INTRODUCTION

The purpose of this Skilled Nursing Care Manual is to provide information to assist our provider allies in administering and providing quality skilled nursing care to all of our members, in both our PacifiCare Commercial product and Secure Horizons. The manual reflects the most recent changes in skilled nursing coverage including the most current SNF guidelines set forth by the Centers for Medicare and Medicaid Services (CMS).

Use the information contained in this manual for reference only. Each member’s situation must be individually reviewed by the participating physician to determine the appropriate level of care. All services must be medically necessary. If there is a discrepancy between any information stated in this manual and the member’s EOC/SOB, the member’s EOC/SOB provision will govern. Information contained in this manual is also subject to any changes in state and/or federal regulations.
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Section I

SKILLED NURSING LEVEL OF CARE GUIDELINES
I. **OVERVIEW**

The objective of skilled nursing care guidelines is to ensure that Secure Horizons / PacifiCare Members, who require continuing care, receive that care at the most appropriate level and in the most appropriate setting. The care should be provided in the least restrictive environment, while maintaining the Members at optimal level of functionality, by maximizing both institutional and non-institutional based supportive services.

A. **Secure Horizons**

   The determination as to whether a Secure Horizons Member qualifies to receive “in-patient skilled services” must be made according to Secure Horizons and Medicare defined guidelines. The guidelines found in this section have been excerpted from Centers for Medicare and Medicaid (CMS) Skilled Nursing Facilities Manual.

B. **PacifiCare**

   The determination as to whether a PacifiCare Member qualifies to receive "in-patient skilled services" will be made according to Medicare defined guidelines but exceptions can be made based on medical necessity. PacifiCare may offer to provide a Member coverage for Medically Necessary Medical or Hospital Services that are otherwise excluded or limited benefits. This coverage is in lieu of providing coverage for certain covered services. (For example, additional coverage may be provided for Skilled Nursing Facility services when the Member has exhausted his or her Skilled Nursing Services benefit in lieu of providing home care.) This section is offered only as a guideline for PacifiCare Members.

II. **SKILLED NURSING AND REHABILITATION GUIDELINES**

A. **Guideline One**

   Does the Member meet the qualifications described in Medicare Guidelines Part A. - which is “...provides for 100 days of post-hospital care in a skilled nursing facility if medically indicated...”

   First, the question of what is medically indicated should be answered. This requirement is fulfilled by any Member who has had an acute hospital admission for at least three days. However, this requirement can be waived. See Section III.
for waiving three day hospital stay. The hospitalized Member has received treatment and should be stabilized to the extent that further treatment, care, and restorative services can be safely provided in a lower level of care or in an environment that prepares the Member for returning home.

In addition, the services must be furnished pursuant to a physician’s orders and be reasonable and necessary for the treatment of patient’s illness or injury. (e.g., be consistent with the nature and severity of the individual’s illness or injury, medical needs and accepted standards of medical practice). The services must also be reasonable in terms of duration and quantity.

B. Guideline Two

Does the Member meet the three criteria litmus test that Medicare requires for qualifying for in-patient SNF care?

1. "The patient requires skilled nursing services or skilled rehabilitation services." (e.g., services that must be performed by or under the supervision of professional or technical personnel) (Medicare Code Section 409.31, 32)

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

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

2. "Must be provided daily, effective the day of discharge from the acute facility or on the day of admission to the SNF." (Medicare Code Section 409.34)

♦ Skilled nursing services or skilled rehabilitation services (or a combination of these services) must be needed and provided on a “daily basis” (essentially a 7-day-a-week basis). However, if skilled rehabilitation services are not available on a 7-day-a-week basis, a patient whose in-patient stay is based solely on the need for skilled rehabilitation services would meet the “daily basis” requirement when the individual needs and receives those services at least 5 days a week.

♦ When rehabilitation services are the primary services, the key issue is whether the skills of a therapist are needed daily. Measurable
progress and/or functional improvement within a reasonable predictable time period are necessary to justify continuation of therapy.

♦ If a facility provides physical therapy only 5 days a week and a patient in the facility requires and receives physical therapy on each of those days, the requirement that skilled rehabilitation services be provided on a daily basis is met. (If the services are available less than 5 days a week, though, 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. (Physicians may put a hold on skilled services up to 30 days)

3. As a practical matter, considering economy and efficiency, the daily Skilled services can be provided only on an in-patient basis in a SNF. (Medicare Code Section 409.35.)

♦ As a practical matter, the Member will more likely achieve maximum functional potential and be less likely to deteriorate in status, if services are provided in a SNF.

♦ As a “practical matter”, daily skilled service can be provided only in a SNF if they are not available on an out-patient basis in the area in which the individual resides and

♦ In-patient care is more efficient and less costly than transporting daily by ambulance.

Resources for non-institutional care such as healthcare community based services or other assistance for the patient should be considered. Even though needed daily skilled services might be available on an out-patient 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 patient would have insufficient assistance at home to reside there safely.

The Availability of Alternative Facilities or Services

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Alternative facilities or services may be available to a patient if healthcare providers such as home health agencies were utilized. These alternatives are not always available when needed.

The issue is feasibility and not whether coverage is provided in one setting and not provided in another. For instance, an individual in need of daily skilled physical therapy might be able to receive the services needed on a more economical basis from an independently practicing therapist rather than a skilled facility. In which case, the key is considering whether available alternatives are more economical and managing each case on an individual basis.

EXAMPLE 1: If a patient’s condition requires daily transportation to the alternative source of care (e.g., a hospital out-patient department) by care ambulance, it might be more economical from a healthcare delivery viewpoint to provide the needed care in the SNF setting.

EXAMPLE 2: If needed care could be provided in the home, but the patient’s residence is so isolated that daily visits would entail inordinate travel cost, care in a SNF might be a more economical alternative.

Question: Whether the patient’s physical condition would permit him to utilize an available, more economical care alternative?

In determining the practicality of using more economical care alternatives, the patient’s medical condition should be considered. If the use of those alternatives would adversely affect the patient’s medical condition, then as a practical matter the daily skilled services can only be provided by a SNF on an in-patient basis.

If the use of a care alternative involves transportation of the individual on a daily basis, and daily transportation would cause excessive physical hardship, then SNF care should be considered. Determinations on whether a patient’s condition would be adversely affected if an available, more economical care alternative were utilized should not be based solely on the fact that the patient is non-ambulatory. There are individuals confined to wheelchairs who, though non-ambulatory, could be transported daily by automobile from their homes to alternative care sources without any adverse impact. Conversely, there are instances where an individual’s condition would be adversely affected by daily transportation to a care facility, even though the individual is able to ambulate to some extent.

The “practical matter” criterion should never be interpreted so strictly that it results in the automatic denial of coverage for patients who have been meeting all of the SNF level of care requirements, but who have occasion to be away from the SNF for a brief period of time. While most
beneficiaries requiring a SNF level of care find that they are unable to leave the facility for even the briefest of time, the fact that a patient is granted an outside pass, or short leave of absence, for the purpose of attending a special religious service, holiday meal or family occasion, for going on a ride or for a trial visit home, is not by itself evidence that the individual no longer needs to be in a SNF for the receipt of required skilled care.

Very often special arrangements, not feasible on a daily basis, have to be made to allow the absence from the facility. Where frequent or prolonged periods away from the SNF become possible, however, then questions as to whether the patient’s care can, as a practical matter, only be furnished on an in-patient basis in a SNF may be raised. Decisions in these cases should be based on information reflecting the care needed and received by the patient while in the SNF and on the arrangements needed for the provision, if any, of this care during any absence.

A conservative approach to retain the presumption for waiver of liability may lead a facility to notify patients that leaving the facility will result in denial of coverage. Such a notice is not appropriate. If a SNF determines that covered care is no longer needed, the situation does not change whether the patient actually leaves the facility or not.

NOTE: In determining whether the level of care requirements are met, the first consideration should be whether a patient needs skilled care. If a need for a skilled service does not exist, then the “daily” and “practical matter” requirements do not have to be addressed.

C. 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 catheters; therapeutic exercises, gait training, swallowing evaluation, functional exercises for daily living and treatment of communication disorders)

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.

♦ The nature of the service and the skills required for safe and effective delivery of that service are considered 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.

“When rehabilitation services are the primary services, the key issue is whether the skills of a therapist are needed. The deciding factor is not the patient’s potential for recovery, but whether the services needed require the skills of a therapist or whether they can be carried out by non-skilled personnel.” (Medicare Code Section 409.32)

♦ A service that is ordinarily considered non-skilled could be considered a skilled service in cases in which, because of special medical complications, skilled nursing or skilled rehabilitation personnel are required to perform or supervise or to observe the patient. In these cases, the complications and special services involved must be documented by physician’s order and nursing or therapy notes.

♦ In determining whether services rendered in a SNF constitute covered care, it is necessary to determine which individual services are skilled, and which are unskilled. Even though many of the specific services are unskilled, if one skilled service is needed, the patient should be considered eligible for covered services.

♦ The importance of a particular service to an individual patient, or the frequency with which it must be performed, does not, by itself, make it a skilled service.

D. Documentation

The reasons why skilled nursing or skilled rehabilitation personnel are essential must be documented in the patient’s record. Nursing and rehabilitation personnel should provide the following, in writing, in each patient’s medical record:

1. A comprehensive, initial evaluation from which both short and long term realistic goals can be projected,

2. An initial estimate of the length of stay,

3. Notes reflecting progress towards goals, specific skilled needs and updated length of stay,

4. Projection of whether transition to home will occur,

5. List of alternatives if patient’s home is not a likely discharge destination,
SKILLED NURSING FACILITY (SNF) CARE GUIDELINES

6. Description of home arrangements that must be done to ensure discharge to a safe environment.

Note: If it is determined that the patient does not require in-patient skilled care or would not benefit from institutional skilled care, consider the following:

♦ Family Training/Support
♦ Community Resources
♦ Adult Day Care
♦ Home Health (Part A or Part B)
♦ Custodial Care
♦ Other Part B Services

E. Skilled Nursing and Rehabilitation Services Guidelines Summary

Criteria for SNF Admission:

1. Must be medically necessary and ordered by a physician

2. Must meet three criteria:
   a. Skilled nursing or skilled rehabilitation services.
   b. The skilled service must be daily
   c. As a practical matter, the services should be provided in a SNF. (Alternatives to the nursing home placement have been discussed and eliminated - See Section II.D. above)

III. SKILLED NURSING AND SKILLED REHABILITATION SERVICES

Skilled Services and/or Skilled Rehabilitation Services (Defined) –
Services that are rendered under physician orders, require the skills of qualified technical or professional health personnel such as RNs, LVN/LPNs, and/or therapists (physical, occupational, speech pathologists or audiologists), and must be provided directly by or under the supervision of these skilled nursing or skilled rehabilitation personnel.

A. Skilled Nursing Services in Skilled Care
1. **Management and Evaluation of Patient Care Plan** — Management and evaluation of patient care plan is only considered a skilled service by itself when the following conditions apply:

   a. It is based on the physician’s orders

   b. The involvement of skilled nursing personnel is needed to meet the patient’s needs, promote recovery, and ensure medical safety.

   c. When the sum total of unskilled services are a necessary part of the medical regimen in consideration of the patient’s overall condition.

   Otherwise, management and evaluation of patient should be part of the overall care. See Clinically Complex criteria below.

2. **Observation and Assessment** — Observation and assessment of patient’s condition is only considered a skilled service by itself when the following conditions apply:

   a. Likelihood of change in the patient’s condition

   b. Patient’s need for modification of treatment needs to be identified and evaluated

   c. Possibility of initiating additional medical procedures

   d. Until the patient’s treatment regimen is essentially stabilized

   Otherwise, observation and assessment should be part of the overall care. See Clinically Complex criteria below.

**Clinically Complex Criteria**

(Proxy for skilled observation and care planning and monitoring through qualifiers of MD visits and order changes) Resident will have one or more of 14 identified Clinical Characteristics.

Qualify if the Resident has:

* Dialysis
* Burns
* Coma
* Septicemia
* Pneumonia
* Internal Bleeding
* Dehydration
* Hemiplegia in combination with (Activities of Daily Living score of 10 or more)
* Receive Chemotherapy
* Tube feedings comprising 26% of daily caloric intake and at least 501 ml of fluid through the tube per day.
* Treatment of foot sores for a diabetic or two or more stasis ulcers.
* Transfusions
* Diabetic who receives insulin injections 7 days per week and who has two or more physician order changes of any kind in the past 14 days.
* Receiving oxygen therapy the past 14 days

To assure inclusion of patients with unstable conditions qualify for coverage the two following criteria have been added to Clinically Complex:

(a) One or more physician visits with at least four order changes over a 14 day period or;

(b) Two or more visits with two order changes over a 14 day period.

3. Teaching and Training Activities

Teaching and training activities which require skilled nursing personnel to teach a patient how to manage his treatment regimen would constitute skilled services. Some examples include:

♦ Teaching self-administration of injectable medications or a complex range of medications. (until patient is self-sufficient or until it is determined that the Member is untrainable)

♦ Teaching a newly diagnosed diabetic to administer insulin injections, to prepare and follow a diabetic diet and to observe foot-care precautions.
Teaching self-administration of medical gases to a patient.

Gait training and teaching of prosthesis care for patient who has had a recent leg amputation.

Teaching patients how to care for recent colostomy or ileostomy.

Teaching bowel and bladder control to a patient with incontinence.

Teaching patients how to perform self-catheterization and self-administration of gastrostomy feedings.

Teaching patients how to care for and maintain central venous lines, such as Hickman catheters.

Teaching patients the use and care of braces, splints and orthotics, and any associated skin care.

Teaching patients the proper care of any specialized dressings or skin treatments.

a) Direct Skilled Nursing Services to Patients

Direct nursing services include:

Intravenous, intramuscular or intravenous injections. It is customary to teach patients to self-administer an injection. **Exception:** Observation of a patient receiving insulin injection is considered a skilled service if given 7 times per week & there are two or more physician order changes in the past 14 day period.

Nasogastric tube, gastrostomy and jejunostomy feedings. Tube feedings must be 26% of total daily calories & minimum of 501 ml fluid per day. Naso-pharyngeal and tracheostomy suction

Insertion, sterile irrigation and replacement of catheters: care of a suprapubic catheter and, in selected patients, urethral catheter (the mere presence of a urethral catheter, particularly one placed for convenience or the control of incontinence, does not justify a need for skilled nursing care). On the other hand, the insertion and maintenance of a urethral catheter as an
adjunct to the active treatment of disease of the urinary tract may justify a need for skilled nursing care. In such instances, the need for a urethral catheter must be justified and documented in the patient’s medical record. (e.g., it must be established that it is reasonable and necessary for the treatment of the patient’s condition)

♦ Application of dressings involving prescription medications and aseptic techniques to surgical wound or treatment of skin ulcer grade III or higher.

♦ 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 early bowel and bladder training programs)

♦ Initial phases of a regimen involving administration of medical gases such as bronchodilator therapy.

♦ 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.

b) Questionable Situations

There must be specific evidence that daily skilled nursing or skilled rehabilitation services are required and received if:

♦ The primary service needed is oral medication or subcutaneous injections when the patient is unable to administer injections (except for insulin dependent diabetics who receive injections 7 days per week with two or more physician order changes in the past 14 day period of time).

♦ The patient is capable of independent ambulation, dressing, feeding and hygiene (physician should document the skilled services needed).

B. Examples of Coverage for In-patient Skilled Rehabilitation Services in Skilled Care

1. Skilled Physical Therapy

General
Physical therapy is medically prescribed treatment directed at increasing or improving mobility in bed, in the wheelchair, and in ambulation. This area of therapy is also focused on restoration of skeletal or muscular function or teaching the patient to compensate for loss of such function. A large part of care is directed at reducing or relieving pain.

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 designed by the physician after any needed consultation with a qualified physical therapist,

♦ 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 expectation that, based on the assessment made by the physician, that 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,

♦ 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.

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, the physical therapy would not be reasonable and necessary and thus would not be covered skilled physical therapy services.

Many SNF in-patients do not require skilled physical therapy services but do require services, which are routine in nature. These services can be performed by supportive personnel. (e.g., aids or nursing personnel, without the supervision of a physical therapist) Such services, as well as services involving activities for the general good and welfare of patients (e.g., general exercises to promote overall fitness and flexibility, and activities to provide diversion or general motivation,) do not constitute skilled physical therapy.
2. Guidelines for Skilled Physical Therapy

a) Assessment - The skills of a physical therapist are required for the ongoing assessment of a patient’s care plan which include tests and measurements of range of motion, strength, balance, coordination, endurance and functional ability.

b) Therapeutic Exercises - Therapeutic exercises which must be performed by or under the supervision of the qualified physical therapist, whether due to the type of exercise employed or to the condition of the patient, constitute skilled physical therapy.

c) Gait Training - Gait evaluation and training furnished to a patient whose ability to walk has been impaired by neurological, muscular, or skeletal abnormality require the skills of a qualified physical therapist and constitute skilled physical therapy if they reasonably can be expected to improve significantly the patient’s ability to walk.

Repetitious exercises to improve gait, or to maintain strength and endurance, and assistive walking are appropriately provided by supportive personnel (e.g., aids or nursing personnel) and do not require the skills of a physical therapist. Thus, such exercises do not qualify as skilled physical therapy.

d) Range of Motion - Only the qualified physical therapist may perform range of motion tests and, therefore, such tests are skilled physical therapy. Range of motion exercises constitute skilled physical therapy only if they are part of active treatment for a specific disease state which has resulted in a loss or restriction of mobility (as evidenced by physical therapy notes showing the degree of motion lost and the degree to be restored).

Range of motion exercises, which are not related to the restoration of a specific loss of function often, may be provided safely by supportive personnel, such as aids or nursing personnel, and may not require the skills of a physical therapist. Passive exercises to maintain range of motion in paralyzed extremities that can be carried out by aids or nursing personnel would not be considered skilled physical therapy.

e) Maintenance Therapy - The repetitive services required to maintain function sometimes involve the use of complex and sophisticated therapy procedures and, consequently, the judgment and skill of a physical therapist might be required for the safe and effective rendition of such services. The specialized knowledge
and judgment of a qualified physical therapist may be required to establish a maintenance program intended to prevent or minimize deterioration caused by a medical condition, if the program is to be safely carried out and the treatment aims of the physician achieved. Establishing such a program is a skilled service.

While a patient is under a restorative physical therapy program, the physical therapist should regularly re-evaluate his condition to make sure that the patient is responding to the restorative sessions and his function is being improved. By the time it is determined that no further restoration is possible, the physical therapist will have already designed a maintenance therapy program and instructed the patient and/or supportive personnel.

f) Ultrasound, Short wave and Microwave Diathermy Treatments
These modalities must always be performed by or under the supervision of a qualified physical therapist and are skilled physical therapy.

g) Hot Packs, InfraRed Treatments, Paraffin Baths and Whirlpool Baths - Treatments and baths of this type ordinarily do not require the skills of a qualified physical therapist. However, the skills, knowledge and judgment of a qualified physical therapist might be required in the giving of such treatments or baths in a particular case. (e.g., where the patient’s condition is complicated by circulatory deficiency, areas of desensitization, open wounds, fractures or other complications)

3. Skilled Occupational Therapy

a) General

Occupational therapy is medically prescribed treatment concerned with improving or restoring functions of the upper extremities which have been impaired by illness or injury or, where function has been permanently lost or reduced by illness or injury, to improve the individual’s ability to perform those tasks required for independent functioning.

Only a qualified occupational therapist has the knowledge, training and experience required to evaluate and re-evaluate a patient’s level of function, determine whether an occupational therapy program could reasonably be expected to improve, restore or compensate for lost function and recommend a plan of treatment to the physician. However, while the skills of a qualified occupational therapist are required to evaluate the patient’s level of

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function and develop a plan of treatment, the implementation of the plan may also be carried out by a qualified occupational therapy assistant functioning under the general supervision of the qualified occupational therapist. (“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.)

b) Guidelines for Skilled Occupational Therapy

(1) The evaluation and re-evaluation as required, of a patient’s level of function by administering diagnostic and prognostic tests.

(2) The selection and teaching of task-oriented therapeutic activities designed to restore physical function. (e.g. use of wood-working activities on an inclined table to restore shoulder, elbow and wrist range of motion lost as a result of burns)

(3) The planning, implementing and supervising of individualized therapeutic activity programs as part of an overall “active treatment” program for a patient with a diagnosed psychiatric illness. (e.g. the use of sewing activities which require following a pattern to reduce confusion and restore reality orientation in a schizophrenic patient)

(4) The teaching of compensatory technique to improve the level of independence in the activities of daily living, for example:

(a) Teaching a patient with swallowing deficit to take appropriate food without choking.

(b) Teaching a patient who has lost the use of an arm how to pare potatoes and chop vegetables with one hand.

(c) Teaching an upper extremity amputee how to operate and functionally utilize prosthesis.

(d) Teaching one-handed techniques to enable a stroke patient to perform feeding, dressing and other activities as independently as possible.
(e) Teaching hip fracture/hip replacement patient techniques of standing tolerance and balance to enable him/her to perform such functional activities as dressing and homemaking tasks.

(f) The designing, fabricating and fitting of orthotic and self-help devices. (e.g., making a hand splint for a patient with rheumatoid arthritis to maintain the hand in a functional position or constructing a device which would enable an individual to independently hold an eating utensil)

(5) Vocational and pre-vocational assessment and training.

4. **Speech Therapy**
   
a) **General**

   Speech pathology services are those services necessary for the diagnosis and treatment of speech and swallowing and language disorders that result in communication disabilities. They must relate directly and specifically to a written treatment regimen established by the physician after any needed consultation with the qualified speech pathologist.

   Speech pathology services must be reasonable and necessary and the following conditions must be met:

   (1) The services must be considered under accepted standards of practice to be a specific and effective treatment for the patient’s condition;

   (2) The services must be of such level of complexity and sophistication, or the patient’s condition must be such that the services required can be safely and effectively performed only by or under the supervision of a qualified speech pathologist;

   (3) There must be expectation that the patient’s condition will improve significantly in a reasonable (and generally predictable) period of time, based on the physician’s assessment of the patient’s restoration potential after any needed consultation with the qualified speech pathologist, or the services must be necessary to the establishment of a
safe and effective maintenance program required in connection with a specific disease state; and

(4) The amount, frequency, and duration of the services must be reasonable under accepted standards of practice.

b) Guidelines for Speech Pathology

The following are guidelines to the more common situations in which the reasonableness and necessity of speech services furnished is a significant issue:

(1) **Restorative Therapy** - If an individual’s expected restoration potential would be insignificant in relation to the extent and duration of speech pathology services required to achieve such potential, the services would not be considered reasonable and necessary. In addition, there must be an expectation that the patient’s condition will improve significantly in a reasonable (and generally predictable) period of time. If, at any point in the treatment of an illness or injury, it is determined that the expectations will not materialize, the services will no longer constitute covered speech pathology services as they would no longer be reasonable and necessary for the treatment of the patient’s condition and would be excluded from coverage under Section 1862(a)(1). Social Security Act, (S.S.A.).

(2) **Maintenance Program** - After the initial evaluation of the extent of the disorder or illness, if the restoration potential is judged insignificant or, after a reasonable period of trial, the patient’s response to treatment is judged insignificant or at a plateau, an appropriate functional maintenance program may be established. The specialized knowledge and judgment of a qualified speech pathologist may be required if the treatment aim of the physician is to be achieved; e.g., a multiple sclerosis patient may require the services of a speech pathologist to establish a maintenance program designed to fit the patient’s level of function. In such a situation, the following would constitute covered speech therapy:

- Initial evaluation of level of function.
Designing a maintenance program which is appropriate to the capacity and tolerance of the patient and treatment objectives of the physician.

Instruction of the patient and supportive personnel. (e.g., aids or nursing personnel, or family Members where speech pathology is being furnished on an outpatient basis), and infrequent re-evaluations as required.

After the maintenance program has been established and instructions have been given for carrying out the program, the services of the speech pathologist would no longer be covered, as they would no longer be considered reasonable and necessary for the treatment of the patient’s condition and would be excluded from coverage under Section 1862(a)(1). (S.S.A.)

If a patient has been under a restorative speech pathology program, the speech pathologist should regularly re-evaluate the condition and adjust the treatment program. Consequently, during the course of treatment, the speech pathologist should determine when the patient’s restorative potential will be achieved and, by the time the restorative program has been completed, should have designed the maintenance program required and instructed the patient, supportive personnel, or family Members in the carrying out of the program. A separate charge for the establishment of the maintenance program under these circumstances would not be recognized. Moreover, where a maintenance program is not established until after the restorative speech pathology programs has been completed, it would not be considered reasonable and necessary to the treatment of the patient’s condition and would be excluded from coverage under section 1862(a)(1) since the maintenance program should have been established during the active course of treatment.

c) Types of Services

Speech pathology services can be grouped into two main categories: Services concerned with diagnostic of evaluation and therapeutic services.

(1) Diagnostic and Evaluation Services - Unless excluded by section 1862(a)(7) of the law, these services are covered if
they are reasonable and necessary. The speech pathologist employs a variety of formal and informal language assessment tests to ascertain the type, casual factor(s), and severity of the speech and language disorders. Re-evaluation would be covered if there were indication of clearing of confusion, a change in functional speech or motivation, or the remission of some other medical condition which previously contraindicated speech pathology. However, monthly re-evaluations (e.g., a Porch Index of Communicative Ability (PICA) for a patient’s undergoing a restorative speech pathology program) are to be considered a part of the treatment session and could not be covered as a separate evaluation for billing purposes.

(2) Therapeutic Services - The following are examples of common medical disorders and resulting communication deficits which may necessitate active restorative therapy;

- Cerebrovascular disease such as cerebral vascular accidents presenting with dysphagia, aphasia/dysphasia, apraxia and dysarthria;
- Neurological disease such as Parkinson’s or Multiple Sclerosis may exhibit dysarthria, dysphagia or inadequate respiratory volume/control;
- Mental retardation with disorders such as aphasia or dysarthria;
- Laryngeal carcinoma requiring laryngectomy resulting in aphonyia may warrant therapy of the laryngectomized patient so he can develop new communication skills through esophageal speech and/or use of the electrolarynx.

Note: Many patient’s who do not require speech pathology services as defined above do require services involving non-diagnostic, non-therapeutic, routine repetitive, and reinforced procedures or services for their general good and welfare. (e.g., the practicing of word drills) Such services do not constitute speech pathology services for Medicare purposes and would not be covered since they do not require performance by or the supervision of a qualified speech pathologist.
5. **Respiratory Therapy**

a) **General**

Respiratory Therapy is a skilled benefit when prescribed by a physician for the assessment, diagnostic evaluation, treatment, management and monitoring of patients with deficiencies and abnormalities of cardiopulmonary function.

Qualifications for Skilled Level of Care:

♦ Therapy must be ongoing on a daily basis;

♦ Must be reasonable and necessary for the Member/patient;

♦ Must be performed by a respiratory therapist or technician, physical therapist, nurse or qualified licensed personnel.

b) **Guidelines for Respiratory Services**

(1) The application of techniques for support of oxygenation and ventilation in the acutely ill patient. These techniques include, but are not limited to:

♦ Establishment and maintenance of artificial airways

♦ Ventilator therapy and other means of airway pressure manipulation

♦ Precise delivery of oxygen concentration

♦ Techniques to aid removal of secretions from the pulmonary tree

(2) The therapeutic use of monitoring of medical gases (especially oxygen), bland or pharmacologically active mists and aerosols, and such equipment as resuscitators and ventilators.

(3) Bronchial hygiene therapy, including deep breathing and coughing exercises, IPPB, postural drainage, chest percussion and vibration and nasotracheal suctioning.
SKILLED NURSING FACILITY (SNF) CARE GUIDELINES

(4) Diagnostic tests for evaluation by a physician. (e.g., pulmonary function tests, spirometry, and blood gas analysis)

(5) Pulmonary rehabilitation techniques which include:
   - Exercise conditioning
   - Breath retraining
   - Patient education regarding the management of the patient’s respiratory problems

(6) Periodic assessment monitoring of the acute and chronically ill patient for indication and effectiveness of respiratory therapy services.

IV. SKILLED NURSING AND REHABILITATION SERVICES GUIDELINES - QUICK REFERENCE

The following list of services is meant to be quick reference of skilled services and to outline Medicare’s available definition of the service. When a more complete definition or circumstance for coverage is needed, the complete reference guide should be used.

SKILLED NURSING AND REHABILITATION SERVICES SUMMARY

<table>
<thead>
<tr>
<th>SKILLED NURSING SERVICE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Management and Evaluation</td>
<td>Patient is so complex or unstable as to require skilled management daily to assure patient’s needs are met, assure medical safety, and promote recovery.</td>
</tr>
<tr>
<td>For Clinically Complex criteria, see III - Clinically Complex.</td>
<td></td>
</tr>
<tr>
<td>Observation and Assessment</td>
<td>A condition is so unstable as to require skilled personnel to identify, evaluate and intervene, (e.g., potential for acute episode or complications)</td>
</tr>
<tr>
<td>For Clinically Complex criteria, III - Clinically Complex.</td>
<td></td>
</tr>
<tr>
<td>Teaching and Training Activities</td>
<td>Daily teaching by licensed personnel to develop patient’s/family’s independence in managing special techniques, such as: medication injections (including I.V. site care), colostomy care, self-catherization, and range</td>
</tr>
<tr>
<td>SKILLED NURSING SERVICE</td>
<td>DESCRIPTION</td>
</tr>
<tr>
<td>-------------------------</td>
<td>-------------</td>
</tr>
<tr>
<td>Nursing Rehabilitation</td>
<td>Requires skilled licensed nursing personnel to perform or direct supervision of: Passive Active ROM, Amputation care, Splint Care, Training in dressing or grooming, Communications, Eating and Swallowing, Transfers, Bed mobility, Scheduled toileting, and Bladder Re-training.</td>
</tr>
<tr>
<td>Injections: Intramuscular, Intravenous, Subcutaneous (only for diabetics receiving insulin injections 7 times/week with two or more physician order changes in past 14 days or for newly diagnosed diabetic training).</td>
<td>Requires skilled service during early postoperative period in presence of associated complication.</td>
</tr>
<tr>
<td>Colostomy/Ileostomy</td>
<td>Requires skilled service during early postoperative period in presence of associated complication.</td>
</tr>
<tr>
<td>Nasogastric Tube (N.G.), Gastrostomy, Jejunostomy feedings</td>
<td>Always considered a skilled service. Must be required daily. Feedings must be 26% of total daily calories &amp; minimum of 501 ml fluid per day.</td>
</tr>
<tr>
<td>Catheter Care</td>
<td>Insertion, sterile irrigation and replacement of catheters. Care of suprapubic catheter. Usually a routine Foley catheter alone is not skilled unless needed as active treatment for a disease of the urinary tract, or as part of the bladder training program.</td>
</tr>
<tr>
<td>Sterile Dressings</td>
<td>Only considered skilled if sterile and medicated, directly placed on a wound/lesion after a surgical procedure is performed by a physician. The dressing change would need to be daily. Simple dry or wet dressing covering an ulcer is an example of a non-skilled service.</td>
</tr>
<tr>
<td>Decubitus Ulcer</td>
<td>Skilled if treating a Stage 3 or 4. DEFINITION: A Stage 3 ulcer is when the “Skin becomes necrotic, with exposure of fat”. Stage 2, in contrast “shows redness, edema at times with epidural blistering or desquamation.” The Merck Manual Definition.</td>
</tr>
</tbody>
</table>

Revision Date: November 2004
<table>
<thead>
<tr>
<th>SKILLED REHABILITATION SERVICE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>PHYSICAL THERAPY</td>
<td></td>
</tr>
<tr>
<td>Management and Evaluation</td>
<td>Need skill of Physical Therapist to evaluate current and ongoing restoration needs.</td>
</tr>
<tr>
<td>Observation and Assessment</td>
<td>Needs licensed personnel to monitor changes in condition and adjust restorative program.</td>
</tr>
<tr>
<td>Therapeutic Exercises</td>
<td>Exercises must relate to a goal of restoring function and be adjusted as changes in function are noted.</td>
</tr>
<tr>
<td>Gait Training</td>
<td>Skilled services include evaluation and retraining. Patient must demonstrate ability to remember instructions. Progressive ambulation is not a skilled service.</td>
</tr>
<tr>
<td>Range of Motion (ROM)</td>
<td>Only a Physical or Occupational Therapist can do range of motion tests so that service is skilled (usually part of assessment). ROM itself is only skilled if the joints are unstable or if for a specific loss of function that can be restored.</td>
</tr>
<tr>
<td>Maintenance Therapy Programs</td>
<td>Skilled services include establishment of maintenance program. The steps include initial evaluation, designing program, and instruction to family, patient or care givers.</td>
</tr>
<tr>
<td>Ultrasound, Short Wave, Microwave Diathermy Treatment, Heat Treatment, and Paraffin Baths and Whirlpool Baths</td>
<td>Specifically ordered by the physician and requires observation by skilled personnel to evaluate progress. The following services are rarely skilled unless patient has open wound or other complications: hotpacks and infrared treatments.</td>
</tr>
<tr>
<td>SKILLED REHABILITATION SERVICE OCCUPATIONAL THERAPY</td>
<td>DESCRIPTION</td>
</tr>
<tr>
<td>----------------------------------------------------</td>
<td>-------------</td>
</tr>
<tr>
<td>Management and Evaluation</td>
<td>Need skill of Occupational Therapist to evaluate current and ongoing needs for upper extremity function and daily living activities.</td>
</tr>
<tr>
<td>Observation and Assessment</td>
<td>Needs licensed personnel to monitor changes in condition and adjust restorative program.</td>
</tr>
<tr>
<td>Range of Motion (ROM)</td>
<td>Only a Physical or Occupational Therapist can do range of motion tests, so that service is skilled (usually part of assessment). ROM itself is only skilled if the joints are unstable or if for a specific loss of function that can be restored.</td>
</tr>
<tr>
<td>Therapeutic Exercises</td>
<td>Exercises must relate to a goal of restoring function, and be adjusted as changes in function are noted.</td>
</tr>
<tr>
<td>Maintenance Therapy Programs</td>
<td>Skilled services include establishment of maintenance program. The steps include initial evaluation, designing program, instruction to family, patient or caregivers.</td>
</tr>
<tr>
<td>Activities of Daily Living Training</td>
<td>Gives initial training for toileting, bathing, grooming, and eating. May perform sensory stimulation and swallowing exercises.</td>
</tr>
</tbody>
</table>
## SKILLED REHABILITATION SERVICE SPEECH PATHOLOGY

<table>
<thead>
<tr>
<th>MANAGEMENT AND EVALUATION</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Need Speech Pathologist to determine language and communication disorders and establish therapeutic program.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>OBSERVATION AND ASSESSMENT</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Determines effectiveness of treatment programs and adjusts program.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>RESTORATIVE THERAPY</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Directed at communication disorders such as expressive and receptive aphasia (dysphasia) which may include apraxia, or dysarthria. Also directs treatment program for swallowing problems or laryngectomy.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SWALLOWING REFLEX DISORDER</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skilled services of speech pathologist needed to determine etiology of disorder and develop treatment program.</td>
<td></td>
</tr>
</tbody>
</table>
SKILLED REHABILITATION SERVICE
RESPIRATORY THERAPY

<table>
<thead>
<tr>
<th>DESCRIPTION</th>
<th>SKILLED REHABILITATION SERVICE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Management and Evaluation</td>
<td>Need skill of respiratory therapist for support of oxygenation and ventilation in acutely ill patient, and to perform diagnostic tests for physician.</td>
</tr>
<tr>
<td>Observation and Assessment</td>
<td>Considered skilled if reasonable and necessary for primary diagnosis of cardiopulmonary deficiencies or abnormalities to monitor effectiveness of respiratory therapy</td>
</tr>
<tr>
<td>Precise Delivery of Oxygen Concentration</td>
<td>Normal delivery of O₂ is not skilled unless in-patient meets O₂ criteria via arterial blood gases. No “PRN O₂” services are considered skilled level of care. Alternative setting for O₂ delivery should be considered.</td>
</tr>
<tr>
<td>Respiratory Therapy/Services for Ventilator or Airway Support Dependent and Administration of Medical Gases</td>
<td>Only skilled during initial phase of regime. (not O₂)</td>
</tr>
<tr>
<td>Bronchial Hygiene Therapy</td>
<td>Requires variety of treatment techniques to achieve goal of respiratory improvements.</td>
</tr>
</tbody>
</table>
V. LEVEL OF SKILLED CARE REIMBURSEMENT GUIDELINES

Payment and reimbursement for Pacificare/Secure Horizons Members receiving skilled care is based on the specific contractual arrangements made by the plan. Contractual arrangements may differ. Please check with your contract administrator to verify specific contractual arrangements.

VI. CUSTODIAL CARE

A. General

Custodial care is excluded from coverage. Custodial care services to assist an individual in the activities of daily living, such as assistance in walking, getting in and out of bed, bathing, dressing, feeding, using the toilet, preparation of special diets, and supervision of medication that usually can be self-administered. Custodial care essentially is personal care that does not require the continuing attention of trained medical or paramedical personnel. In determining whether a person is receiving custodial care, the factors considered are the level of care and medical supervision required and furnished. The decision should not be based on diagnosis, type of condition, degree of functional limitation or rehabilitation potential.

Institutional care that does not meet the three criteria for skilled care is Custodial Care. Some examples of custodial care in hospitals and SNFs are:

♦ A stroke patient who is ambulatory, has no bladder or bowel involvement, no serious associated or secondary illness, and does not require medical or paramedical care, but requires only the assistance of an aide in feeding, dressing and bathing.

♦ A cardiac patient, who is stable and compensated, has reasonable cardiac reserve, and no associated illness, but whom, because of advanced age, has difficulty in managing alone in the home and requires assistance in meeting the activities of daily living.

♦ A senile patient who has diabetes and remains stabilized, as long as someone oversees patient taking oral medication and adherence to a prescribed diet.

Even if a patient’s stay in a SNF is determined to be custodial, some individual services may still be covered if they are reasonable and necessary. Exhaustion of the SNF benefit limitation for medically complex cases does not relinquish the PMG/IPA from financial responsibility for continued medically necessary services such as those that are provided under Medicare Part B.

Revision Date: November 2004
As with any Member in a "home" setting, acute and/or skilled medical benefits must continue to be provided for.

Payment may be made for the following medical and health services when furnished by a participating SNF (either directly or under arrangements) to an in-patient of the SNF even if the beneficiary has exhausted his allowed days of in-patient SNF coverage (Part A) or is determined to be receiving a non-covered level of care. Payment for the services will only be made if ordered by the PCP and authorized by the appropriate PMG/IPA. Examples of covered services:

1. Diagnostic X-ray tests (including portable X-ray), diagnostic laboratory tests, and other diagnostic tests. Payment under Part B for a clinical diagnostic laboratory test can be made only to the entity that performed the test. Thus, a SNF cannot furnish services under an arrangement for clinical diagnostic laboratory tests under Part B.

2. X-ray, radium, and radioactive isotope therapy, including materials and services of technicians.

3. Surgical dressings, and splints, casts, and other devices used for the reduction of fractures and dislocations.

4. Prosthetic devices (other than dental) which replace all or part of an internal body organ (including contiguous tissue) or replace all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repair of such devices.

5. Leg, arm, back, and neck braces, trusses, and artificial legs, arms, and eyes, including adjustments, repairs, and replacement required because of breakage, wear, loss, or a change in the patient’s physical condition.

6. Outpatient physical therapy, outpatient occupational therapy, or outpatient speech pathology services.

7. Secure Horizons only: Most vaccinations or inoculations are excluded from coverage as “immunizations” unless they are directly related to the treatment of an injury or direct exposure to a disease or condition. Exceptions: Pneumococcal and influenza vaccines, varicella and hepatitis B vaccines for individuals at high risk and meningococcal vaccine for college freshman determined to be high risk for meningococcal disease.
B. Examples of Non-Skilled Supportive or Personal Care Services

The following services are not skilled services unless rendered so as part of a skilled care treatment plan:

♦ Administration of routine oral medications, eye drops and ointments (the fact that a patient cannot be relied upon to self-administer or that State Law requires all medications to be dispensed by a nurse to institutional patients would not change this service to a skilled service);

♦ General maintenance care of colostomy and ileostomy;

♦ Routine services to maintain satisfactory functioning of indwelling bladder catheters (this would include emptying and cleaning containers and cleaning them, and clamping tubing);

♦ Changes of dressings for non-infected post-operative or chronic conditions;

♦ Prophylactic and palliative skin care, including bathing and application of creams, or treatment of minor skin problems;

♦ Routine care of the incontinent patient, including use of diapers and protective sheets;

♦ General maintenance care in connection with a plaster cast (skilled supervision or observation may be required where the patient has pre-existing skin or circulatory condition or needs to have traction adjusted);

♦ Routine care in connection with braces and similar devices;

♦ Use of heat as a palliative and comfort measure, such as whirlpool or steam pack;

♦ Routine administration of medical gases after a regimen of therapy has been established (e.g., administration of medical gases after the patient has been taught how to institute therapy);

♦ Assistance in dressing, eating, and going to the toilet;

♦ Periodic turning and positioning in bed;

♦ General supervision of exercise that has been taught to the patient and the performance of repetitious exercises that do not require skilled rehabilitation personnel for their performance. (This includes the actual carrying out of maintenance programs where the performance of repetitive exercises that may
be required to maintain function do not necessitate a need for the involvement and services of skilled rehabilitation personnel. It also includes the carrying out of repetitive exercises to improve gait, maintain strength or endurance; passive exercises to maintain range of motion in paralyzed extremities which are not related to a specific loss of function and assistive walking.)

C. Examples of Non-Skilled Physical Therapy Services

These services are not a covered in-patient benefit:

♦ Range of motion exercises which are not related to restoration of a specific loss or function;

♦ Passive exercises;

♦ Repetitious exercises to improve gait or to maintain strength and endurance, and assisting walking;

♦ Simple maintenance therapy, general exercises to promote overall fitness and flexibility;

♦ Use of heat as a palliative and comfort measure, such as whirlpool or steam pack;

♦ Carrying out of a maintenance program after the therapist has established the program;

♦ Evaluation provided as a screening device;

D. Convalescent/Custodial Drug Coverage

1. Requirement

Prescription drug coverage will only be provided if the patient has the prescription medication benefit obtains the drugs through the Secure Horizons or PacifiCare participating network. For Secure Horizons, prescription drugs must be on the Secure Horizons Covered Medications List to be covered. For PacifiCare, the prescription drugs must be on the PacifiCare formulary or be prior authorized by Prescription Solutions to be a covered benefit.

2. Procedure
SKILLED NURSING FACILITY (SNF) CARE GUIDELINES

♦ Prescription drugs must be obtained through in-plan pharmacies regardless of the patient’s ability to utilize the Secure Horizons or PacifiCare participating pharmacy network.

♦ Prescription drugs must be prescribed by the authorized treating physician assigned by the primary medical group.

VII. DME COVERAGE (FOR SECURE HORIZONS) AND HOSPICE CARE IN A SNF

A. Secure Horizons Durable Medical Equipment Coverage After Exhaustion of the SNF Benefit or at Custodial Level of Care

For Members of Secure Horizons, routine DME including Oxygen are not covered benefits when a Member exhausts the SNF coverage 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 routine DME items are front-wheeled walkers, standard wheelchairs and hospital beds. Medicare does not recognize these institutions as the Member’s residence. (Medicare and Medicaid Guide: Vol. I, 1305, 1259, and 3144).

Exceptions:

1. Prosthetics and orthotics

2. Diabetic supplies are not considered DME by CMS. Diabetic supplies and equipment are considered to be part of basic health care and must be furnished to the resident. (1997 BBA)

Note: A Member is still eligible for coverage of any non-routine and specialized DME item even after exhausting the SNF coverage or is receiving a non-covered level of care as payment is considered to be made under Part B for these items. Some examples of non-routine DME items are: C-Pap Machines, Air-Fluidized Beds, TENs Units.

B. HOSPICE CARE IN A SNF

1. Secure Horizons
Secure Horizons does not pay for Hospice Care. The Member signs a waiver for the Medicare Certified Hospice Agency to be reimbursed by Medicare. Neither Medicare nor Secure Horizons pays room and board in a SNF when a Member is on Hospice. The Medicare Certified Hospice bills directly to the Part B Carriers (e.g., NHIC, Noridian) for reimbursement for services to the resident.

2. **PacifiCare**

PacifiCare covers hospice care if a Member is certified by his attending physician to be terminally ill (one year of life expectancy or less) and has elected to no longer pursue aggressive medical treatment in order to receive supportive nursing care and counseling during the terminal phase of the Member's illness. Hospice care must be provided by a certified hospice and may include short term inpatient care in a facility such as a SNF for procedures necessary for pain control, acute or chronic symptom management or respite for the Member's family or other persons caring for the Member at home. It should be determined that the Member requires a level of care that cannot be provided in the Member's home and that other alternatives facilities or services have been ruled out. Member would be considered at the hospice level of care even if skilled services are provided. Therefore, Member would be restricted to benefits provided under hospice care and not skilled nursing care.
Section II

Authorization/Utilization Review Procedures
A. AUTHORIZATION PROCEDURES

1. A Skilled Nursing Facility (SNF) stay is considered authorized when a Secure Horizons/PacifiCare or PMG/IPA physician or designated specialist admits a patient at a skilled level of care to a Medicare certified SNF bed (See CMS Letter 94-10, question #1).

   a. To qualify as a SNF, the institution must be licensed by the State as an SNF and must meet the Soc. Sec. Act §1819 (a)(1) requirements as described below:
      • 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.
      • To qualify as a skilled nursing facility, a distinct part of an institution must be physically separate from the rest of the institution i.e., it must represent an entire physically identifiable unit consisting of all the beds within that unit such as a separate building, floor, wing or ward. Although it is required that the distinct part be identifiable as a separate unit with the institution, it does not necessarily need to be confined to a single location within the institution's physical plant.

   b. Screening guides when an individual is in a SNF:
      1) Where an institution is classified as a participating SNF, an 1819(a)(1) institution or where a SNF has a part classified as participating and a part classified as meeting 1819(a)(1), it cannot be considered that individual’s home.
      2) If an institution has a part which is participating or a part which meets 1819(a)(1), and a remaining part which does not meet 1819(a)(1), identify the part in which the patient was physically located during the use period. The institution may be considered the individual’s home only if he/she was in the part which does not meet 1819(a)(1).

2. Orders for treatments, medications, appropriate therapies and skilled services, including but not limited to laboratory work, x-ray, special supplies and ambulance transportation, must be written separately. These orders are considered authorized when written either by the primary care physician or designated specialist, and must be part of the patient’s admitting orders when transferred to the SNF.

3. Durable Medical Equipment needs are divided into two categories:
   a. Inpatient: Durable medical equipment necessary or required during an authorized SNF stay should be provided by the facility.
b. **Outpatient:** If a patient requires use of durable medical equipment at home after discharge from the SNF, the PMG/IPA or PacifiCare/Secure Horizons will specify who is to authorize and where the item will be obtained and delivered.  
*(Note: See Section D – Spell of Illness/Benefit Period for coverage of routine DME after Member exhausts the 100-day SNF benefits)*

4. Utilization review for skilled level of care should be performed weekly, either by phone or on-site. The utilization review is done by a nurse or case manager from the PMG/IPA or PacifiCare/Secure Horizons (Refer to Physician Visits Guidelines for schedule of visits)

5. Failure to comply with PacifiCare's authorization verification, review and reporting requirements will result in retrospective review. The review may result in a potential delay in payment or non-payment of facility and provider services for all days and charges in question until proper information, which supports the claim is received.

6. The PMG/IPA or Secure Horizons/PacifiCare should send a letter outlining their preferred provider network for ancillary services with the admitting orders to the SNF. Some PMG/IPAs provide the SNF with a form to be attached to the front of the chart to denote the preferred provider network *(see Sample Form below).* If services are required that are not a part of the PMG/IPA's or PacifiCare/Secure Horizons standard contracts, PacifiCare/Secure Horizons or the PMG/IPA Health Plan Coordinator must be contacted by the SNF to make the necessary arrangements.

7. If the PMG/IPA is responsible for payment of the SNF claims, they should be sent to the Member’s PMG/IPA Claims Department. If PacifiCare/Secure Horizons is responsible for payment of the SNF claims, they should be sent directly to:

   **Secure Horizons/PacifiCare Claims Department**
   
P. O. Box 489
   Cypress, CA  90630-0006

   All claims will be paid according to negotiated contracted rates. On occasion, should a non-contracted facility be authorized for use, the claim will be paid at Medicare reimbursement rates.

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Revision Date: November 2004
Name of Primary Medical Group
Primary Care Physician
(must be affiliated with medical group or IPA)
Address
Phone Number

The providers listed below are to be used for services ordered by the Primary Care Physician for patient __________________________.

<table>
<thead>
<tr>
<th>Service</th>
<th>Provider Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Laboratory</td>
<td>______________</td>
</tr>
<tr>
<td>X-ray</td>
<td>______________</td>
</tr>
<tr>
<td>Ambulance</td>
<td>______________</td>
</tr>
<tr>
<td>Hospital</td>
<td>______________</td>
</tr>
<tr>
<td>Home Health</td>
<td>______________</td>
</tr>
</tbody>
</table>

(This generic form may be revised to meet the medical group needs.)
B. THREE-DAY QUALIFYING STAY

Medicare requires prior acute hospitalization of at least 3 days to qualify for skilled nursing facility admission. In a Medicare Advantage organization (i.e., Secure Horizons), the Primary Care Physician may waive the three (3) day qualifying stay in an acute care hospital. However, from the date of admission to a SNF, days will be counted towards the 100-day SNF benefit limit (See CMS Letter 94-10, question #2).

A three-day acute hospital stay is not necessary for a Secure Horizons Member in order to qualify for a payment of the room and board in a skilled nursing facility. Secure Horizons, as well as PacifiCare Members, may have the three-day stay waived under the following criteria:

- Member meets the criteria for admission to an acute facility, or
- Member will be given the same level of care and services in the skilled nursing facility as would be given in the acute hospital setting (Member’s needs are no greater than needed at SNF level), or
- Determination is made by the PCP that the Member is receiving the necessary care to treat the condition, and that the care is equal to the care the Member would receive in an acute care setting

Example: Mrs. Jones has a stage IV decubitus ulcer. Mrs. Jones’ Secure Horizons participating physician determines that Mrs. Jones can be treated in the skilled nursing facility, where she is a patient with decubitus ulcer protocol and a special bed. Mrs. Jones does not need the three-day qualifying stay

C. SPELL OF ILLNESS (BENEFIT PERIOD)

A spell of illness (benefit period) begins when a Member is furnished inpatient hospital or skilled nursing facility services by a qualified provider and ends with the close of a period of 60 consecutive days during which the patient was neither an inpatient of a hospital nor of a licensed (Medicare certified) SNF regardless of the payer source. To determine the 60 consecutive day period, begin counting with the day the Member was discharged. A Member may have more than one benefit period per year.

Coverage:

- For specific benefit coverage and limitations, refer to the Secure Horizons or PacifiCare Skilled Nursing Facility Benefit Interpretation Policy.
- If a Member’s Secure Horizons coverage begins while in a SNF, any Medicare SNF days used in the benefit period prior to the Member’s effective date with Secure Horizons will apply toward the 100-day benefit.
**Exhaustion of Benefits:**

- **Secure Horizons**
  - Secure Horizons Members may still qualify for Part B services in accordance with Medicare criteria when the patients’ level does not qualify for payment of room and board or Member has exhausted a benefit period (100 days).
  - Routine DME including oxygen are 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.
    a) Exceptions:
      1. The Balanced Budget Act of 1997 requires coverage for blood glucose monitors and supplies (strips & lancets) for diabetic Members as a basic medical service.
      2. Prosthetics and orthotics
         - **Note:** Specialized DME not routinely found in the SNF (e.g., Clinitron bed, specialized wheelchair) will still be covered after a Member exhausts the 100-day benefit.

- **PacifiCare**
  - Exhaustion of the SNF benefit limitation for medically complex cases does not relinquish the PMG/IPA from financial responsibility for continued medically necessary services. As with any Member in the “home setting”, acute and/or skilled medical benefits must continue to be provided.
### Patient A Example: Initial Spell of Illness (Benefit Period)

<table>
<thead>
<tr>
<th>Event</th>
<th>SNF</th>
<th>Acute Hospital</th>
<th>SNF</th>
<th>Acute Hospital</th>
<th>SNF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fractured Hip – Admit to Acute Hosp</td>
<td>4 Days</td>
<td>20 Days</td>
<td>5 Days</td>
<td>40 Days</td>
<td>8 Days</td>
</tr>
<tr>
<td>Total SNF Benefit Period Days Left:</td>
<td>80 Days</td>
<td>80 Days</td>
<td>40 Days</td>
<td>40 Days</td>
<td>0 Days (Exhausted Benefit)</td>
</tr>
</tbody>
</table>

### Patient B Example: New Spell of Illness (Benefit Period)

<table>
<thead>
<tr>
<th>Event</th>
<th>SNF</th>
<th>Discharge to Home</th>
<th>Acute Hospital</th>
<th>Admit to SNF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hip Replacement – Admit to Acute Hosp</td>
<td>4 Days</td>
<td>40 Days</td>
<td>75 Days</td>
<td>3 Days</td>
</tr>
<tr>
<td>Total SNF Benefit Period Days Left:</td>
<td>60 Days</td>
<td>New Period of Illness</td>
<td>100 Days</td>
<td></td>
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Consistent with Medicare, managed care plans offer a minimum of 100 days per benefit period of skilled nursing facility (SNF) care. Recently we have had a number of questions regarding the SNF benefit.

Listed below are questions and answers regarding the SNF benefit:

**QUESTION 1.** May plans use non-certified SNF beds to provide Medicare benefits?

**ANSWER 1.** No. To count as part of Medicare's 100-day SNF care benefit, plans must use Medicare certified beds. Plans may use non-certified (distinct part) SNF beds only if the days are not counted as part of Medicare's basic 100-day benefit. In this case, the days in non-certified beds would be considered an additional benefit to the enrollee. However, each Medicare beneficiary is allowed 100 days of SNF care per benefit period in a Medicare certified bed.

**QUESTION 2.** If plans waive the three-day hospital stay preceding admission to a SNF are these days then counted against the required 100-day minimum?

**ANSWER 2.** Yes, but only if the enrollee is in a Medicare certified bed.

Sincerely,

Elizabeth H. Foley, Director
Managed Care Operations
D. **CHANGE IN SECURE HORIZONS/PACIFICARE MEMBERSHIP STATUS WHILE HOSPITALIZED**

- If a Member’s enrollment with Secure Horizons/PacifiCare becomes effective while the Member is an inpatient in a SNF at a skilled level of care, Secure Horizons/PacifiCare shall be responsible for all services (Part A and Part B) beginning on the Member’s effective date with Secure Horizons/PacifiCare.

- If a Member’s disenrollment with Secure Horizons/PacifiCare becomes effective while the Member is a patient in a SNF at a skilled level of care, the new health plan carrier shall be responsible for all services (Part A and Part B) beginning on the Member’s disenrollment effective date with Secure Horizons/PacifiCare.

E. **UTILIZATION REVIEW PROCEDURES**

The Secure Horizons/PacifiCare or PMG/IPA’s Medical Management Committee (MMC) assumes ultimate responsibility for the level of care (LOC) determinations for skilled nursing facility patients.

- The PMG/IPA or Secure Horizons/PacifiCare Utilization Review (UR) Nurse or designee monitors LOC status of all skilled patients. Monitoring should include a routine phone review with the UR designee from the SNF. For patients that are stable, with a single skilled level (i.e., has gastric tube feeding), every two to three weeks is adequate. All rehabilitation patients should be monitored weekly.

- The PMG/IPA or Secure Horizons/PacifiCare and SNF should work closely together to ensure a smooth transfer to a lesser level of care. The SNF should not be caught by a sudden, hasty discharge as the patient could experience untoward effects.

- The PMG/IPA or Secure Horizons/PacifiCare must develop a comprehensive written continuity of care plan (a nursing care plan), prior to the time of discharge, when a Member is discharged to a lower level of care. (*See Section IV, Continuity of Care Guidelines*)

- When necessary, denial letters are issued to the enrollee or enrollee’s representative. Standard Pre-Service Denial letters may be issued prospectively for non-qualifying admissions for which prior authorization was requested. All letters to Secure Horizons Members must use the CMS-approved templates without modification. Templates may be found at [http://www.cms.hhs.gov/manuals/116_mmc/mc86toc.asp](http://www.cms.hhs.gov/manuals/116_mmc/mc86toc.asp), select Chapter 13 Medicare Advantage Beneficiary Grievances, Organization Determinations, and Appeals, and go to Appendices 8 and 9.
After admission, procedures differ for PacifiCare and Secure Horizons Members, and are discussed in depth in Section III Change in Level of Care. (Refer to Section III, Change in Level of Care).

The Medicare Advantage enrollee or enrollee’s authorized representative can file an immediate appeal of the decision to the Quality Improvement Organization (QIO) no later than noon of the day after receipt of Notice of Medicare Non-Coverage (NOMNC). The QIO is an independent reviewer authorized by CMS to review the determination. If the enrollee missed the deadline for an immediate appeal to the QIO, the enrollee may request an expedited appeal from Secure Horizons by calling Secure Horizons Member Services Department at (800) 228-2144. The enrollee may obtain additional information about appeals by contacting the health plan or calling 1-800-MEDICARE (1-800-633-4227), or TTY/TDD: 1-877-486-2048.

The PacifiCare enrollee or enrollee’s authorized representative may file an appeal by calling PacifiCare Member Services Department at (800) 624-8822. (See Section III, Change in Level of Care).

The PMG/IPA is responsible for reporting SNF admits to PacifiCare/Secure Horizons as stated in the following institutional notification procedure.
F. INSTITUTIONALIZED MEMBERS NOTIFICATION PROCEDURE

1. The PMG/IPA must promptly report Secure Horizons/PacifiCare Members that have been institutionalized for a minimum of 30 consecutive days immediately prior to the first of the current month. A completed log should be submitted via E-mail, fax or mail on a weekly basis.

2. Secure Horizons/PacifiCare re-verifies the Members’ continued institutionalized status with the facilities.

Notes:

- Secure Horizons receives additional capitation from the Centers for Medicare & Medicaid Services (CMS), the federal agency that administers Medicare, for Members meeting the requirements for institutionalized status. The additional capitation that Secure Horizons receives is also passed along to the Member’s contracting PMG/IPA and capitated hospital.

- To qualify for institutionalized status, as defined by CMS, the Secure Horizons Member must be a resident of a Medicare certified skilled nursing facility, swing-bed facility, intermediate care facility, sanitarium, rest home, convalescent home, long-term care hospital, psychiatric hospital, rehabilitation hospital, or a domiciliary home for a minimum of 30 consecutive days prior to the first day of the current month, i.e., immediately prior to the month the institutionalization is reported by Secure Horizons to CMS.

- Prompt reporting is necessary since no retro-payment from CMS is possible. A facility tracking report is generated and sent to CMS on a monthly basis.
SECTION III

CHANGE IN LEVEL OF CARE

Revision Date: November 2004
A. Change in Level of Care & Length of Stay

A change in level of care occurs when a Member’s condition is such that they can safely be transferred to a lower level of care. This may include discharge to home. The criteria used to determine level of care and length of stay include, but are not limited to: Milliman Care Guidelines, HCIA length of stay tables, Medicare guidelines, other standard industry sources.

B. Process for Notification

A written denial letter for PacifiCare Members or Notice of Medicare Non-Coverage (NOMNC) for Secure Horizons Members is issued to notify the Member or responsible party that coverage for a provided service will end after a specified date. This alerts the Member that, if no action is taken, he or she will become financially responsible for those services after the specified date. (See Section C for specific types of letters.)

1. PacifiCare enrollees:

- The PMG/IPA is responsible to inform PacifiCare Members of decisions to deny continued stay in writing within two business days of the decision. In the case of concurrent review, care shall not be discontinued until the enrollee's treating provider has been notified of the plan's decision, and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of that patient [California Health & Safety Code 1367.01(h)(3)]

  - If the Member or responsible party refuses to sign the receipt of letter/notice, obtain the signature of a witness that the responsible party refused to sign the receipt (document on the receipt).

  - Copies of the letter should be sent to the SNF business office, PacifiCare Medical Information Coordinator, Member’s PCP and the PMG/IPA Health Plan Coordinator. A copy of the letter should be placed in the Member’s medical record.

2. Secure Horizons enrollees:

- **Advance Notification**: The first notice to be issued: Notice of Medicare Non-Coverage or “Advance Notice”. This “Advance Notice” is required to be issued to all Medicare Advantage beneficiaries (Members) when services will terminate. The facility must notify the enrollee of PacifiCare/Secure Horizons’ or the PMG/IPA’s decision to terminate covered services no later than two days before the proposed end of the services. If the enrollee’s services
SKILLED NURSING FACILITY (SNF) CARE GUIDELINES

are expected to be fewer than two days in duration, the facility should notify the enrollee at the time of admission to the facility.

While it is the responsibility of the facility to issue the NOMNC, it is the responsibility of the PMG/IPA to ensure that the facility delivers the letter and provides the PMG/IPA with a copy. Thus the PMG/IPA must have a mechanism to coordinate with the facility. All letters to Secure Horizons Members must use the CMS-approved templates without modification. Templates may be found at http://www.cms.hhs.gov/manuals/116_mmc/mc86toc.asp, select Chapter 13 Medicare Advantage Beneficiary Grievances, Organization Determinations, and Appeals, and go to Appendices 8 and 9.

The notice must be validly delivered. CMS defines valid delivery to mean that the enrollee must be able to understand the purpose and contents of the notice in order to sign for receipt of it. The enrollee must be able to understand that he or she may appeal the termination decision. If the enrollee is not able to comprehend the contents of the notice, it must be delivered to and signed by an authorized representative. Valid delivery does not preclude the use of assistive devices, witnesses, or interpreters for notice delivery. Thus, if an enrollee is not able to physically sign the notice to indicate receipt, then delivery may be proven valid by other means.

Notice Delivery to Incompetent Enrollees in an Institutionalized Setting CMS requires that notification of changes in coverage for an institutionalized enrollee who is not competent be made to an authorized representative acting on behalf of the enrollee. Notification to the authorized representative may be problematic because that person may not be available in person to acknowledge receipt of the required notification. Facilities are required to develop procedures to use when the enrollee is incapable or incompetent, and the facility cannot obtain the signature of the enrollee’s representative through direct personal contact. If the Medicare Advantage organization is unable to personally deliver a notice of non-coverage to a person acting on behalf of an enrollee, then the Medicare Advantage organization should telephone the representative to advise him or her when the enrollee’s services are no longer covered. The date of the conversation is the date of the receipt of the notice. Confirm the telephone contact by written notice mailed on that same date. When direct phone contact cannot be made, send the notice to the representative by certified mail, return receipt requested. The date that someone at the representative’s address signs (or refuses to sign) the
receipt is the date of receipt. Place a dated copy of the notice in the enrollee’s medical file. When notices are returned by the post office, with no indication of a refusal date, then the enrollee’s liability starts on the second working day after the PMG/IPA’s mailing date.

Copies of the letter should be sent to the Member’s PCP and the PMG/IPA Health Plan Coordinator. A copy of the letter should be placed in the Member’s medical record.

- Detailed Explanation of Non-Coverage
  The second notice to be issued: “Detailed Explanation of Non-Coverage” or “Detailed Notice”. This “Detailed Notice” is only issued if the Member disagrees with Notice 1 - “Advance Notice” and requests an appeal. Therefore when the CMS-appointed Quality Improvement Organization notifies Secure Horizons or the PMG/IPA that an enrollee has requested an appeal, Secure Horizons or the PMG/IPA must issue a Detailed Explanation of Non-Coverage to both the QIO and the enrollee no later than close of business. The letter must
  - specify the kind of service being terminated (i.e., skilled nursing),
  - indicate whether the type of review involves medical necessity, coverage limitations, or both,
  - and include the facts used to make this decision: The facts are the patient-specific information that describes the current functioning and progress of the enrollee with respect to the services being provided.
  - Use full sentences in plain English. Alternatively, if coverage is being terminated because of benefit exhaustion or non-Medicare covered services, describe how the enrollee’s benefit does not cover the services.

C. Denial Letters

- Skilled Nursing Facility: (SNF) Pre-service Denial: Letter issued prior to transfer from home, institution or acute hospital to a skilled nursing facility when the Member does not meet the requirements for skilled nursing facility care benefits.

- SNF Reinstatement Notice: Letter issued at the time a Member’s level of care increases from custodial level back to skilled level of care (optional).

- Notice of Non-coverage (PacifiCare enrollees): Letter issued to the enrollee or enrollee’s representative when the Member or representative objects to discontinuation of services.
• Notice of Medicare Non-Coverage (Secure Horizons enrollees): Issued by the skilled nursing facility to all Secure Horizons enrollees prior to change to a lower level of care (which may include discharge) or exhaustion of benefit. This letter is issued regardless of Member’s agreement with or objection to the determination.

• Detailed Explanation of Non-Coverage (Secure Horizons): Letter issued by PMG/IPA or Secure Horizons to enrollee (or enrollee’s representative to whom the NOMNC was issued) when they are notified by the Quality Improvement Organization (QIO) that the enrollee has appealed the discharge or change to a lower level of care.

D. Member’s Right to Dispute a Determination

1. PacifiCare enrollees

   • Standard Grievance Process: The Department of Managed Healthcare (DMHC) specify that denial letters include language stating that the Member or Member’s representative has the right to appeal the decision by filing with PacifiCare. The Member or appointed representative may submit an appeal or grievance verbally or in writing.

   • Expedited Review: The denial letters must include 72 hour Expedited Review language. The Member or Member’s representative may request verbally or in writing an expedited review when a delay in the decision making might pose an imminent and serious threat to the Member’s health, including but are not limited to severe pain, potential loss of life, limb, or major bodily functions.

2. Secure Horizons enrollees

   The CMS-approved Notice of Medicare Non-Coverage or “Advanced Notice” includes CMS-prescribed appeals language addressing

   • Immediate Appeal through the QIO: informs the enrollee how and when to submit an appeal to the independent reviewer (the QIO) authorized by CMS. In California, the QIO is:

     Lumetra Medicare Operations
     One Sansome St., #600
     San Francisco, CA 94104-4488
     Phone: 1-800-841-1602
• **Expedited Appeal through Secure Horizons:** If the enrollee missed the deadline for an immediate appeal to the QIO, the enrollee may request an expedited appeal from Secure Horizons by calling Secure Horizons Member Services Department at (800) 228-2144.

• The enrollee may obtain additional information about appeals by contacting the health plan or calling 1-800-MEDICARE (1-800-633-4227), or TTY/TDD: 1-877-486-2048

E. **Discharge Planning Process**

Discharge planning is the identification, documentation and coordination of a Member’s anticipated needs for a safe and appropriate discharge. Early identification of any social, financial, or physical issues that may delay or complicate discharge is essential in the discharge planning process.

Discharge planning should begin at the time of admission and no later than 24 hours after admission.

A comprehensive discharge plan includes, but is not limited to:

- Evaluating available support and assistance, financial, home health, medication and DME needs that will be required upon discharge.

- Arranging multi-disciplinary meeting as needed, which includes Member and family where appropriate in the process and planning.

- Developing and implementing an appropriate and comprehensive discharge plan.

- Documenting and communicating the discharge plan to all relevant parties, (SNF Clinical Team, PacifiCare, Member, and family).

- Anticipating and obtaining authorizations for all post-discharge needs.

- Ensuring patient and family understand discharge orders and post-discharge care requirements.

- Making referrals to PacifiCare’s Case Management, community-based and Disease Management Programs, as applicable to the Member.

The attending physician is required to facilitate discharge planning by...
documenting the Member’s anticipated discharge position (home, custodial or other) and any services the Member may require.

PacifiCare’s Concurrent Review Nurse will work with the SNF case managers and discharge planning resources to assist in arranging discharge needs to the Member.
CONTINUITY OF CARE

GUIDELINES
GUIDELINES FOR A CONTINUITY OF CARE PLAN

I. INTRODUCTION

When making a determination that a Secure Horizons (or PacifiCare) Member is a candidate for skilled care, questions must be answered before a transfer can be completed:

♦ What is the current condition and functional level of the Member?
♦ What skilled care is required to achieve the Member’s maximum, potential function?
♦ What is the predicted length of time necessary for the Member to reach an optimal level of function?
♦ Is the care and observation medically necessary for 24 hours a day?
♦ What is the likely potential for the Member’s status to deteriorate without skilled care?

A. In order to answer these questions, staff from many disciplines and various agencies must get involved in the assessment and analysis of the Member. To ensure a smooth transition of the Member to a change in level of care, the participating medical group and ancillary care facilities, such as a skilled nursing facility, acute rehabilitation, or board and care facility, must work closely together.

Care Plan -- As part of the transition process, a comprehensive written continuity of care plan must be developed PRIOR to the discharge of the Member to a lower level of care or to arrange a change in the level of care. The participating medical group is responsible to work with key individuals from the discharging facility:

♦ Discharge Planners
♦ Case Managers
♦ Physician Overseeing Member’s Care

The input of these individuals, especially the discharging physician’s written orders, should be incorporated into the overall care plan.

B. The participating medical group is responsible for:

1. Developing and implementing the care plan
2. Overseeing and evaluating the Member’s progress
3. Monitoring and re-evaluating the appropriateness of the Member’s level of care on a regular basis

4. Documenting each step of the care plan and the Member’s progress in the permanent medical record (located wherever the Member is residing) or overseeing the documentation by the appropriate provider

C. The process of developing a continuity of care plan involves many different considerations, which, taken together, are designed to assure that the Member obtains appropriate care and that the level of care is timely and specific to the Member’s needs.

Developing the continuity of care plan is an evolutionary process with six distinct steps:

1. Identification of Member

2. Assessment of Member

3. Development of the Continuity of Care Plan

4. Implementation of Plan and Coordination of Services

5. On-going Monitoring and Reevaluation of the Plan

6. Documentation in the Medical Record

Each of these steps must be considered as an important element in determining the Member’s level of care. Each one must be explored completely with all Members of the health team as well as the Member and Member’s family.

These elements are explained more fully in the following flow process.

**CONTINUITY OF CARE PLAN FLOW PROCESS**

<table>
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<tr>
<th>SIX CONSIDERATIONS</th>
<th>ELEMENTS</th>
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| 1. **Identify Member** | **Demographics** [Including age, sex, home address, marital status, etc.]

**Eligibility** [Ensure that Membership is active and up-to-date]

**Criteria** [See Section II for Level of Care] |

(May be transferring from acute care to... |
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<th>SIX CONSIDERATIONS</th>
<th>ELEMENTS</th>
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<td>skilled nursing or skilled service at home, from skilled nursing to home, from home to skilled nursing, from lower level of care to skilled services or to home.)</td>
<td>Guidelines</td>
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2. **Assess Member**  
   Physical  
   Mental/Cognitive  
   Psycho/social  
   (Must be completely performed to adequately plan to meet goals for satisfactory outcomes.)

| | **Past Medical History and Pre-morbid Status**  
| Functional Level of abilities at time of current illness or injury |
| **Current Medical Condition**  
Include all chronic conditions |
| **Current Medications/History** |
| **Physical Condition/Functional Limitations**  
such as:  
- Musculo-neurological impairment, (upper or lower motor-neuron disease, skeletal deficit)  
- Sensory impairment, sight, hearing, skin sensation or proprioception  
- Cognitive impairment, including judgment and loss of body awareness  
- Communication impairment, expressive or receptive aphasia, articulation, or swallowing problems |
| **Psycho/Social Screen**  
Include: Family, Home Environment review, Alternative Care options such as family training/support, community resources, Adult Day Care, Home Health Services, Available benefits, as well as needs for non-covered benefits |
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<th>SIX CONSIDERATIONS</th>
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| 3. Develop Written Care Plan with Multidisciplinary Assessments | Include physician’s anticipated needs for skilled or home care for Member  
Determine short and long term goals and whether patient, family and physician agree  
Evaluate need for skilled services. Include specific needs for skilled nursing and rehabilitation services. [Physical, occupational, speech therapies, psycho/social counseling and respiratory therapy if indicated]  
Identify need for long-term care  
Consider all resources available to Member including family, friends, community resources |
| 4. Implement and Coordinate Services | Inform all parties of completion of plan  
Put plan into action by transferring Member to location decided upon  
Look for opportunities to intervene to improve Member’s health status |
| 5. Monitor and Re-evaluate | Watch for changes in condition or status that would require consideration of another level of care  
Monitor all outcomes until condition becomes static or improved  
Be aware that a custodial status can be changed to a skilled level |
| 6. Document in Medical Records | All baseline evaluations and assessments by all disciplines. All changes in condition or status. Each written continuity-of-care plan will include documentation on the following elements:  
For Members discharged from in-patient acute care or skilled nursing facilities to convalescent or residential care: |
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| 6. Document in Medical Records (cont’d) | • Member’s current medical condition, including diagnosis and co-morbid conditions  
• Member’s current functional status, including a thorough assessment of Member’s sensory, motor and cognitive abilities  
• Medications and medication regimen  
• Name and phone number of primary care physician and/or participating medical group contact person  
• Date/timeframe for follow-up visits with primary care physician  
• Assessment of the Member’s covered vs. non-covered needs  
• Consideration of transportation needs, if medically indicated  

For Members discharged from in-patient acute care or skilled nursing facilities to home.  

• Member’s functional status including a thorough assessment of motor, sensory and cognitive abilities  
• Adequacy of home support  
• Member’s and/or caregiver’s ability to perform patient care tasks appropriately  
  • Guidelines for tasks must be described in writing |
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<th>SIX CONSIDERATIONS</th>
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<td>6. Document in Medical Records (cont’d)</td>
<td>- Member or caregiver must be able to acknowledge and demonstrate the ability to carry out the homecare tasks required</td>
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<td>- Assessment of home environment for safety, especially if there is a change in the Member’s functional status during hospitalization</td>
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<td>- Documentation of the alternative care options discussed with Member and/or family</td>
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<td>- Medication requirements should be written, complete with instructions for use</td>
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<td>- Member and/or caregiver must be able to demonstrate ability to carry out the medication regime correctly</td>
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<td>- The name and phone number of the primary care physician or medical contact should be given in writing to the Member and/or caregiver</td>
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<td>- Dates for follow-up visits with all healthcare workers, including physicians, should be given in writing to the Member and/or caregiver</td>
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<td>- Discharge instruction should be in writing and contain all follow-up care needed by the Member</td>
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GUIDELINES FOR PHYSICIAN VISITS TO SKILLED NURSING FACILITIES
Physician Visits to Nursing Facilities

General Requirement

♦ PacifiCare/Secure Horizons requires an assessment of a resident’s functional status at SNF or custodial level of care at the time of admission & periodically thereafter.

SNF Requirements

♦ The facility must ensure that the medical care of each resident is supervised by a physician and another physician supervises the medical care of residents when their attending physician is unavailable.

♦ The facility must provide or arrange for the provision of physician services 24 hours a day, in case of emergency.

Physician Visit Procedures

♦ Initial admission certification requires a complete history and a physical examination and written report by a physician within 48 hours of admission.

♦ If patient is a direct admit from an acute care hospital, a complete history and a physical examination by a physician must be completed 5 days prior to SNF admission and accurately reflect the patient’s current status. The attending physicians must make a follow-up visit within 72 hours of admission.

♦ Subsequent physician exams and written reports must occur at least once every 30 days for the first 90 days following admission then at least once every 60 days thereafter. (Alternative assessment schedules must comply with facility policy.)

♦ A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required.

♦ At the option of the physician, subsequent visits to the patient after the initial visit may be alternated by the physician, a physician assistant (PA), a clinical nurse specialist or nurse practitioner (NP). Visits must be under the supervision of the physician and visits must be made no less than every 30 days.

♦ At no time shall an alternative schedule of visits result in more than 60 days elapsing between physician visits.

Revision Date: November 2004
♦ Under special circumstances such as an episode of acute illness more frequent visits may be necessary.

♦ If review suggests the patient may be appropriately treated at a different level of care or an alternative treatment setting, the SNF personnel should discuss the case with the treatment physician. If a discrepancy occurs, PacifiCare’s Medicare Director or designee should be contacted to allow the discussion of the Member's clinical status and treatment plan with the treating physician.

PMG/IPA Requirements

♦ Onsite physician assessments of SNF and custodial level patients must be provided by the authorizing PMG/IPA. If the PMG/IPA physician is unable to comply with the assessment requirements then the PMG/IPA must be responsible for making alternate physician arrangements.

♦ The skilled nursing facility benefit includes payment for physician visits every 30 days and more frequently for periods of acute illness.
SKILLED NURSING FACILITY (SNF) CARE GUIDELINES

FREQUENTLY ASKED QUESTIONS (FAQ)

Revision Date: November 2004
Frequently Asked Questions

1. **A patient requires daily injections of a medication but is unable to self-administer. Would this alone qualify the patient to remain in a SNF as a skilled service?**

   Direct skilled nursing services include teaching patients to self-administer an injection until the patient is self sufficient. If a patient is unable to administer an injection because of a physical limitation (e.g. cerebral palsy) this becomes a questionable situation depending on the medication needed and the availability or feasibility of providing other alternatives (such as home health). However, an insulin dependent diabetics who receive injections 7 days per week with two or more physician order changes in the past 14 day period of time would always be considered a skilled need.

2. **A patient requires enteral tube feedings on a daily basis. Would this alone, qualify the patient to remain in a SNF as a skilled service?**

   A patient on a nasogastric, gastrostomy or jejunostomy tube must require at least 26% of total daily calories & minimum of 501 ml fluid per day through the tube in order to meet the skilled criteria.

3. **Would a patient who has a Stage 2 decubitus ulcer qualify to remain in a SNF?**

   Treatment of stage 3 or stage 4 decubiti is considered a skilled service. Stage 2 would not meet criteria by itself. However, if the patient needs other non skilled services the patient may be considered skilled as part of the overall care needed by the Member. Taken as a whole, the patient may be considered clinically complex and should be considered for skilled care even if the individual specific services would normally be considered unskilled.

4. **Is an Advance Health Care Directive different from a "living will"?**

   The Advance Health Care Directive allows a patient to do more than the traditional living will, which only states the patient's desire not to receive life-sustaining treatment if he/she becomes terminally ill or permanently unconscious. An Advance Health Care Directive allows you to state your wishes about refusing or accepting life-sustaining treatment in any situation. An Advance Health Care Directive also can be used to state desires about health care in any situation the patient would be unable to make decisions, not just when he/she is in...
a coma or terminally ill. The patient is also able to appoint someone to speak on his/her behalf in case the patient becomes incapacitated.

5. **If a patient has already executed a Durable Power of Attorney for Health Care or a Natural Death Act Declaration, is it still valid and does the patient have to complete a new Advance Health Care Directive?**

Unless an existing Durable Powers of Attorney for Health Care (DPAHC) has expired (executed before 1992) it remains valid. A patient does not have to complete a new Advance Health Care Directive if there is a valid DPAHC.

6. **Is Nursing Home accreditation the same thing as Medicare or Medicaid certification?**

No. The Centers for Medicare & Medicaid Services (CMS) does not recognize nursing home accreditation. Accreditation represents a certification by a private-sector organization (such as the Joint Commission on the Accreditation of Healthcare Organizations or the Long-term Care Evaluation Program) that a nursing home meets certain standards it has established. Accreditation is voluntary for nursing homes and does not affect the home's eligibility to act as a Medicare or Medicaid care provider.

7. **When a Member becomes effective with SH or PacifiCare while in a SNF, when does SH or PacifiCare become financially responsible for the services.**

SH or PacifiCare will be financially responsible for the services (Part A & B) beginning on the Member’s effective date.

8. **When a Member becomes effective with SH while in a SNF, is the Member entitled to another 100-day SNF benefit through SH?**

If the Member was covered by another HMO senior plan or by original Medicare, any SNF days used prior to the SH effective date will apply towards the 100-day benefit.

If the Member was a covered by a Commercial HMO plan, the Member will be entitled to another 100-day.
Additional Information/Resources

Additional information on Skilled Nursing Care is available at the following resources:

- PacifiCare & Secure Horizons Benefit Interpretation policies: *Skilled Nursing Facility (SNF) Care*
- PacifiCare/Secure Horizons Medical Management Guideline: *Skilled Nursing Facility (SNF) Level Selection for Patient Referral*
- PacifiCare & Secure Horizons Policy and Procedure Manuals
- Medicare Skilled Nursing Manual (also available for download)
  http://www.cms.hhs.gov/manuals/12_snf/sn00.asp

If you need further assistance with these guidelines or would like to provide us with feedback, we invite you to contact the Benefit Interpretation Unit (BIU) at the following address and telephone number:

**PacifiCare/Secure Horizons Benefit Interpretation Unit**
Mail Stop: CY44-149
5757 Plaza Drive
Cypress, CA 90630
1-800-329-6606
E-mail: BenefitInterpretation@phs.com

Revision Date: November 2004