Coverage Summary

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

Approved by: UnitedHealthcare Medicare Benefit Interpretation Committee  Last Review Date: 05/16/2017

Related Medicare Advantage Policy Guideline:
Hospital and Skilled Nursing Facility Admission Diagnostic Procedures (NCD 70.5)

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The benefit information in this Coverage Summary is based on existing national coverage policy, however Local Coverage Determinations (LCDs) may exist and compliance with these policies is required where applicable.

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I. COVERAGE

Coverage Statement: Inpatient skilled nursing facility care (up to 100 days per benefit period) including room and board, skilled nursing care and other customarily provided services in a Medicare
Guidelines/Notes:
1. Skilled Nursing Facility (SNF) Care
   a. Coverage Factors - Care in a Skilled Nursing Facility (SNF) is covered if all of the following four factors are met:
      1) The patient requires skilled nursing services or skilled rehabilitation services, i.e., services that must be performed by or under the supervision of professional or technical personnel; are ordered by a physician and the services are rendered for a condition for which the patient received inpatient hospital services or for a condition that arose while receiving care in a SNF for a condition for which he received inpatient hospital services.
      Skilled nursing and/or skilled rehabilitation services are those services, furnished pursuant to physician orders, that:
         • Require the skills of qualified technical or professional health personnel such as registered nurses, licensed practical (vocational) nurses, physical therapists, occupational therapists, and speech-language pathologists or audiologists; and
         • Must be provided directly by or under the general supervision of these skilled nursing or skilled rehabilitation personnel to assure the safety of the patient and to achieve the medically desired result.
      NOTE: “General supervision” requires initial direction and periodic inspection of the actual activity. However, the supervisor need not always be physically present or on the premises when the assistant is performing services.
      Skilled care may be necessary to improve a patient’s current condition, to maintain the patient’s current condition, or to prevent or slow further deterioration of the patient’s condition.
      2) These skilled services are required on a daily basis:
      Skilled nursing services or rehabilitation services (or a combination of these services) must be needed by the member and provided for the member on a “daily basis,” i.e., on essentially a 7-days-a-week basis. A member whose inpatient stay is based solely on the need for skilled rehabilitation services would meet the “daily basis” requirement when they need and receive those services on at least 5 days a week. (If therapy services are provided less than 5 days a week, the “daily” requirement would not be met.)
      This requirement should not be applied so strictly that it would not be met merely because there is an isolated break of a day or two during which no skilled rehabilitation services are furnished and discharge from the facility would not be practical.
      EXAMPLE: A patient who normally requires skilled rehabilitation services on a daily basis may exhibit extreme fatigue, which results in suspending therapy sessions for a day or two. Coverage may continue for these days since discharge in such a case would not be practical.
      In instances when a patient requires a skilled restorative nursing program to positively affect his functional well-being, the expectation is that the program be rendered at least 6 days a week. (Note that when a patient’s skilled status is based on a restorative program, medical evidence must be documented to justify the services. In most instances, it is expected that a skilled restorative program will be, at most, only a few
The daily basis requirement can be met by furnishing a single type of skilled service every day, or by furnishing various types of skilled services on different days of the week that collectively add up to “daily” skilled services. However, arbitrarily staggering the timing of various therapy modalities though the week, merely in order to have some type of therapy session occur each day, would not satisfy the SNF coverage requirement for skilled care to be needed on a “daily basis.” To meet this requirement, the patient must actually need skilled rehabilitation services to be furnished on each of the days that the facility makes such services available.

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

3) As a practical matter, considering economy and efficiency, the daily skilled services can be provided only on an inpatient basis in a SNF.

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

4) The services delivered are reasonable and necessary for the treatment of a patient’s illness or injury, i.e., are consistent with the nature and severity of the individual’s illness or injury, the individual’s particular medical needs, and accepted standards of medical practice. The services must also be reasonable in terms of duration and quantity.

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

Coverage of nursing care and/or therapy to perform a maintenance program does not turn on the presence or absence of an individual’s potential for improvement from the nursing care and/or therapy, but rather on the beneficiary’s need for skilled care.

See the Medicare Benefit Policy Manual, Chapter 8, §30 - Skilled Nursing Facility Level of Care - General. (Accessed April 11, 2017)

b. Principles for Determining Whether a Service is Skilled

- If the inherent complexity of a service prescribed for a patient is such that it can be performed safely and/or effectively only by or under the general supervision of skilled nursing or skilled rehabilitation personnel, the service is a skilled service; e.g., the administration of intravenous feedings and intramuscular injections; the insertion of suprapubic catheters; and ultrasound, shortwave, and microwave therapy treatments.

- The Health Plan considers the nature of the service and the skills required for safe and effective delivery of that service in deciding whether a service is a skilled service. While a patient’s particular medical condition is a valid factor in deciding if skilled services are needed, a patient’s diagnosis or prognosis should never be the sole factor in deciding that a service is not skilled.

For specific examples, see the Medicare Benefit Policy Manual, Chapter 8, §30.2.2 - Principles for Determining Whether a Service is Skilled. (Accessed April 11, 2017)

c. Documentation to Support Skilled Care Determinations

Claims for skilled care coverage need to include sufficient documentation to enable a reviewer to determine whether—

a. Skilled involvement is required in order for the services in question to be furnished safely and effectively; and

b. The services themselves are, in fact, reasonable and necessary for the treatment of a patient’s illness or injury, i.e., are consistent with the nature and severity of the individual’s illness or injury, the individual’s particular medical needs, and accepted standards of medical practice. The documentation must also show that the services are appropriate in terms of duration and quantity, and that the services promote the documented therapeutic goals.

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

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

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

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

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

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

See the Medicare Benefit Policy Manual, Chapter 8, §30.2.2.1 – Documentation to Support Skilled Care Determinations. (Accessed April 11, 2017)

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

1) Management and Evaluation of a Patient Care Plan

The development, management, and evaluation of a patient care plan, based on the physician’s orders and supporting documentation, constitute skilled nursing services when, in terms of the patient’s physical or mental condition, these services require the involvement of skilled nursing personnel to meet the patient’s medical needs, promote recovery, and ensure medical safety. However, the planning and management of a treatment plan that does not involve the furnishing of skilled services may not require skilled nursing personnel; e.g., a care plan for a patient with organic brain syndrome who requires only oral medication and a protective environment. The sum total of non skilled services would only add up to the need for skilled management and evaluation when the condition of the beneficiary is such that there is an expectation that a change in condition is likely without that intervention.

The patient’s clinical record may not always specifically identify “skilled planning and management activities” as such. Therefore, in this limited context, if the documentation of the patient’s overall condition substantiates a finding that the patient’s medical needs and safety can be addressed only if the total care, skilled or not, is planned and managed by skilled nursing personnel, it is appropriate to infer that skilled management is being provided, but only if the record as a whole clearly establishes that there was a likely potential for serious complications without skilled management, as illustrated in the following Examples.

For specific examples, see the Medicare Benefit Policy Manual, Chapter 8, §30.2.3.1 - Management and Evaluation of a Patient Care Plan. (Accessed April 11, 2017)

2) Observation and Assessment of Patient’s Condition

Observation and assessment are skilled services when the likelihood of change in a patient’s condition requires skilled nursing or skilled rehabilitation personnel to identify and evaluate the patient’s need for possible modification of treatment or initiation of additional medical procedures, until the patient’s condition is essentially stabilized.

For specific examples, see the Medicare Benefit Policy Manual, Chapter 8, §30.2.3.2 - Observation and Assessment of Patient’s Condition. (Accessed April 11, 2017)

3) Teaching and Training Activities

Teaching and training activities, which require skilled nursing or skilled rehabilitation personnel to teach a patient how to manage their treatment regimen, would constitute skilled services.

For specific examples, see the Medicare Benefit Policy Manual, Chapter 8, §30.2.3.3 - Teaching and Training Activities. (Accessed April 11, 2017)

See specific examples in the Medicare Benefit Policy Manual, Chapter 8, §30.2.3 - Specific Examples of Some Skilled Nursing or Skilled Rehabilitation Service. (Accessed April 11, 2017)
e. **Direct Skilled Nursing to Patients**

Nursing services are considered skilled when they are so inherently complex that they can be safely and effectively performed only by, or under the supervision of, a registered nurse or, when provided by regulation, a licensed practical (vocational) nurse. (See 42CFR §409.32) If all other requirements for coverage under the SNF benefit are met, skilled nursing services are covered when an individualized assessment of the patient’s clinical condition demonstrates that the specialized judgment, knowledge, and skills of a registered nurse or, when provided by regulation, a licensed practical (vocational) nurse are necessary. Skilled nursing services would be covered where such skilled nursing services are necessary to maintain the patient’s current condition or prevent or slow further deterioration so long as the beneficiary requires skilled care for the services to be safely and effectively provided, and all other requirements for coverage under the SNF benefit are met. Coverage does not turn on the presence or absence of an individual’s potential for improvement from nursing care, but rather on the beneficiary’s need for skilled care.

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

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

Some examples of direct skilled nursing services are:

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

- Initial phases of a regimen involving administration of medical gases such as bronchodilator therapy; and
- Care of a colostomy during the early post-operative period in the presence of associated complications. The need for skilled nursing care during this period must be justified and documented in the patient’s medical record.

See the Medicare Benefit Policy Manual, Chapter 8, §30.3 – Direct Skilled Nursing Services to Patients. (Accessed April 11, 2017)

f. Direct Skilled Therapy Services

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

Coverage for such skilled therapy services does not turn on the presence or absence of a beneficiary’s potential for improvement from therapy services, but rather on the beneficiary’s need for skilled care. Therapy services are considered skilled when they are so inherently complex that they can be safely and effectively performed only by, or under the supervision of, a qualified therapist. (See 42CFR §409.32) These skilled services may be necessary to improve the patient’s current condition, to maintain the patient’s current condition, or to prevent or slow further deterioration of the patient’s condition.

If all other requirements for coverage under the SNF benefit are met, such skilled therapy services are covered when an individualized assessment of the patient’s clinical condition demonstrates that the specialized judgment, knowledge, and skills of a qualified therapist are necessary for the performance of the rehabilitation services.

See the Medicare Benefit Policy Manual, Chapter 8, §30.4 - Direct Skilled Therapy Services to Patients. (Accessed April 11, 2017)

1) Skilled Physical Therapy

Skilled physical therapy services must meet all of the following conditions:

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

- The services must be considered under accepted standards of medical practice to be specific and effective treatment for the patient’s condition; and
- The services must be reasonable and necessary for the treatment of the patient’s condition; this includes the requirement that the amount, frequency, and duration of the services must be reasonable.

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

**EXAMPLE 2:**
A patient with congestive heart failure also has diabetes and previously had both legs amputated above the knees. Consequently, the patient does not have a reasonable potential to achieve ambulation, but still requires daily skilled physical therapy to learn bed mobility and transferring skills, as well as functional activities at the wheelchair level. If the patient has a reasonable potential for achieving those functions in a reasonable period of time in view of the patient’s total condition, the physical therapy services are reasonable and necessary and must be documented in the medical record (see §30.2.2.1 of the Medicare Benefit Policy Manual, Chapter 8).

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

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

**Some of the more common skilled physical therapy modalities and procedures are:**

**a) Assessment**
The skills of a physical therapist are required for the ongoing assessment of a patient’s rehabilitation needs and potential. Skilled rehabilitation services concurrent with the management of a patient’s care plan 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, due either to the type of exercise employed or to the condition of the patient.

**c) Gait Training** Gait evaluation and training furnished to a patient whose ability to
walk has been impaired by neurological, muscular, or skeletal abnormality often require the skills of a qualified physical therapist.

Repetitious exercises to improve gait, or to maintain strength and endurance, and assistive walking can be appropriately provided by supportive personnel, e.g., aides or nursing personnel, and would not necessarily require the skills of a physical therapist. Thus, such services are not inherently skilled. However, see §30.2.2. Of the Medicare Benefit Policy Manual, Chapter 8 (#1.b - Principles for Determining Whether a Service is Skilled above) for the specific circumstances in which an ordinarily non skilled service can nevertheless be considered skilled.

Documentation of the patient’s condition in the medical record must describe the circumstances which delineate the need for skilled rather than unskilled services during gait training.

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, the degree to be restored and the impact on mobility and/or function).

Generally, range of motion exercises which are not related to the restoration of a specific loss of function may be provided safely by supportive personnel, such as aides or nursing personnel, and as such would not necessarily require the skills of a physical therapist. Passive exercises to maintain range of motion in paralyzed extremities that can be carried out by aides or nursing personnel would not be considered skilled care. However, see §30.2.2 of the Medicare Benefit Policy Manual, Chapter 8 (#1.b - Principles for Determining Whether a Service is Skilled above) for the specific circumstances in which an ordinarily non skilled service can nevertheless be considered skilled. Documentation of the patient’s condition in the medical record must describe the circumstances which delineate the need for skilled rather than unskilled services during range of motion training.

e) **Maintenance Therapy**

Therapy services in connection with a maintenance program are considered skilled when they are so inherently complex that they can be safely and effectively performed only by, or under the supervision of, a qualified therapist. (See 42CFR §409.32) If all other requirements for coverage under the SNF benefit are met, skilled therapy services are covered when an individualized assessment of the patient’s clinical condition demonstrates that the specialized judgment, knowledge, and skills of a qualified therapist are necessary for the performance of a safe and effective maintenance program. Such a maintenance program to maintain the patient’s current condition or to prevent or slow further deterioration is covered so long as the beneficiary requires skilled care for the safe and effective performance of the program. When, however, the individualized assessment does not demonstrate such a necessity for skilled care, including when the performance of a maintenance program does not require the skills of a therapist because it could safely and effectively be accomplished by the patient or with the assistance of non-therapists, including unskilled caregivers, such maintenance services do not constitute a covered level of care.

A service is not considered a skilled therapy service merely because it is furnished
by a therapist or by a therapist/therapy assistant under the direct supervision of a
therapist. If a service can be self-administered or safely and effectively furnished by
an unskilled person, without the direct supervision of a therapist, the service cannot
be regarded as a skilled therapy service even when a therapist actually furnishes the
service. Similarly, the unavailability of a competent person to provide a non-skilled
service, regardless of the importance of the service to the patient, does not make it a
skilled service when a therapist furnishes the service.

However, even though it would not otherwise require the skills of a therapist, the
performance of a maintenance program may nevertheless require such skills under
certain circumstances. Specifically, skilled therapy services are necessary for the
performance of a safe and effective maintenance program only when (a) the
particular patient’s special medical complications require the skills of a qualified
therapist to perform a therapy service that would otherwise be considered non-
skilled; or (b) the needed therapy procedures are of such complexity that the skills
of a qualified therapist are required to perform the procedure.

If the specialized knowledge and judgment of a qualified therapist are required, the
establishment or design of a maintenance program by a qualified therapist, the
instruction of the beneficiary or appropriate caregiver by a qualified therapist
regarding a maintenance program, and the necessary periodic reevaluations by a
qualified therapist of the beneficiary and maintenance program are considered
skilled therapy services, to the extent provided by regulation.

EXAMPLE: A patient with Parkinson’s disease may require the services of a
physical therapist to determine the type of exercises that are required to maintain
his present level of function. The initial evaluation of the patient’s needs, the
designing of a maintenance program which is appropriate to the capacity and
tolerance of the patient and the treatment objectives of the physician, the instruction
of the patient or supportive personnel (e.g., aides or nursing personnel) in the
carrying out of the program, would constitute skilled physical therapy and must be
documented in the medical record (see §30.2.2.1 of the Medicare Benefit Policy
Manual, Chapter 8).

While a patient is receiving a skilled physical therapy program, the physical
therapist should regularly reevaluate the patient’s condition and adjust any exercise
program the patient is expected to carry out independently or with the aid of
supportive personnel to maintain the function being restored. Consequently, by the
time it is determined that no further skilled therapy services are needed, i.e., by the
end of the last skilled session, the physical therapist will have already designed any
maintenance program required and instructed the patient or supportive personnel in
the carrying out of the program.

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

g) Hot Packs, Infra-Red Treatments, Paraffin Baths, and Whirlpool Baths
Heat 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. There must be clear documentation in the medical record of the special medical complications that describe the need for the skilled therapy provided by the therapist.

See the Medicare Benefit Policy Manual, Chapter 8, §30.4.1 Skilled Physical Therapy. (Accessed April 11, 2017)

2) Speech-Language Pathology; see the Medicare Benefit Policy Manual, Chapter 1, §110 Inpatient Rehabilitation Facility (IRF) Services. (Accessed April 11, 2017)

3) Occupational Therapy; see the Medicare Benefit Policy Manual, Chapter 1, §110 Inpatient Rehabilitation Facility (IRF) Services. (Accessed April 11, 2017)

2. Three-Day Prior Hospitalization

The Original Medicare required three (3) consecutive hospital days stay before transferring to a SNF is waived for UnitedHealthcare Medicare Advantage members.

For Medicare’s requirement information, see the Medicare Benefit Policy Manual, Chapter 8, §20.1 - Three-Day Prior Hospitalization. (Accessed April 11, 2017)

3. Benefit Period (Spell of Illness)

- Inpatient skilled care and services are covered for up to 100 days per benefit period. (See Section II for the definition of Benefit Period.) If a member’s coverage begins while in a SNF, any SNF days used in that benefit period prior to the member’s effective date will apply toward the 100-day benefit. While an inpatient in a SNF, should the member be admitted to an acute care hospital for an illness related to the original problem or a new diagnosis, the consecutive days will stop temporarily until the member is transferred back to the SNF.

- If a member is discharged from a SNF and within 60 days requires readmission to the SNF, the member must use the existing benefit period.
  - It is important to note that a benefit period (spell of illness) cannot end while a beneficiary is an inpatient of a hospital, even if the hospital does not meet all of the requirements that are necessary for starting a benefit period. Similarly, a benefit period cannot end while a beneficiary is an inpatient of a SNF, as defined below. (Meaning a new benefit period cannot be started)
  - For a member to have a new benefit period: to end a benefit period, a beneficiary cannot have been an inpatient of a hospital nor a SNF for at least 60 consecutive days; where SNF is defined as a facility which is primarily engaged in providing skilled nursing care and related services to residents who require medical or nursing care, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons.
  - An individual may be discharged from and readmitted to a hospital or SNF several times during a benefit period and still be in the same benefit period of 60 consecutive days have not elapsed between discharge and readmission. The stays need not be for related physical or mental conditions.

See the Medicare General Information, Eligibility and Entitlement Manual, Chapter 3, §10.4 - Benefit Period (Spell of Illness). (Accessed April 11, 2017)

Note: When a member changes membership (i.e., from one MA plan to a UHC MA plan, or from one UHC MA plan to another UHC MA plan) while in the middle of SNF admission, the member
does not automatically get a new 100-day benefit. The member continues on with the benefit period started with the previous plan and the member must meet all the SNF coverage criteria and requirements to begin a new benefit period.

4. **Medicare SNF Coverage Guidelines Under PPS - Covered Services under Part A**

Under SNF PPS, covered SNF services include post-hospital SNF services for which benefits are provided under Part A (the hospital insurance program) and all items and services which, prior to July 1, 1998, had been paid under Part B (the supplementary medical insurance program) but furnished to SNF residents during a Part A covered stay other than the following:

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

b. Certain dialysis-related services;

c. Erythropoietin (EPO) for certain dialysis patients;

d. Hospice care related to a terminal condition;

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

f. Ambulance transportation related to dialysis services;

g. Certain services involving chemotherapy and its administration;

h. Radioisotope services;

i. Certain customized prosthetic devices; and

j. Services furnished during 1998 only, the transportation costs of electrocardiogram equipment for electrocardiogram test services.

**Note:** These services can be considered for payment separately under Part B during a covered Part A SNF stay since items a. through j. are excluded from the PPS consolidated billing methodology.

For information regarding hospice coverage see the [Coverage Summary for Hospice Services](#)


5. **Members who exhaust their SNF benefits while inpatient or in a skilled nursing facility (SNF) are entitled to coverage of certain services under Part B.**

These services and supplies would continue to be covered until a new benefit period begins or they are no longer considered to be medically necessary or reasonably necessary for the diagnosis and treatment of the member’s illness/injury. Examples include, but are not limited to:

a. Diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests

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

c. Prosthetic devices (other than dental) which replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices (Example: Accessories and supplies used directly with an enteral or parenteral device (e.g., catheters, filters, extension tubing, infusion bags, pumps, IV poles, needles, syringes,
dressings, tape, flushing solutions, volumetric monitors, and parenteral and enteral nutrient solutions)

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

e. Outpatient physical therapy, outpatient speech language pathology services, and outpatient occupational therapy

Note: Therapy services are payable under the Physician Fee Schedule when furnished by 1) a provider to its outpatients in the patient’s home; 2) a provider to patients who come to the facility’s outpatient department; 3) a provider to inpatients of other institutions, or 4) a supplier to patients in the office or in the patient’s home. Coverage includes therapy services furnished by participating hospitals and SNFs to their inpatients who have exhausted Part A inpatient benefits or who are otherwise not eligible for Part A benefits. Providers of therapy services that have inpatient facilities, other than participating hospitals and SNFs, may not furnish covered therapy services to their own inpatients. However, since the inpatients of one institution may be considered the outpatients of another institution, all providers of therapy services may furnish such services to inpatients of another health facility.

See the Medicare Benefit Policy Manual, Chapter 15, §220.1.4 - Requirement That Services Be Furnished on an Outpatient Basis. (Accessed April 11, 2017)

f. Surgical dressings, splints and casts, and other devices used for reduction of fractures and dislocations;

g. Physician, Physician Nurse Practitioner or Clinical Nurse Specialist services (usually billed to part B)

h. Screening mammography services

i. Screening pap smears and pelvic exams;

j. Influenza, pneumococcal pneumonia, and hepatitis B vaccines

k. Some colorectal screening

l. Diabetes self-management (e.g., diabetic supplies and equipment including blood glucose monitors, strips and lancets)

m. Prostate screening; also see the Coverage Summary for Preventive Health Services and Procedures

n. Ambulance services

o. Hemophilia clotting factors

p. Epoetin Alfa (EPO) for ESRD beneficiaries when given in conjunction with dialysis.

See the Medicare Benefit Policy Manual, Chapter 15, §250 - Medical and Other Health Services Furnished to Inpatients of Hospitals and Skilled Nursing Facilities. (Accessed April 11, 2017)

Also see the Medicare Benefit Policy Manual, Chapter 8, §70 - Medical and Other Health Services Furnished to SNF Patients. (Accessed April 11, 2017)

6. The following are services not covered when member has exhausted the SNF benefit:

a. SNF fees (room and board)

b. DME is not covered after a member exhausts the 100-day benefit (per spell of illness), or is determined to be at a custodial level of care and resides in an institution or distinct part of
an institution that is an acute hospital or skilled nursing facility. Some examples of DME items are oxygen, front-wheeled walkers, standard wheelchairs and hospital beds. **Exception:** The UnitedHealthcare Nursing Home Plan makes separate payment for certain DME while a member is on a Part A benefit and reimburses for certain DME items under Part B when a member is not receiving skilled care. All items must meet Medicare coverage criteria in order to be covered. **Contact the Customer Service Department to determine if member is enrolled in the UnitedHealthcare Nursing Home Plan.**

**Note:** For purposes of rental and purchase of DME a member’s home may be his/her own dwelling, an apartment, a relative’s home, a home for the aged, or some other type of institution. However, an institution may not be considered a beneficiary’s home if it:

- Meets at least the basic requirement in the definition of a hospital, i.e., it is primarily engaged in providing by or under the supervision of physicians, to inpatients, diagnostic and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, and sick persons, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons; or

- Meets at least the basic requirement in the definition of a skilled nursing facility, i.e., it is primarily engaged in providing to inpatients skilled nursing care and related services for patients who require medical or nursing care, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons.

Therefore, if a member is a patient in an institution or distinct part of an institution which provides the services described in the bullets above, the individual is not entitled to have separate Part B payment made for rental or purchase of DME because such an institution may not be considered the member’s individual’s home.

See the Medicare Benefit Policy Manual, Chapter 6, §80 - Rental or Purchase of Durable Medical Equipment. (Accessed April 11, 2017)

Also see the Medicare Benefit Policy Manual, Chapter 15, §110 - Durable Medical Equipment. (Accessed April 11, 2017)

7. The following are examples of non-covered services, but are not limited to:
   b. Respite services
   c. Services of a private duty nurse or private duty attendant; see the Medicare Benefit Policy Manual, Chapter 1, §20 - Nursing and Other Services. (Accessed April 11, 2017)

8. **Bed-Hold Charge**

   Charges to the member for admission or readmission to a Skilled Nursing Facility (SNF) are not allowed by Medicare, and will not be covered by UnitedHealthcare Medicare Advantage. However, when temporarily leaving a SNF, a resident member can choose to make bed-hold payments to the SNF. Bed-hold payments are the financial responsibility of the member, and will not be reimbursed or paid by the health plan.

   For more specific information, refer to the Medicare Claims Processing Manual, Chapter 1, §30.1.1 - Provider Charges to Beneficiaries and §30.1.1.1 - Charges to Hold a Bed During SNF Absence. (Accessed April 11, 2017)
9. **Home Skilled Nursing Facility**

An MA plan must provide coverage through a home SNF (defined at 42 CFR § 422.133 (b)) of post-hospital extended care services to members who resided in a nursing facility prior to the hospitalization, provided:

- The member elects to receive the coverage through the home SNF; and
- The home SNF either has a contract with the MAO or agrees to accept substantially similar payment under the same terms and conditions that apply to similar nursing facilities that contract with the MAO.

This requirement also applies if the MAO offers SNF care without requiring a prior qualifying hospital stay.

The post-hospital extended care scope of services, cost-sharing, and access to coverage provided by the home SNF must be no less favorable to the member than post-hospital extended care services coverage that would be provided to the member by a SNF that would be otherwise covered under the MA plan (42 CFR § 422.133 (c)). In particular, in a PPO, in-network cost-sharing applies.

See the Medicare Managed Care Manual, Chapter 4, §10.9 - Return to Enrollee’s Home Skilled Nursing Facility (SNF). (Accessed April 11, 2017)

**IMPORTANT NOTE:** Effective immediately, in accordance with the Supreme Court’s ruling in United States v. Windsor, Medicare Advantage (MA) organizations must cover services in a skilled nursing facility (SNF) in which a validly married same sex spouse resides to the extent that they would be required to cover the services if an opposite sex spouse resided in the SNF.


II. **DEFINITIONS**

**Benefit Period (Spell of Illness):** Period of time for measuring the use of hospital insurance benefits. A benefit period begins with the first day (not included in a previous benefit period) on which a patient is furnished inpatient hospital or skilled nursing facility services by a qualified provider. The benefit period ends with the close of a period of 60 consecutive days during which the patient was neither an inpatient of a hospital nor an inpatient of a SNF. To determine the 60-consecutive-day period, begin counting with the day on which the individual was discharged. Medicare General Information, Eligibility and Entitlement Manual, Chapter 3, §10.4 Benefit Period (Spell of Illness). (Accessed April 11, 2017)

**Custodial Care:** Non-medically necessary personal health care for the purposes of assisting the patient in meeting the requirements of daily living. Does not require the continuing attention of trained medical or paramedical personnel. Medicare Benefit Policy Manual, Chapter 16, §110 - Custodial Care. (Accessed April 11, 2017)

**Hospital:** As defined in Sec. 1861(e) of the Social Security Act, the term “hospital” means an institution which: (1) is primarily engaged in providing, by or under the supervision of physicians, to inpatients (A) diagnostic services and therapeutic services for medical diagnosis, treatment, and care of injured, disabled or sick persons, or (B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons; (2) maintains clinical records on all patients; (3) has bylaws in effect with respect to its staff of physicians; (4) requires every patient to be under the care of a physician; (5)
provides 24-hour nursing services rendered or supervised by a registered professional nurse, and has a licensed practical nurse or registered professional nurse on duty at all times; (6)(A) has in effect a hospital utilization review plan that meets the requirements of the law [§1861(k) of the Act ], and (B) has in place a discharge planning process that meets the requirements of the law [§1861(ee) of the Act].  
(Accessed April 11, 2017)

**Private Duty Nursing Services:** The services provided by a private-duty nurse or other private-duty attendant. Private-duty nurses or private-duty attendants are registered nurses, licensed practical nurses, or any other trained attendant whose services ordinarily are rendered to, and restricted to, a particular patient by arrangement between the patient and the private-duty nurse or attendant. Such persons are engaged or paid by an individual patient or by someone acting on their behalf, including a hospital that initially incurs the costs and looks to the patient for reimbursement for such noncovered services.  *Medicare Benefit Policy Manual, Chapter 1, §20 - Nursing and Other Services.*  
(Accessed April 11, 2017)

**Skilled Nursing Facility:** As defined in *Section 1819(a) of the Social Security Act*, the term “skilled nursing facility” means an institution (or a distinct part of an institution) which (1) is primarily engaged in providing to residents—(A) skilled nursing care and related services for residents who require medical or nursing care, or (B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons, and is not primarily for the care and treatment of mental diseases; (2) has in effect a transfer agreement (meeting the requirements of section 1861(l)) with one or more hospitals having agreements in effect under section 1866; and (3) meets the requirements for a skilled nursing facility described in subsections (b), (c), and (d) of this section.  
(Accessed April 11, 2017)

### III. REFERENCES

See above.

### IV. REVISION HISTORY

05/16/2017  Re-review with the following updates:

Guideline 4 (Medicare SNF Coverage Guidelines Under PPS - Covered Services under Part A):

- Added guideline based on the Medicare Benefit Policy Manual, Chapter 8, §10.2 - Medicare SNF Coverage Guidelines Under PPS.
- Added the following language “These services can be considered for payment separately under Part B during a covered Part A SNF stay since items a. through j. are excluded from the PPS consolidated billing methodology.”
- Added cross reference to the Coverage Summary for Hospice Services.

04/18/2017  Annual review; no updates.

04/19/2016  Annual review with the following updates:

Guideline 6.a – added reference link to the Medicare Benefit Policy Manual Chapter 16 General Exclusions From Coverage, Section 110 Custodial Care

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

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

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

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


10/24/2013 Guideline #1.b Services are required on a daily basis - Updated guidelines based on the Medicare Benefit Policy Manual Chapter 8 - Coverage of Extended Care (SNF) Services Under Hospital Insurance, Section 30.6 Daily Skilled Services Defined.

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

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

Effective immediately, in accordance with the Supreme Court’s ruling in United States v. Windsor, Medicare Advantage (MA) organizations must cover services in a skilled nursing facility (SNF) in which a validly married same sex spouse resides to the extent that they would be required to cover the services if an opposite sex spouse resided in the SNF. Refer to the CMS Memorandum: Impact of United States v. Windsor on Skilled Nursing Facility Benefits for Medicare Advantage Enrollees – Immediate Action Required dated August 29, 2013 at http://hr.cch.com/hld/SNF-Benefits-after-USvWindsorDOMA-decision8-29-13.pdf.


04/29/2013 Annual review with the following updates:

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

04/23/2012 Annual review with the following updates:

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

08/29/2011 Updated Guidelines #4 to include coverage clarification for SNF benefit when a member changes membership while in the middle of SNF admission.

04/26/2011 Annual review; no updates.