

MEDICA®
UTILIZATION MANAGEMENT POLICY

TITLE: SKILLED NURSING FACILITY

EFFECTIVE DATE: August 20, 2018

IMPORTANT INFORMATION – PLEASE READ BEFORE USING THIS POLICY

These services may or may not be covered by all Medica plans. Please refer to the member's plan document for specific coverage information. If there is a difference between this general information and the member's plan document, the member's plan document will be used to determine coverage.

With respect to Medicare and Minnesota Health Care Programs, this policy will apply unless those programs require different coverage.

Medica may use tools developed by third parties, such as MCG Care Guidelines®, to assist in administering health benefits. Medica utilization management (UM) policies and MCG Care Guidelines are not intended to be used without the independent clinical judgment of a qualified health care provider taking into account the individual circumstances of each member's case. Medica UM policies and MCG Care Guidelines do not constitute the practice of medicine or medical advice. The treating health care providers are solely responsible for diagnosis, treatment, and medical advice.

Members may contact Medica Customer Service at the phone number listed on their member identification card to discuss their benefits more specifically. Providers with questions about this Medica UM policy may call the Medica Provider Service Center toll-free at 1-800-458-5512.

PURPOSE

To promote consistency between reviewers in utilization management decision-making by providing the criteria that generally determines the medical necessity of skilled nursing facility admissions and continued stay. The Benefit Considerations box below outlines the process for addressing the needs of individuals who do not meet these criteria.

MEDICAL NECESSITY CRITERIA

For medical necessity criteria, Medica uses MCG™ Care Guidelines, 21st edition, 2017: *Recovery Facility Care (RFC)*.

BENEFIT CONSIDERATIONS

1. Prior authorization **is required** for skilled nursing facility (including an extended care facility, hospital swing-bed, and transitional care unit) admissions. Please see the prior authorization list for product specific prior authorization requirements.
2. Patients who meet criteria for skilled nursing facility admission are approved for continued stay based on medical necessity.
3. Coverage may vary according to the terms of the member's plan document.
Under some contracts, including Medicare, the transfer or admission to the skilled nursing facility must have occurred within 30 calendar days of discharge from a hospital during which the patient was inpatient for not less than three consecutive calendar days, all of which were deemed medically necessary.
4. Swing bed will only be considered for coverage if a skilled nursing facility bed is not available or if the skilled nursing facility cannot meet the member's needs. The member must be transferred to a skilled nursing facility as soon as a bed becomes available.
5. Swing bed will not be approved for coverage if a skilled nursing facility bed is available and able to meet the

- member's needs.
6. For commercial products, charges to hold a bed during a skilled nursing facility absence, due to hospitalization or any other reason, is not covered. The member may choose to pay the skilled nursing facility privately for the bed-hold.
 7. For patients not meeting criteria for skilled nursing facility services, alternative levels of care may be appropriate such as hospice, observational status, or short-term home health services.
 8. Court ordered placement in a skilled nursing facility for chemical dependency, substance abuse, or other behavioral health treatments may require coverage according to the terms of the member's plan document.
 9. The following services are generally excluded from coverage. Refer to member's plan document for details.
 - A. Respite care (sole reason for request)
 - B. Custodial care or supportive care.
 - C. Routine or maintenance medication administration
 10. If the Medical Necessity and Coverage Criteria are met, Medica will authorize benefits within the clinical criteria and day limits in the member's plan document.
 11. If it appears that the Medical Necessity and Coverage Criteria are not met, the individual's case will be reviewed by the medical director or an external reviewer. Practitioners are advised of the appeal process in their Medica Provider Administrative Manual.

- CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS)
- For Medicare members, refer to the following, as applicable at:
 - <http://www.cms.hhs.gov/mcd/search.asp?>
 - Medicare Benefit Policy Manual. Chapter 8: Coverage of Extended Care (SNF) Services Under Hospital Insurance. <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS012673.html>

DOCUMENT HISTORY

Original Effective Date	December 1, 2003
MPC Endorsement Date(s)	09/2004, 09/2005, 09/2006, 09/2007, 09/2008, 09/2009, 09/2010, 09/2011, 09/2012, 09/2013, 09/2014, 02/2015
Began use of MCG™ Care Guidelines	12/01/2015 (19 th edition)
MCG Care Guidelines Edition Updates (<i>Medica Effective Date</i>)	20 th edition: 10/10/2016, 21 st edition: 08/31/2017, 21 st edition reaffirmed: 08/20/2018
Administrative Updates	04/01/2017, 05/01/2017