CareSource

MEDICAL POLICY STATEMENT
D-SNP

Policy Name & Number	Date Effective
Skilled Nursing Facility Level of Care-DSNP-MM-1325	10/01/2024-03/31/2025
Policy Type	
MEDICAL	

Medical Policy Statement prepared by CareSource and its affiliates are derived from literature based on and supported by clinical guidelines, nationally recognized utilization and technology assessment guidelines, other medical management industry standards, and published MCO clinical policy guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

Medical Policy Statements prepared by CareSource and its affiliates do not ensure an authorization or payment of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced in the Medical Policy Statement. If there is a conflict between the Medical Policy Statement and the plan contract (i.e., Evidence of Coverage), then the plan contract (i.e., Evidence of Coverage) will be the controlling document used to make the determination. According to the rules of Mental Health Parity Addiction Equity Act (MHPAEA), coverage for the diagnosis and treatment of a behavioral health disorder will not be subject to any limitations that are less favorable than the limitations that apply to medical conditions as covered under this policy.

This policy applies to the following Marketplace(s):	
☒ **Georgia**	☒ **Ohio**

Table of Contents

A. Subject
Skilled Nursing Facility

B. Background
Skilled nursing facilities (SNFs) provide professional inpatient skilled nursing services, rehabilitative services, and other health related services. Post-acute care must be considered when a member continues to need medical, nursing, and/or rehabilitative services that can only be managed in the recovery facility environment.

C. Definitions
- **Assistance** – Assistance is defined by CMS as "the hands-on provision of help in the initiation and/or completion of a task." Hands-on help is generally considered to be any aid in which the caregiver makes direct, physical contact with members to provide assistance with tasks, rather than just supervision or cueing.
- **Benefit Period** – For DSNP, up to 100 days in a SNF within a benefit period.. A benefit period begins the day a member goes into a hospital or skilled nursing facility. The benefit period ends when a member has not received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. There is no limit to the number of benefit periods.
- **Clinical Care Reviewer (CCR)** – A clinical professional who reviews clinical information, applies criteria, and evaluates the care needs of a member who needs inpatient or outpatient services that require a prior authorization.
- **Custodial Care** – Institutional care that is below the level of care covered in a SNF and includes personal care that does not require the continuing attention of trained medical or paramedical personnel (eg, assisting a member in activities of daily living, preparation of special diets, supervision of medication that usually can be self-administered.
- **Skilled Nursing Facility (SNF)** – A facility meeting specific regulatory certification requirements that provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.
- **Skilled Nursing Facility Care** – A level of care that requires daily skilled nursing and/or rehabilitation care. Examples of skilled nursing facility care include intravenous injections and physical therapy. The need for custodial care (for example, assistance with activities of daily living, like bathing and dressing) cannot, in itself, qualify a member for Medicare coverage in an SNF. However, if qualifying for coverage based on a need for skilled nursing or rehabilitation, Medicare covers all care needs in the facility including assistance with activities of daily living.

D. Policy
I. CareSource will review all Skilled Nursing Facility requests for admission and continued stays for skilled level of care using the coverage criteria outlined in the CMS *Medicare Benefit Policy Manual, Chapter 8 - Coverage of Extended Care (SNF) Services Under Hospital Insurance* during the benefit period.

A. Skilled Level of Care Criteria for Admission to SNF. CareSource considers skilled care in a nursing facility a covered benefit when any of the following factors have been met:
   1. The member meets the Medicare skilled level of care criteria through review of supporting clinical documentation provided by the SNF or treating hospital.
   2. Skilled nursing and/or skilled rehabilitation are services, furnished according to physician orders that
      i. require the skills of qualified technical or professional health personnel such as registered nurses, licensed practical (vocational) nurses, physical therapists, occupational therapists, and speech-language pathologists or audiologists
      ii. must be provided directly by or under the general supervision of skilled nursing or skilled rehabilitation personnel to assure the safety of the patient and achieve the medically desired result
   3. Skilled care may be necessary to improve a patient's current condition, maintain the patient's current condition or preserve capabilities, or prevent or slow further deterioration of the patient's condition.

B. Services provided are required to treat, manage, observe, and evaluate a member's care. Observation and assessment are skilled services when the likelihood of change in a patient's condition requires skilled nursing or skilled rehabilitation personnel to identify and evaluate the patient's need for possible modification of treatment or initiation of additional medical procedures until the patient's condition is essentially stabilized. For examples, see §30.2.3.2.

II. SNF Interrupted Stay
When a member covered under a Part A SNF stay is discharged from the SNF and returns to the same SNF no more than 3 consecutive calendar days after having been discharged, the SNF stay is considered a continuation of the previous stay. A new prior authorization is not required.

III. Direct Skilled Nursing Services to Patients
Nursing services are considered skilled when so inherently complex that the services can be safely and effectively performed only by or under the supervision of a registered nurse or when provided by regulation, a licensed practical (vocational) nurse. (See 42 CFR § 409.32).

A. If all other requirements for coverage under the SNF benefit are met, skilled nursing services are covered when an individualized assessment of the patient's clinical condition demonstrates that the specialized judgment, knowledge, and skills of a registered nurse or, when provided by regulation, a licensed practical (vocational) nurse are necessary.

B. A condition that does not ordinarily require skilled services may qualify due to special medical complications. Under those circumstances, a service that is usually nonskilled (such as those listed in § 409.33(d)) may be considered skilled, because the service must be performed or supervised by skilled nursing or rehabilitation personnel.

IV. Non-covered services in an SNF
   A. The following items are non-covered services in a SNF:
      1. nonskilled supportive or personal care services unless rendered under circumstance detailed in §§30.2
      2. custodial care

V. Discharge Planning
   In compliance with CMS guideline 42 CFR § 483.21 (c)(1)(2), members will be assessed for discharge planning.
   Upon admission to the SNF, the member will be assessed for discharge planning needs by the SNF staff. The discharge plan will be provided by the SNF when updates are submitted to CareSource.
   When the member no longer meets the medical necessity criteria for **skilled nursing** facility care or skilled benefits are exhausted, the member will be evaluated for discharge to a lower level of care that meets the member's identified care needs which may include but is not limited to, custodial care, home with skilled home care, or a community living setting with needed long-term services and supports.

VI. Termination of Skilled Nursing Facility Services
   A. Notice of Medicare Non-Coverage (NOMNC)**:** In compliance with CMS guidelines 42 CFR 405.1200(b)(1)(2) and 422.624(b)(1)(2), a Medicare provider or health plan must deliver a completed copy of the Notice of Medicare Non-Coverage (NOMNC) to beneficiaries/enrollees receiving SNF services at least 2 calendar days before Medicare covered services end. The 2-day advance notice requirement is not a 48-hour requirement.
   B. A NOMNC is not required to be issued to a member in the following situations:
      1. when a member never received Medicare covered care in the SNF setting
      2. when services are reduced (e.g., physical therapy is discontinued but the member continues to require SNF care for treatment of an infection with IV antibiotics)
      3. when a member is admitted to a higher level of care (eg, admitted to a hospital)
      4. when a member exhausts benefits (e.g., a member reaches 100 days of coverage in the SNF during the benefit period)
      5. when a member transfers to another SNF at the same level of care (e.g., member transfers from 1 SNF to another with an authorization in place for a skilled level of care in the new SNF)
      Note: If a member requests coverage of skilled nursing facility services in any of the situations listed, CareSource must issue to the member the CMS Notice of Denial of Medical Coverage.
         a. When CareSource issues the Notice of Medicare Non-Coverage, the SNF provider is required to deliver the notice to the member.
         b. CareSource will provide the notice to the SNF no later than 2 calendar days prior to the last day of covered services.
         c. The SNF must deliver the NOMNC to the member/member representative on the day the NOMNC is issued.

d. The SNF should return the member/member representative signed or acknowledged copy of the NOMNC to CareSource to validate delivery of the notice.

6. When the SNF issues the Notice of Medicare Non-Coverage, the SNF must deliver the notice to the member/member representative within 2 calendar days of last day of covered services. Expedited Reviews/Fast Track Appeals: Enrollees are eligible to request an expedited review/fast track appeal to the CMS Quality Improvement Organization (BFCC-QIO) upon notification of a determination to terminate skilled services. When an enrollee exercises their right to an expedited review/ fast track appeal, the Detailed Explanation of Non-Coverage (DENC) is provided to the member per the CMS Chapter 10, Parts C & D Enrollees Grievances, Organization/Coverage Determinations, and Appeals Guidance.
   a. Upon receipt of the expedited review/fast track appeal notice from the BFCC-QIO, CareSource will request a copy of the signed/acknowledged NOMNC from the SNF if not already provided and create the DENC.
   b. CareSource will provide a copy of the DENC to the SNF to deliver to the member/member representative as soon as possible but no later than close of business on that day of the appeal notice from the BFCC-QIO.
   c. CareSource will upload the signed/acknowledged NOMNC, DENC and supporting clinical documentation requested by the BFCC-QIO to the appropriate site as directed in the expedited review request letter.
   d. CareSource will implement the outcome of the expedited review/fast track appeal upon notification from the BFCC-QIO.

E. Conditions of Coverage

NA

F. Related Policies/Rules

Medical Necessity Determinations

G. Review/Revision History

	DATE	ACTION
Date Issued	07/17/2024	New Policy. Approved at Committee.
Date Revised		
Date Effective	10/01/2024	
Date Archived	03/31/2025	This Policy is no longer active and has been archived. Please note that there could be other Policies that may have some of the same rules incorporated and CareSource reserves the right to follow CMS/State/NCCI guidelines without a formal documented Policy.

H. References

1. 1055 - Level of Care Procedure Policy. CareSource; 2023.
2. Comprehensive Person-Centered Care Planning, 42 C.F.R. § 483.21 (2023).
3. Form instructions for the Notice of Medicare Non-Coverage (NOMNC) CMS-10123.

The MEDICAL Policy Statement detailed above has received due consideration as defined in the MEDICAL Policy Statement Policy and is approved.

Centers for Medicare & Medicaid Services. Accessed June 12, 2024. https://www.cms.gov/medicare/medicare-general-information/bni/downloads/instructions-for-notice-of-medicare-non-coverage-nomnc.pdf
4. Long term services & supports. Centers for Medicare & Medicaid Services. Accessed June 12, 2024. www.cms.gov
5. *Medicare Benefit Policy Manual, VIII: Coverage of Extended Care (SNF) Services Under Hospital Insurance*. Centers for Medicare & Medicaid Services; 2023. Accessed June 12, 2024. www.cms.gov
6. *Medicare Benefit Policy Manual, XVI: General Exclusions from Coverage*. Centers Medicaid & Medicare Services; 2014. Accessed June 12, 2024. www.cms.gov
7. *Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeal Guidance*. Centers for Medicare & Medicaid Services; 2022. Accessed June 12, 2024. www.cms.gov