a Service is Skilled. (Accessed April 1, 2019)

   c. Documentation to Support Skilled Care Determinations
      Claims for skilled care coverage need to include sufficient documentation to enable a reviewer to determine whether
      1) Skilled involvement is required in order for the services in question to be furnished safely and effectively; and
      2) 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, see the Medicare Benefit Policy Manual, Chapter 8, §30.2.2.1 - Documentation to Support Skilled Care Determinations. (Accessed April 1, 2019)

d. Specific Examples of Some Skilled Nursing or Skilled Rehabilitation Services

1) 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 beneficiary 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, see the Medicare Benefit Policy Manual, Chapter 8, §30.2.3.1 - Management and Evaluation of a Patient Care Plan. (Accessed April 1, 2019)

2) 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, see the Medicare Benefit Policy Manual, Chapter 8, §30.2.3.2 - Observation and Assessment of Patient’s Condition. (Accessed April 1, 2019)

3) 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, see the Medicare Benefit Policy Manual, Chapter 8, §30.2.3.3 - Teaching and Training Activities. (Accessed April 1, 2019)

e. 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 beneficiary 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 beneficiary’s need for skilled care.

For more detailed guideline, see the Medicare Benefit Policy Manual, Chapter 8, §30.3 – Direct Skilled Nursing Services to patients. (Accessed April 1, 2019)

f. 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 beneficiary’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, see the Medicare Benefit Policy Manual, Chapter 8, §30.4 - Direct Skilled Therapy Services to Patients. (Accessed April 1, 2019)

2. 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, see the Medicare Benefit Policy Manual, Chapter 8, §20.1 - Three-Day Prior Hospitalization. (Accessed April 1, 2019)

3. 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 beneficiary 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 beneficiary is an inpatient of a SNF (meaning a new benefit period cannot be started).

- To end a benefit period, a beneficiary 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 guidelines, see the Medicare General Information, Eligibility and Entitlement Manual, Chapter 3, §10.4 - Benefit Period (Spell of Illness). (Accessed April 1, 2019)

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.

4. 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:

a. Physician services, physician assistant services, nurse practitioner and clinical nurse specialist services, certified mid-wife services, qualified psychologist services, certified registered nurse anesthetist services;

b. Certain dialysis-related services;

c. Erythropoietin (EPO) for certain dialysis patients;

d. Hospice care related to a terminal condition;

e. Ambulance trips that convey a beneficiary to the SNF for admission or from the SNF following discharge;

f. Ambulance transportation related to dialysis services;

g. Certain services involving chemotherapy and its administration;

h. Radioisotope services;

i. Certain customized prosthetic devices; and

j. 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 items a. through j. are excluded from the PPS consolidated billing methodology.

For information regarding hospice coverage see the Coverage Summary for Hospice Services.
5. **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:

a. Diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests
b. X-ray, radium, and radioactive isotope therapy, including materials and services of technicians
c. 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)
d. 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;
e. 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. See the *Medicare Benefit Policy Manual, Chapter 15, §220.1.4 - Requirement That Services Be Furnished on an Outpatient Basis.* (Accessed April 1, 2019)
f. Surgical dressings, splints and casts, and other devices used for reduction of fractures and dislocations;
g. Physician, Physician Nurse Practitioner or Clinical Nurse Specialist services (usually billed to part B)
h. Screening mammography services
i. Screening pap smears and pelvic exams;
j. Influenza, pneumococcal pneumonia, and hepatitis B vaccines
k. Some colorectal screening
l. Diabetes self-management (e.g., diabetic supplies and equipment including blood glucose monitors, strips and lancets)
m. Prostate screening; also see the *Coverage Summary for Preventive Health Services and Procedures*

n. Ambulance services
o. Hemophilia clotting factors
p. Epoetin Alfa (EPO) for ESRD beneficiaries when given in conjunction with dialysis.

See the Medicare Benefit Policy Manual, Chapter 15, §250 - Medical and Other Health Services Furnished to Inpatients of Hospitals and Skilled Nursing Facilities. (Accessed April 1, 2019)
Also see the Medicare Benefit Policy Manual, Chapter 8, §70 - Medical and Other Health Services Furnished to SNF Patients. (Accessed April 1, 2019)

6. The following are services not covered when member has exhausted the SNF benefit:
   a. SNF fees (room and board)
   b. 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 beneficiary’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.

See the Medicare Benefit Policy Manual, Chapter 6, §80 - Rental or Purchase of Durable Medical Equipment. (Accessed April 1, 2019)
Also see the Medicare Benefit Policy Manual, Chapter 15, §110 - Durable Medical Equipment. (Accessed April 1, 2019)

7. 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.

8. **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.

*See the Medicare Benefit Policy Manual, Chapter 1, §20 - Nursing and Other Services. (Accessed April 1, 2019)*

9. **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 1, 2019)*

10. **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.

*See the Medicare Managed Care Manual, Chapter 4, §10.9 - Return to Enrollee's Home Skilled Nursing Facility (SNF). (Accessed April 1, 2019)*

**IMPORTANT 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.


11. **Religious Non-medical Health Care Institution (RNHCI) Services**; see the Coverage Summary for Hospital Services (Inpatient and Outpatient) for coverage guideline.
II. 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 1, 2019)

**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 1, 2019)

III. REFERENCES

See above.

IV. REVISION HISTORY

04/16/2019 Annual review with the following updates:

Guideline 1.a. Coverage Factors

- Revised statement to see reference Medicare manual to:

  *For more detailed guideline and examples, see the Medicare Benefit Policy Manual, Chapter 8, §30 - Skilled Nursing Facility Level of Care - General.*

- Deleted the following (same language are outlined in the reference Medicare manual):

  1) Skilled nursing and/or skilled rehabilitation services are those services, furnished pursuant to physician orders, that:

  Require the skills of qualified technical or professional health personnel such as registered nurses, licensed practical (vocational) nurses, physical therapists, occupational therapists, and speech-language pathologists or audiologists; and

  Must be provided directly by or under the general supervision of these skilled nursing or skilled rehabilitation personnel to assure the safety of the patient and to achieve the medically desired result.

  NOTE: “General supervision” requires initial direction and periodic inspection of the actual activity. However, the supervisor need not always be physically present or on the premises when the assistant is performing services.

  Skilled care may be necessary to improve a patient’s current condition, to maintain the patient’s current condition, or to prevent or slow further deterioration of the patient’s condition.

  2) Skilled nursing services or rehabilitation services (or a combination of these services) must be needed by the member and provided for the member on a “daily basis,” i.e., on essentially a 7-days-a-week basis. A member whose inpatient stay is based solely on the need for skilled rehabilitation services would meet the “daily basis” requirement when they need and receive those services on
at least 5 days a week. (If therapy services are provided less than 5 days a week, the “daily” requirement would not be met.)

This requirement should not be applied so strictly that it would not be met merely because there is an isolated break of a day or two during which no skilled rehabilitation services are furnished and discharge from the facility would not be practical.

EXAMPLE: A patient who normally requires skilled rehabilitation services on a daily basis may exhibit extreme fatigue, which results in suspending therapy sessions for a day or two. Coverage may continue for these days since discharge in such a case would not be practical.

In instances when a patient requires a skilled restorative nursing program to positively affect his functional well-being, the expectation is that the program be rendered at least 6 days a week. (Note that when a patient’s skilled status is based on a restorative program, medical evidence must be documented to justify the services. In most instances, it is expected that a skilled restorative program will be, at most, only a few weeks in duration.)

The daily basis requirement can be met by furnishing a single type of skilled service every day, or by furnishing various types of skilled services on different days of the week that collectively add up to “daily” skilled services. However, arbitrarily staggering the timing of various therapy modalities though the week, merely in order to have some type of therapy session occur each day, would not satisfy the SNF coverage requirement for skilled care to be needed on a “daily basis.” To meet this requirement, the patient must actually need skilled rehabilitation services to be furnished on each of the days that the facility makes such services available.

It is not sufficient for the scheduling of therapy sessions to be arranged so that some therapy is furnished each day, unless the patient's medical needs indicate that daily therapy is required. For example, if physical therapy is furnished on 3 days each week and occupational therapy is furnished on 2 other days each week, the “daily basis” requirement would be satisfied only if there is a valid medical reason why both cannot be furnished on the same day. The basic issue here is not whether the services are needed, but when they are needed. Unless there is a legitimate medical need for scheduling a therapy session each day, the “daily basis” requirement for SNF coverage would not be met.

3) Notes:
   - In determining whether the daily skilled care needed by an individual can, as a “practical matter,” only be provided in a SNF on an inpatient basis, the individual’s physical condition and the availability and feasibility of using more economical alternative facilities or services should be considered.
   - As a “practical matter,” daily skilled services can be provided only in a SNF if they are not available on an outpatient basis in the area in which the individual resides or transportation to the closest facility would be:
     - An excessive physical hardship;
     - Less economical; or
     - Less efficient or effective than an inpatient institutional setting.
   - The availability of capable and willing family or the feasibility of obtaining other assistance for the member at home should be considered. Even though needed daily skilled services might be available on an outpatient or home care basis, as a practical matter, the care can be furnished only in the SNF if home care would be ineffective because the member would have insufficient assistance at home to reside there safely.

4) Notes:
   - If any one of these four factors is not met, a stay in a SNF, even though it might include the delivery of some skilled services, is not covered. For example, payment for a SNF level of care could not be made if a patient needs an intermittent rather than daily skilled service.
   - In reviewing claims for SNF services to determine whether the level of care requirements are met, the Plan first considers whether a patient needs skilled care. If a need for a skilled service does not exist, then the “daily” and “practical matter” requirements are not addressed. See section 30.2.2.1 (#1.c - Documentation to Support Skilled Care Determinations below) for a discussion of the role of appropriate documentation in facilitating accurate coverage determinations for claims involving skilled care. Additional material on documentation appears in the various clinical scenarios that are presented throughout these levels of care guidelines.
   - Coverage of nursing care and/or therapy to perform a maintenance program does not turn on the presence or absence of an individual’s potential for improvement from the nursing care
Guideline 1.c (Documentation to Support Skilled Care Determinations)

- Revised statement to see reference Medicare manual to:
  
  For more detailed guideline and examples, see the Medicare Benefit Policy Manual, Chapter 8, §30.2.2.1 – Documentation to Support Skilled Care Determinations.

- Deleted the following (same language are outlined in the reference Medicare manual):

  Such determinations would be made from the perspective of the patient’s condition when the services were ordered and what was, at that time, reasonably expected to be appropriate treatment for the illness or injury. Thus, when a service appears reasonable and necessary from that perspective, it would not then be appropriate to deny the service retrospectively merely because the goals of treatment have not yet been achieved. However, if it becomes apparent at some point that the goal set for the patient is no longer a reasonable one, then the treatment goal itself should be promptly and appropriately modified to reflect this, and the patient should then be reassessed to determine whether the treatment goal as revised continues to require the provision of skilled services. By the same token, the treatment goal itself cannot be modified retrospectively, e.g., when it becomes apparent that the initial treatment goal of restoration is no longer a reasonable one, the provider cannot retroactively alter the initial goal of treatment from restoration to maintenance. Instead, it would make such a change on a prospective basis only.

  Although the presence of appropriate documentation is not, in and of itself, an element of the definition of a “skilled” service, such documentation serves as the means by which a provider would be able to establish and a contractor would be able to confirm that skilled care is, in fact, needed and received in a given case.

It is expected that the documentation in the patient’s medical record will reflect the need for the skilled services provided. The patient’s medical record is also expected to provide important communication among all members of the care team regarding the development, course, and outcomes of the skilled observations, assessments, treatment, and training performed. Taken as a whole, then, the documentation in the patient’s medical record should illustrate the degree to which the patient is accomplishing the goals as outlined in the care plan. In this way, the documentation will serve to demonstrate why a skilled service is needed.

Thorough and timely documentation with respect to treatment goals can help clearly demonstrate a beneficiary’s need for skilled care in situations where such need might not otherwise be readily apparent, as when the treatment’s purpose changes (for example, from restoration to maintenance), as well as in establishing the efficacy of care that serves to prevent or slow decline—where, by definition, there would be no “improvement” to evaluate. For example, when skilled services are necessary to maintain the patient’s current condition, the documentation would need to substantiate that the services of skilled personnel are, in fact, required to achieve this goal. Similarly, establishing that a maintenance program’s services are reasonable and necessary would involve regularly documenting the degree to which the program’s treatment goals are being accomplished. In situations where the maintenance program is performed to maintain the patient’s current condition, such documentation would serve to demonstrate the program’s effectiveness in achieving this goal. When the maintenance program is intended to slow further deterioration of the patient’s condition, the efficacy of the services could be established by documenting that the natural progression of the patient’s medical or functional decline has been interrupted. Assessments of all goals must be performed in a frequent and regular manner so that the resulting documentation provides a sufficient basis for determining the appropriateness of coverage.

Therefore the patient’s medical record must document as appropriate:

- The history and physical exam pertinent to the patient’s care, (including the response or changes in behavior to previously administered skilled services);
- The skilled services provided;
- The patient’s response to the skilled services provided during the current visit;
- The plan for future care based on the rationale of prior results.
- A detailed rationale that explains the need for the skilled service in light of the patient’s overall medical condition and experiences;
- The complexity of the service to be performed;
• Any other pertinent characteristics of the beneficiary.

Guideline 1.d.1 (Documentation to Support Skilled Care Determinations) - deleted “as illustrated in the following examples.” Also deleted duplicate reference to Medicare Benefit Policy Manual, Chapter 8, §30.2.3 - Specific Examples of Some Skilled Nursing or Skilled Rehabilitation Service.

Guideline 1.e (Direct Skilled Nursing to Patients)

- Revised statement to see reference Medicare manual reference to:
  
  For more detailed guideline and examples, see the Medicare Benefit Policy Manual, Chapter 8, §30.3 – Direct Skilled Nursing Services to patients.

- Deleted the following (same language are outlined in the reference Medicare manual):

  A condition that would not ordinarily require skilled nursing services may nevertheless require them under certain circumstances. In such instances, skilled nursing care is necessary only when (a) the particular patient’s special medical complications require the skills of a registered nurse or, when provided by regulation, a licensed practical nurse to perform a type of service that would otherwise be considered non-skilled; or (b) the needed services are of such complexity that the skills of a registered nurse or, when provided by regulation, a licensed practical nurse are required to furnish the services.

  A service is not considered a skilled nursing service merely because it is performed by or under the direct supervision of a nurse. If a service can be safely and effectively performed (or self-administered) by an unskilled person, the service cannot be regarded as a skilled nursing service although a nurse actually provides the service. Similarly, the unavailability of a competent person to provide a non-skilled service, regardless of the importance of the service to the patient, does not make it a skilled service when a nurse provides the service.

  Some examples of direct skilled nursing services are:

  • Intravenous or intramuscular injections and intravenous feeding;
  • Enteral feeding that comprises at least 26 percent of daily calorie requirements and provides at least 501 milliliters of fluid per day (Note: To meet the definition of a skilled service, enteral feedings administered by nasogastric, gastrostomy, or gastro-jejunostomy tube are covered only when the member receives at least 26% of daily caloric requirements and at least 501 milliliters of fluid per day through such feedings.)
  • Naso-pharyngeal and tracheotomy aspiration;
  • Insertion, sterile irrigation, and replacement of suprapubic catheters;
  • Application of dressings involving prescription medications and aseptic techniques (see §30.5 for exception);
  • Treatment of decubitus ulcers, of a severity rated at Stage 3 or worse, or a widespread skin disorder (see §30.5 for exception);
  • Heat treatments which have been specifically ordered by a physician as part of active treatment and which require observation by skilled nursing personnel to evaluate the patient’s progress adequately (see §30.5 for exception);
  • Rehabilitation nursing procedures, including the related teaching and adaptive aspects of nursing, that are part of active treatment and require the presence of skilled nursing personnel; e.g., the institution and supervision of bowel and bladder training programs;
  • Initial phases of a regimen involving administration of medical gases such as bronchodilator therapy; and
  • Care of a colostomy during the early post-operative period in the presence of associated complications. The need for skilled nursing care during this period must be justified and documented in the patient’s medical record.

Guideline 1.f (Direct Skilled Therapy Services)

- Based on the language in the Medicare manual reference; deleted the following first sentence:

  The following sections contain examples and guidelines concerning direct skilled therapy services
to patients, including skilled physical therapy, occupational therapy, and speech/language pathology therapy.

- Re-worded next sentence to:

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 beneficiary’s need for skilled care.

- Deleted the following language (same language are in the reference Medicare manual)

  - Skilled physical therapy services must meet all of the following conditions:
  
  - The services must be directly and specifically related to an active written treatment plan that is based upon an initial evaluation performed by a qualified physical therapist after admission to the SNF and prior to the start of physical therapy services in the SNF that is approved by the physician after any needed consultation with the qualified physical therapist. In those cases where a beneficiary is discharged during the SNF stay and later readmitted, an initial evaluation must be performed upon readmission to the SNF, prior to the start of physical therapy services in the SNF;
  
  - The services must be of a level of complexity and sophistication, or the condition of the patient must be of a nature that requires the judgment, knowledge, and skills of a qualified physical therapist;
  
  - The services must be provided with the expectation, based on the assessment made by the physician of the patient’s restoration potential, that the condition of the patient will improve materially in a reasonable and generally predictable period of time, or the services must be necessary for the establishment of a safe and effective maintenance program; or, the services must require the skills of a qualified therapist for the performance of a safe and effective maintenance program. (NOTE: See Section E Maintenance Therapy below for more guidance regarding when skilled therapy services are necessary for the performance of a safe and effective maintenance program.)
  
  - The services must be considered under accepted standards of medical practice to be specific and effective treatment for the patient’s condition; and
  
  - The services must be reasonable and necessary for the treatment of the patient’s condition; this includes the requirement that the amount, frequency, and duration of the services must be reasonable.

**EXAMPLE 1:**

An 80-year old, previously ambulatory, post-surgical patient has been bed-bound for 1 week, and, as a result, had developed muscle atrophy, orthostatic hypotension, joint stiffness and lower extremity edema. To the extent that the patient requires a brief period of daily skilled physical therapy to restore lost functions, those services are reasonable and necessary and must be documented in the medical record (see §30.2.2.1 of the Medicare Benefit Policy Manual, Chapter 8).

**EXAMPLE 2:**

A patient with congestive heart failure also has diabetes and previously had both legs amputated above the knees. Consequently, the patient does not have a reasonable potential to achieve ambulation, but still requires daily skilled physical therapy to learn bed mobility and transferring skills, as well as functional activities at the wheelchair level. If the patient has a reasonable potential for achieving those functions in a reasonable period of time in view of the patient’s total condition, the physical therapy services are reasonable and necessary and must be documented in the medical record (see §30.2.2.1 of the Medicare Benefit Policy Manual, Chapter 8).

Physical therapy services are not reasonable and necessary and would not be covered if the expected results are insignificant in relation to the extent and duration of physical therapy services that would be required to achieve those results.

Some SNF inpatients do not require skilled physical therapy services but do require services, which are routine in nature. When services can be safely and effectively performed by supportive personnel, such as aides or nursing personnel, without the supervision of a physical therapist, they do not constitute skilled physical therapy. Additionally, services involving activities for the general
good and welfare of the patient (e.g., general exercises to promote overall fitness and flexibility and activities to provide diversion or general motivation) do not constitute skilled physical therapy.

- **Speech-Language Pathology:** see the Medicare Benefit Policy Manual, Chapter 1, §110 Inpatient Rehabilitation Facility (IRF) Services.
- **Occupational Therapy:** see the Medicare Benefit Policy Manual, Chapter 1, §110 Inpatient Rehabilitation Facility (IRF) Services.

**Guideline 3 [Benefit Period (Spell of Illness)]**
- Deleted “See Section II (Definitions) for the definition of Benefit Period”
- Added the following definition (moved from the Definition section):

  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.

- Deleted “as defined below” and “For a member to have a benefit period”
- Updated Medicare manual reference link to:

  For more detailed guideline and examples, see the Medicare General Information, Eligibility and Entitlement Manual, Chapter 3, §10.4 -Benefit Period (Spell of Illness).

**Guideline 7**
- Deleted “The following are examples of non-covered services, but are not limited to”
- Added the following coverage language for custodial care (move language from Definition section)

  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.

**Guideline 8 (Private Duty Nurse or Private Duty Nurse)** - added the following coverage language for custodial care (move language from Definition section)

  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.

**Definitions** – deleted the following definitions; move to the the Guideline section:

- Benefit Period (Spell of Illness)
- Custodial Care
- Private Duty Nursing Services

04/01/2019  Updated policy introduction; added language to clarify:
- There are instances where [the Coverage Summary] 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)

04/17/2018 Annual review with the following updates:
Guideline 2 (Three-Day Prior Hospitalization)
• Deleted the following:
The Original Medicare required three (3) consecutive hospital days stay before transferring to a SNF is waived for UnitedHealthcare Medicare Advantage members.
• Replaced with the following:
The Original Medicare requirement of three (3) consecutive calendar hospital day stay before transferring to a SNF is waived for UnitedHealthcare Medicare Advantage members.

Guideline 7.b (Respite Care) - deleted guideline; there’s no specific Medicare reference that states respite care is not covered; may be covered under the hospice benefit.

02/20/2018 Re-review with the following update:
Guideline 10 [Religious Non-medical Health Care Institution (RNHCI) Services] – added cross reference link to the Coverage Summary for Hospital Services (Inpatient and Outpatient) for coverage guideline for RNHCI.

05/16/2017 Re-review with the following updates:
Guideline 4 (Medicare SNF Coverage Guidelines Under PPS - Covered Services under Part A):
• Added guideline based on the Medicare Benefit Policy Manual, Chapter 8, §10.2 - Medicare SNF Coverage Guidelines Under PPS.
• Added the following language “These services can be considered for payment separately under Part B during a covered Part A SNF stay since items a. through j. are excluded from the PPS consolidated billing methodology.”
• Added cross reference to the Coverage Summary for Hospice Services.

04/18/2017 Annual review; no updates.

04/19/2016 Annual review with the following updates:
Guideline 6.a - added reference link to the Medicare Benefit Policy Manual Chapter 16 General Exclusions From Coverage, Section 110 Custodial Care

Guideline 6.a - added reference link to the Medicare Benefit Policy Manual, Chapter 1 Inpatient Hospital Services Covered Under Part A, Section 20 Nursing and Other Services

Guideline 8 (Home Skilled Nursing Facility - added current Medicare language from the Medicare Managed Care Manual (Pub. 100-16), Chapter 4 - Benefits and Beneficiary Protections, Section 10.9 Return to Home Skilled Nursing Facility (SNF)

04/21/2015 Annual review; Removed “For claims and billing information” from coverage summary.

04/15/2014 Annual review; Definition of Skilled Nursing Facility updated to include the full definition based on Section 1819 (a) the Social Security Act.


Guideline #1.b Services are required on a daily basis - Updated guidelines based on the Medicare Benefit Policy Manual Chapter 8 - Coverage of Extended Care (SNF) Services Under Hospital Insurance, Section 30.6 Daily Skilled Services Defined.

Guideline #5 Services qualifying as skilled nursing services - updated guidelines based on the Medicare Benefit Policy Manual, Chapter 8 - Coverage of Extended Care (SNF) Services Under Hospital Insurance Section 30.2.3 - Specific Examples of Some Skilled Nursing or Skilled Rehabilitation Service.

Guidelines #10 Home Skilled Nursing Facility - added the following language:

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 at http://hr.cch.com/hld/SNF-Benefits-after-USvWindsorDOMA-decision8-29-13.pdf.

Guidelines #11 (Home Skilled Nursing Facility) - added a note pertaining to the Windsor case decision; based on 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.

Annual review with the following updates:

Added a note pertaining to the January 24, 2013 court approval of settlement agreement in the case of Jimmo v. Sebelius.

Guidelines #3.a - revised to read “Services must be provided with the expectation that the member’s condition will improve or that the service is necessary to establish or perform a safe and effective maintenance program.”

Annual review with the following updates:

- Guidelines #7 - updated to include additional examples of covered services under Part B when members exhaust their SNF benefits
- Guidelines #9
  - Updated to clarify that DME is not covered after a member exhausts the 100-day SNF benefit and resides in an institution or distinct part of an institution that is an acute hospital or skilled nursing facility. Deleted the language “Non-routine DME, e.g., air-fluidized beds and insulin pumps, continues to be covered when a Member exhausts his/her SNF benefit.”
  - Updated to include the note regarding the exception for coverage for certain DME items for UnitedHealthcare Nursing Home Plan members.
08/29/2011  Updated Guidelines #4 to include coverage clarification for SNF benefit when a member changes membership while in the middle of SNF admission.

04/26/2011  Annual review; no updates.