TITLE: SKILLED NURSING FACILITY

EFFECTIVE DATE: August 31, 2017

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 Coverage Issues box below outlines the process for addressing the needs of individuals who do not meet these criteria.

MEDICAL NECESSITY CRITERIA

COVERAGE ISSUES
1. Prior authorization is required for skilled nursing facility (including an extended care facility, hospital swing-bed, and transitional care unit) admissions.
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. For Medicare members, refer to the following, as applicable:
     of Extended Care (SNF) Services Under Hospital Insurance. Rev. 183, 04-04-14.
     August 19, 2014.
9. 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.
10. 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
11. 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.
12. 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.

DOCUMENT HISTORY

<table>
<thead>
<tr>
<th>Original Effective Date</th>
<th>December 1, 2003</th>
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<tbody>
<tr>
<td>Began use of MCG™ Care Guidelines</td>
<td>12/01/2015 (19th edition)</td>
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<tr>
<td>MCG Care Guidelines Edition Updates (Medica Effective Date)</td>
<td>20th edition: 10/10/2016, 21st edition: 08/31/2017</td>
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<tr>
<td>Administrative Updates</td>
<td>04/01/2017, 05/01/2017</td>
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