



Easy Choice Health Plan

Harmony Health Plan of Illinois

Missouri Care

'Ohana Health Plan, a plan offered by WellCare Health Insurance of Arizona

OneCare (Care1st Health Plan Arizona, Inc.)

Staywell of Florida

WellCare (Arizona, Arkansas, Connecticut, Florida, Georgia, Illinois, Kentucky, Louisiana, Mississippi, Nebraska, New Jersey, New York, South Carolina, Tennessee, Texas)

WellCare Prescription Insurance

WellCare Texan Plus (Medicare – Dallas & Houston markets)

Post-Acute Care

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APPLICATION STATEMENT

The application of the Clinical Coverage Guideline is subject to the benefit determinations set forth by the Centers for Medicare and Medicaid Services (CMS) National and Local Coverage Determinations and state-specific Medicaid mandates, if any.

DISCLAIMER

The Clinical Coverage Guideline (CCG) is intended to supplement certain standard WellCare benefit plans and aid in administering benefits. Federal and state law, contract language, etc. take precedence over the CCG (e.g., Centers for Medicare and Medicaid Services [CMS] National Coverage Determinations [NCDs], Local Coverage Determinations [LCDs] or other published documents). The terms of a member's particular Benefit Plan, Evidence of Coverage, Certificate of Coverage, etc., may differ significantly from this Coverage Position. For example, a member's benefit plan may contain specific exclusions related to the topic addressed in this CCG. Additionally, CCGs relate exclusively to the administration of health benefit plans and are NOT recommendations for treatment, nor should they be used as treatment guidelines. Providers are responsible for the treatment and recommendations provided to the member. The application of the CCG is subject to the benefit determinations set forth by the Centers for Medicare and Medicaid Services (CMS) National and Local Coverage Determinations, and any state-specific Medicaid mandates. Links are current at time of approval by the Medical Policy Committee (MPC) and are subject to change. Lines of business are also subject to change without notice and are noted on www.wellcare.com. Guidelines are also available on the site by selecting the Provider tab, then "Tools" and "Clinical Guidelines".

BACKGROUND

Post-acute care refers to a wide range of services, which include skilled nursing facilities, inpatient rehabilitation facilities, home health aides, outpatient physical and occupational therapy, and long-term care facilities.¹ Medicare spends more than \$59 billion on post-acute care, which has more than doubled since 2001. Discharges to post-acute care facilities have increased nearly 50% during the past 15 years.² Post-acute care is a major contributor to the costs of a hospitalization episode, because 42% of Medicare beneficiaries are discharged from hospitals to post-acute care settings.³

One in five Medicare beneficiaries is readmitted to the hospital within 30 days of discharge. The 90-day readmission rate for skilled nursing facilities (SNF) and Acute Inpatient Rehabilitation Facilities (IRF) are largely equivalent. Skilled nursing facilities (SNFs) represent the most common setting for post-acute care in the United States. Rates of readmission from SNFs are high. One in four patients discharged to a SNF is readmitted within 30 days⁴ and two-thirds of these readmissions may be preventable.⁵ Hence, preventing readmissions is a goal that aligns with CMS expectations that readmissions are an event that can be preventable.

Skilled Nursing Facility (SNF)⁶

A skilled nursing facility (SNF) is an institution (or part of an institution) licensed under state laws and whose primary focus is to provide skilled nursing care and related services for residents requiring medical or nursing care. A SNF may also be a place of rehabilitation services for injured, disabled, or sick members. The following information is a synopsis from the Medicare Benefit Policy Manual. For complete guidance please click [here](#).

Skilled nursing and/or skilled rehabilitation services are services, furnished in accordance physician orders, that:

- A. 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**,
- B. 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.

In order for a nursing service to be considered a “skilled service” it must be a service that it can only be safely and effectively performed by, or under the supervision of, a registered nurse or, when provided by regulation, a licensed practical nurse. 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 nurse are necessary. Skilled nursing services are 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 depend 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 still require skilled nursing 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.

The Medicare law provides for up to 100 days of coverage per benefit period. The benefit period tracks how many days of SNF benefits have been used, and how many are still available. A benefit period begins on the day a member starts using hospital or SNF benefits under Part A of Medicare. A member can get up to 100 days of SNF coverage in a benefit period. Once those 100 days are used, the member’s current benefit period must end before they can renew SNF benefits. A benefit period ends:

- When a member has not been in a SNF or a hospital for at least 60 days in a row; **OR**,
- If a member remains in a SNF when they have not received skilled care there for at least 60 days in a row.

Continued authorization for skilled nursing services will require updated clinical documentation and evidence of ongoing medical necessity or minimal improvement or plateauing of needs as determined by functional status and ability to perform activities of daily living (ADLs).

ADL Scoring - An important part of SNF review is calculating the member's activities of daily living (ADL) score. The score is based on the member's bed mobility, ability to transfer, toileting and eating or feeding. For each of the 4 items the member is scored from 0-4. A score of 0-1 means the member is independent or only requires supervision, 2 means the member requires minimum assistance, 3 is moderate assistance and a score of 4 means the member is totally dependent or requires maximum assistance.

Inpatient Rehabilitation Facility (IRF)⁷

The following information is a synopsis from the Medicare Benefit Policy Manual. For complete guidance please click [here](#).

Inpatient rehabilitation facility services include intense, multidisciplinary programs and rehabilitation therapies in an inpatient rehab hospital setting for patients who are medically complex and have multiple rehab needs. Although an IRF can provide medical management, a patient must complete their full inpatient hospital course of treatment before being appropriate for IRF care. Because of the intensity of the rehabilitation program patients must be able to fully participate and be expected to benefit from services before being transferred. An IRF stay will only be considered reasonable and necessary if, **at the time of admission** to the IRF, the documentation in the patient's IRF medical record indicates a reasonable expectation that the complexity of the patient's nursing, medical management and rehabilitation needs require an inpatient stay and an interdisciplinary team approach for their rehabilitation care. The general goal of IRF treatment is to enable the patient's safe return to the home or community-based environment upon discharge from the IRF. This goal does not require the patient to achieve complete independence in self-care or to return to his or her prior level of functioning in order to be considered successful.

Within 48 hours of being admitted to an IRF a patient must have a full pre-admission screening and medical evaluation. The preadmission screening must document the patient's prior level of function, expected level of improvement, and the expected length of time necessary to achieve that level of improvement. It must also include an evaluation of the patient's risk for clinical complications, the conditions that caused the need for rehabilitation, the treatments needed, expected frequency and duration of treatment in the IRF, anticipated discharge destination, any anticipated post-discharge treatments and other information relevant to the care needs of the patient.

Once the patient has arrived at the IRF they must have a full post-admission physician evaluation by a rehabilitation physician. The post-admission evaluation must be completed within 24 hours of the patient arriving and must document the patient's status upon admission to the IRF. The purpose of the post-admission evaluation is to compare the patient's pre-admission status with their post-admission status and note any significant changes. The post-admission evaluation will also allow the physician to begin development of their care plan and expected course of treatment. A primary difference between IRF and other rehab settings is the interdisciplinary approach to rehabilitation. Therefore, a patient requiring only one discipline would not be appropriate for this type of care. Because of this approach, care planning is completed with input from all of the interdisciplinary team members who will be involved in the patient's care.

The care plan must include the patient's medical prognosis and the anticipated interventions, functional outcomes, and patient's discharge plan and destination once they have completed their stay at the IRF. Interventions must include the number of hours per day, number of days per week, and total days in the IRF in which the patient is expected to participate in physical, occupational, speech-language pathology, and/or prosthetic/orthotic therapies. The interventions must also take into account the patient's impairments, functional status, comorbidities, and any other contributing factors. The patient's care plan must be completed within the first 4 days of their IRF admission and must support the decision that IRF admission is reasonable and necessary.

Another major difference between rehabilitation services performed in an IRF and any other setting is the intensity, or time spent, on rehab and therapy services. In general, the patient is expected to participate in intensive therapies for at least 3 hours per day at least 5 days per week. However, the patient could also meet the required therapy participation time by doing at least 15 hours of therapy per week over the course of a 7 consecutive day period as long as the reasons for the patient's need for this program of intensive rehabilitation are well-documented and the overall amount of therapy can reasonably be expected to benefit the patient. Many patients will benefit from more

than the minimum required therapy hours. The intensity of therapy must be reasonable and must never exceed the patient's level of need or tolerance, or compromise their safety. Therapy treatments must begin within 36 hours from midnight of the day of the patient's admission to the IRF. Therapy evaluations constitute the beginning of the required therapy services.

Inpatient rehabilitation facilities provide a high level of physician involvement. While admitted to an IRF a patient will have a face to visit with their rehabilitation physician at least 3 times per week. These frequent face-to-face visits allow for the patient to have their progress as well as their medical and functional status assessed as well as to modify the course of treatment as needed to maximize the patient's capacity to benefit from the rehabilitation process.

An IRF operates with an interdisciplinary approach and at minimum a team must consist of a rehabilitation physician, a registered nurse with training in rehabilitation, a social worker or case manager and a licensed or certified therapist from each discipline involved in treating the patient. Each member of the team works within their own scopes of practice and is expected to coordinate his or her efforts with team members of other specialties, as well as with the patient and the patient's significant others and caregivers. The purpose of the interdisciplinary team is to foster frequent, structured, and documented communication among disciplines to establish, prioritize, and achieve treatment goals.

Each patient's interdisciplinary care team must hold a minimum of one care planning meeting per week. The meetings will focus on assessing progress toward rehab goals, considering resolutions to problems encountered in reaching the goals, reassessing previously established goals and monitoring and revising the treatment plan as necessary. The interdisciplinary team is led by the rehabilitation physician who ultimately is responsible for making the final decisions in the patient's plan of care.

Since discharge planning is an integral part of any rehabilitation program, planning must begin upon the patient's admission to the IRF. An extended period of time in the IRF is not considered reasonable or necessary once the patient has met established goals and it has been determined that any further progress is unlikely. To justify a continued need for an IRF stay, the documentation in the IRF medical record must show the patient's ongoing need for an intense level of rehab services and an interdisciplinary approach to care. Further, the IRF medical record must also demonstrate the patient is making functional improvements that are ongoing and sustainable, as well as of practical value. During most IRF stays the emphasis of therapies generally shifts from traditional, patient-centered therapeutic services to patient/caregiver education, durable medical equipment training, and other functional therapies that prepare the patient for a safe discharge to the home or community-based environment.

Long Term Acute Care (LTAC)

Long Term Acute Care (LTAC) facilities specialize in the care and rehabilitation of medically complex patients with a prolonged anticipated length of stay. Common medical problems of patients requiring LTAC care are those on ventilators and those with severe pulmonary disease and patients with skin problems or wounds complicated by secondary diagnoses. LTAC care can also be appropriate for certain patients with severe traumatic brain injuries and some cases of pre and post organ transplant patients.⁸

POSITION STATEMENT

Applicable To:

- Medicaid
- Medicare

Skilled Nursing Facility (SNF)⁶

Exclusions

The need for and length of stay (LOS) in a SNF is dependent upon a member's medical condition, type, amount, and frequency of skilled nursing services provided. Members may receive medically necessary services in a less intensive care setting (outpatient or home therapy services) when he/she is:

1. Ambulatory/mobile for household distances (70 feet or more) with less than minimal assistance, and is capable of performing activities of daily living with less than minimal assistance (the need for some minimal or contact guard assistance is not, in itself, a reason for admission or continued stay in a skilled nursing facility); **OR**,
2. In need of only custodial care; **OR**, ***NOTE*** - Custodial care is comprised of services and supplies, including room and board and other facility services, which are provided to the patient, whether disabled or not, primarily to assist him or her in the activities of daily living rather than to provide therapeutic treatment. Custodial care includes but is not limited to help in walking, bathing, dressing, feeding, preparation of special diets, supervision over self-administration of medications and other activities that can be safely and adequately provided by persons without the technical skills of a covered health care provider (nurse). Such services and supplies are custodial as determined by WellCare without regard to the provider prescribing or providing the services.
3. In need of maintenance programs or care. Functional maintenance programs are drills, techniques and exercises that preserve the patient's present level of function and prevent regression of that function. Maintenance begins when the therapeutic goals of a treatment plan have been achieved and/or when no further functional progress is apparent or expected to occur. Maintenance medical care occurs when the patient's condition is stable or predictable; the plan of care does not require a skilled nurse to be in continuous attendance; or the patient, family, or caregivers have been taught the nursing services and have demonstrated the skills and ability to carry out the plan of care.

Mandatory Secondary Review

Medical director review for requests for SNF admissions are required for the following groups of high readmission risk patients:

1. History of sepsis admission and assistance required is less than minimal assistance such as contact guard or supervision;
2. Unilateral knee replacement surgery (major joint replacement) and no active co-morbidities;
3. Members only receiving intravenous or total parenteral nutrition (TPN) or hyperalimentation (TPN);
4. Multiple SNF admissions in past 90 days;
5. Any description of maximal assistance (MaxA), dependent transfers or ADLs; or Total Assistance, Minimal Assistance (MinA) **and** a member's current functional status at their baseline/prior level of function, or Contact Guard Assistance (CGA), Stand-by Assist (SBA), Mod Independent (Mod I), or Supervision (SPV);
6. Amputation status surgery with Previous Level of Function (PLOF) determined to be a custodial nature due to lower functional status or who could benefit equally from Home Health, physical therapy (PT), or occupational therapy (OT).

Coverage

Initial care in a SNF **is considered medically necessary** when all of the following criteria are met:

1. The member 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); services are ordered by a physician; **AND**,
2. The patient requires these skilled services on a daily basis; **AND**,
3. As a practical matter, considering economy and efficiency, the daily skilled services can be provided only on an inpatient basis in a SNF; **AND**,
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; **AND**,
5. Following review for medical necessity, each approval must have a level of care documented – Continue to SNF level of care review.

Skilled Nursing Facility Continued Stay

Exclusions

Medicare covers medically necessary skilled nursing care needed on a daily basis. Examples of non-covered services for (SNF) include any of the following:

1. Nonskilled care – member takes oral medications, needs assistance with daily activities and general supportive services that do not require the skills of a licensed provider to perform the service or to manage a member's care.
2. Observation and management of care plan - no significant change.
3. Observation and management of care plan - condition improved.
4. Therapy services for overall fitness and well-being. (Skilled therapy is physical therapy, occupational therapy, and/or speech-language pathology.)
5. Therapy to maintain function after a maintenance program has been established.
6. Skilled rehabilitation services not received daily - no skilled nursing.

Mandatory Secondary Review

Medical director review for requests for SNF admissions are required for the following groups of high readmission risk patients:

1. Services do not meet the medically necessary criteria below; **OR**,
2. A member's condition has changed such that skilled medical or rehabilitative care is no longer needed; **OR**,
3. Member refuses to participate in the recommended treatment plan; **OR**,
4. Member's care is or has become custodial; **OR**,
5. Services are provided by a family member or another non-medical person. When a service can be safely and effectively self-administered or performed by the average non-medical person without the direct supervision of a nurse, the service cannot be regarded as a skilled service.

Coverage

Continued care in a Skilled Nursing Facility **is considered medically necessary** when all of the following criteria are met:

1. Member requires skilled nursing or skilled rehabilitation services that must be performed by, or under the supervision of, professional or technical personnel; **AND**,
2. Skilled nursing is required at least daily or skilled therapy 1-2 hours per day at least 5 days per week; **AND**
3. Medical practitioner, Nurse Practitioner (NP) or Physician Assistant (PA) assessment or oversight required ≥ 1 time per week; **AND**,
4. Interdisciplinary and goal oriented treatment by professional nursing, social worker, or case manager and/or rehab therapists with specialized training, education, and/or certification; **AND**,
5. Daily documentation of treatment and response to interventions with progress toward meeting goals documented at least weekly or more frequently; **AND**,
6. Medical specialty consultative services, pharmacy and diagnostic services available; **AND**,
7. Practically, daily skilled services can only be provided on an inpatient basis in a SNF setting; **AND**,
8. SNF services must be furnished pursuant to a physician's orders and be reasonable and necessary for the treatment of a member's illness or injury (e.g., consistent with the nature and severity of the illness/injury, particular medical needs, and accepted standards of medical practice); **AND**,
9. Initial admission and subsequent stay in a SNF for skilled nursing services or rehabilitation services must include development, management and evaluation of a plan of care as follows:
10. Involvement of skilled nursing personnel is required to meet the member's medical needs, promote recovery and ensure medical safety (in terms of the member's physical or mental condition); **AND**,
11. A significant probability must exist that complications would arise without skilled supervision of the treatment plan by a physician, licensed nurse, or licensed therapist; **AND**,

12. Care plans must include realistic nursing goals and objectives for the member, discharge plans and the planned interventions by the medical staff to meet those goals and objectives; **AND**,
13. Updated care plans must document the outcome of the planned interventions; **AND**,
14. Daily documentation of the individual's progress or complications must exist; **AND**,
15. Following review for medical necessity, each additional approval must have a level of care documented – Continue to SNF level of care review.

NOTE: The need for respiratory therapy, either by a nurse or by a respiratory therapist, does not alone qualify an individual for SNF care.

Skilled Nursing Facility (SNF) Levels of Care

Levels 1-3 are based on InterQual criteria. The Level of Care is based on nationally accepted clinical care guidelines and the Health Plan's clinical coverage guidelines. For assistance with ADL scoring please see the section on ADL scoring in the Background.

SNF Setting (Short-Term) – Level of Care 1

These criteria are appropriate when the following Patient Status and Program Requirements are met:

Patient Status

- Medically stable with medical or surgical comorbidities manageable and not requiring acute medical attention; **AND**
- Requires care that is directly related and reasonable for the presenting condition and/or illness; **AND**
- There is expected improvement from medical and/or rehab intervention (or end-stage disease) within a reasonable and predictable period of time; **AND**
- Patients who require rehabilitative services must exhibit a decline in physical function (compared to prior level of function) in order for rehab services to be considered medically appropriate. Prior level of function can include: independent, modified independent in the community, supervised or minimum assistance in the community with caregiver support, or long-term resident.

Program Requirements

- Skilled nursing at least daily (1 to 4 hours) or skilled therapy up to 1 hour per day at least 5 days per week; **AND**
- Assessment and oversight by a medical practitioner such as a Nurse Practitioner (NP) or Physician Assistant (PA) required ≥ 1 time per week; **AND**
- Interdisciplinary and goal oriented treatment by professional nursing, social worker, or case manager, and/or rehab therapists with specialized training, education and/or certification; **AND**
- Treatment plan developed within 2 days of admission; **AND**
- Daily documentation of treatment and response to interventions with progress toward meeting goals documented at least weekly or more frequently; **AND**
- Medical specialty consultative service, pharmacy and diagnostic services available.

OR,

Member requires any of the following:

Special Care High (HC2) - Residents satisfying the following **two** conditions:

1. Member is depressed and has an ADL score of 6-10; **AND**,
2. Receiving complex clinical care or have serious medical conditions involving any **one** of the following:
 - A. Comatose; **OR**,
 - B. Septicemia; **OR**,
 - C. Diabetes with insulin injections and insulin order changes; **OR**,
 - D. Quadriplegia with a higher minimum ADL dependence criterion (ADL score of 5 or more); **OR**,

- E. Chronic obstructive pulmonary disease (COPD) with shortness of breath when lying flat; **OR**,
- F. Fever with pneumonia; **OR**,
- G. Vomiting, weight loss, or tube feeding meeting intake requirement; **OR**,
- H. Parenteral/IV feeding; **OR**,
- I. Respiratory therapy.

Special Care Low (LB1, LE1) - Residents satisfying the following **two** conditions:

- 1. Member is not depressed and has ADL score of 2-10; **AND**,
- 2. Receiving complex clinical care or have serious medical conditions involving **any** of the following:
 - A. Cerebral palsy with ADL dependency score of 5 or more; **OR**,
 - B. Multiple sclerosis with ADL dependency score of 5 or more; **OR**,
 - C. Parkinson's disease with ADL dependency score of 5 or more; **OR**,
 - D. Respiratory failure and oxygen therapy while a resident; **OR**,
 - E. Tube feeding meeting intake requirement; **OR**,
 - F. Ulcer treatment with two or more ulcers including venous ulcers; **OR**,
 - G. Arterial ulcers or Stage II pressure ulcers; **OR**,
 - H. Ulcer treatment with any Stage III or IV pressure ulcer; **OR**,
 - I. Foot infections or wounds with application of dressing; **OR**,
 - J. Radiation therapy while a resident; **OR**,
 - K. Dialysis while a resident

Clinically Complex (CA1, CB1, CC1, CD1, CE1, CA2, CC2, CD2) - Residents receiving complex clinical care **or** have conditions requiring skilled nursing management, interventions or treatments involving **any** of the following:

- 1. Pneumonia; **OR**,
- 2. Hemiplegia with ADL dependency score of 5 or more; **OR**,
- 3. Surgical wounds or open lesions with treatment; **OR**,
- 4. Burns; **OR**,
- 5. Chemotherapy while a resident; **OR**,
- 6. Oxygen therapy while a resident; **OR**,
- 7. IV medications while a resident; **OR**,
- 8. Transfusions while a resident; **OR**,
- 9. Extensive or Special Care with ADL Score of 0 or 1

Behavioral Symptoms and Cognitive Performance (BA1, BB1) - Residents satisfying the following **two** conditions:

- 1. Having a maximum ADL dependency score of 5 or less; **AND**,
- 2. Having behavioral or cognitive performance symptoms, involving any of the following:
 - A. Difficulty in repeating words, temporal orientation, or recall (score on the Brief Interview for Mental Status ≤ 9); **OR**,
 - B. Difficulty in making self understood, short term memory, or decision making (score on the Cognitive Performance Scale ≥ 3); **OR**,
 - C. Hallucinations; **OR**,
 - D. Delusions; **OR**,
 - E. Physical behavioral symptoms toward others; **OR**,
 - F. Verbal behavioral symptoms toward others; **OR**,
 - G. Other behavioral symptoms; **OR**,
 - H. Rejection of care; **OR**,
 - I. Wandering

Reduced Physical Function (PB1, PC1, PD1, PE1, PA1) - Residents whose needs are primarily for support with activities of daily living and general supervision.

Skilled Sub-Acute Setting (Short-Term) – Level of Care 2

These criteria are appropriate to use when the patient is medically stable and the following Patient Status and Program Requirements are met:

Patient Status

- Medically stable with medical or surgical comorbidities manageable and not requiring acute medical attention; **AND**
- Requires care that is directly related and reasonable for the presenting condition and/or illness; **AND**
- Expected improvement from medical and/or rehab intervention (or end-stage disease) within a reasonable and predictable period of time; **AND**
- Patients who require rehabilitative services must exhibit a decline in physical function (compared to prior level of function) in order for the rehab services to be considered medically appropriate. Prior level of function can include: independent, modified independent in the community, supervised or minimum assistance in the community with caregiver support, or long-term resident.

Program Requirements

- Skilled nursing at least 4-6 hours per day, or skilled therapy up to 2 hours per day at least 5 days per week; **AND**
- Assessment and oversight by a medical practitioner such as a Nurse Practitioner (NP) or Physician Assistant (PA) required ≥ 2 times per week; **AND**
- Interdisciplinary and goal oriented treatment by professional nursing, social worker, or case manager, and/or rehab therapists with specialized training, education and/or certification; **AND**
- Treatment plan developed within 2 days of admission; **AND**
- Daily documentation of treatment and response to interventions with progress toward meeting goals documented at least weekly or more frequently; **AND**
- Medical specialty consultative services, pharmacy and diagnostic services available.

OR,

Member requires any of the following:

Rehabilitation (RMB, RMC, RMA, RLA) – Residents satisfying the following **two** conditions

1. Member is receiving 45 minutes to 4 and a half hours of therapy per week; **AND,**
2. Residents receiving physical therapy, occupational therapy, **and/or** speech-language pathology services while a resident.

Extensive Services (ES2) - Residents satisfying the following **two** conditions:

1. Having a minimum ADL dependency score of 2 or more meaning member could not fully performed the ADL activity without minimal assistance/help from staff; **AND,**
2. While a resident, receiving complex clinical care and have needs involving: tracheostomy care or ventilator/respirator care.

Special Care High (HC1, HD1, HE1) - Residents satisfying the following **two** conditions:

1. Member is not depressed and has an ADL score of 6-10; **AND,**
2. Receiving complex clinical care or have serious medical conditions involving any **one** of the following:
 - A. Comatose; **OR,**
 - B. Septicemia; **OR,**
 - C. Diabetes with insulin injections and insulin order changes; **OR,**
 - D. Quadriplegia with a higher minimum ADL dependence criterion (ADL score of 5 or more); **OR,**
 - E. Chronic obstructive pulmonary disease (COPD) with shortness of breath when lying flat; **OR,**
 - F. Fever with pneumonia; **OR,**
 - G. Vomiting, weight loss, or tube feeding meeting intake requirement; **OR,**

- H. Parenteral/IV feeding; **OR**,
- I. Respiratory therapy.

Special Care Low (LD1, LB2) - Residents satisfying the following **two** conditions:

1. Member is depressed and has an ADL score of 2-5 **OR** member is not depressed and has an ADL score of greater than 11; **AND**,
2. Receiving complex clinical care or have serious medical conditions involving **any** of the following:
 - A. Cerebral palsy with ADL dependency score of 5 or more; **OR**,
 - B. Multiple sclerosis with ADL dependency score of 5 or more; **OR**,
 - C. Parkinson's disease with ADL dependency score of 5 or more; **OR**,
 - D. Respiratory failure and oxygen therapy while a resident; **OR**,
 - E. Tube feeding meeting intake requirement; **OR**,
 - F. Ulcer treatment with two or more ulcers including venous ulcers; **OR**,
 - G. Arterial ulcers or Stage II pressure ulcers; **OR**,
 - H. Ulcer treatment with any Stage III or IV pressure ulcer; **OR**,
 - I. Foot infections or wounds with application of dressing; **OR**,
 - J. Radiation therapy while a resident; **OR**,
 - K. Dialysis while a resident

Sub-Acute Setting (Short-Term) – Level 3 of Care Complex

These criteria are appropriate to use when the patient is medically stable and the following Patient Status and Program Requirements are met:

Patient Status

- Medically stable with medical or surgical comorbidities manageable and not requiring acute medical attention; **AND**
- Requires care that is directly related and reasonable for the presenting condition and/or illness; **AND**
- Expected improvement from medical and rehab intervention within a reasonable and predictable period of time; **AND**
- Patients who require rehabilitative services must exhibit a decline in physical function (compared to prior level of function) in order for the rehab services to be considered medically appropriate. Prior level of function can include: independent, modified independent in the community, supervised or minimum assistance in the community with caregiver support, or long-term resident.

Program Requirements

- Skilled nursing at least up to 6 hours per day and skilled therapy up to 3 hours per day at least 5 days per week; ; **AND**
- Assessment and oversight by a medical practitioner such as a Nurse Practitioner (NP) or Physician Assistant (PA) required ≥ 2 times per week; **AND**
- Interdisciplinary and goal oriented treatment by professional nursing, social worker, or case manager, and rehab therapists with specialized training, education and/or certification; **AND**
- Treatment plan developed within 2 days of admission; **AND**
- Daily documentation of treatment and response to interventions with progress toward meeting goals documented at least weekly or more frequently; **AND**
- Medical specialty consultative services, pharmacy and diagnostic services available.

OR,

Member requires any of the following:

Rehabilitation (RHB, RHA, RHC) –Residents satisfying the following **two** conditions

1. Member is receiving over to 4 and a half hours to 8 and a half hours of therapy per week; **AND**,

2. Residents receiving physical therapy, occupational therapy, **and/or** speech-language pathology services while a resident.

Extensive Services (ES3, ES1) - Residents satisfying the following **two** conditions:

3. Having a minimum ADL dependency score of 2 or more meaning member could not fully performed the ADL activity without minimal assistance/help from staff; **AND**,
4. While a resident, receiving complex clinical care and have needs involving: tracheostomy care, ventilator/respirator, and/or infection isolation.

Special Care High (HB1, HB2) - Residents satisfying the following **two** conditions:

3. Member is or isn't depressed and has an ADL score of 11 or greater; **AND**,
4. Receiving complex clinical care or have serious medical conditions involving any **one** of the following:
 - A. Comatose; **OR**,
 - B. Septicemia; **OR**,
 - C. Diabetes with insulin injections and insulin order changes; **OR**,
 - D. Quadriplegia with a higher minimum ADL dependence criterion (ADL score of 5 or more); **OR**,
 - E. Chronic obstructive pulmonary disease (COPD) with shortness of breath when lying flat; **OR**,
 - F. Fever with pneumonia; **OR**,
 - G. Vomiting, weight loss, or tube feeding meeting intake requirement; **OR**,
 - H. Parenteral/IV feeding; **OR**,
 - I. Respiratory therapy.

Level of Care 4 Complex

This subset is for review of patients who require medical and rehab services in a (Level IV Complex) subacute setting for short-term care, such as, but not limited to bedside dialysis, severe CVA, severe head injury, stabilized spinal cord injuries, etc. These criteria are appropriate to use when the patient is medically stable and the following Patient Status and Program Requirements are met:

Patient Status

- Medically stable with medical or surgical comorbidities manageable and not requiring acute medical attention; **AND**
- Requires care that is directly related and reasonable for the presenting condition and/or illness; **AND**
- Expected improvement from medical and rehab intervention within a reasonable and predictable period of time; **AND**
- Patients who require rehabilitative services must exhibit a decline in physical function (compared to prior level of function) in order for the rehab services to be considered medically appropriate. Prior level of function can include: independent, modified independent in the community, supervised or minimum assistance in the community with caregiver support, or long-term resident.

Program Requirements

- Skilled nursing at least 4-5 hours per day and skilled therapy up to 3 hours per day at least 5 days per week; **AND**
- Assessment and oversight by a medical practitioner such as a Nurse Practitioner (NP) or Physician Assistant (PA) required ≥ 2 times per week; **AND**
- Interdisciplinary and goal oriented treatment by professional nursing, social worker, or case manager, and rehab therapists with specialized training, education and/or certification; **AND**
- Treatment plan developed within 2 days of admission; **AND**
- Daily documentation of treatment and response to interventions with progress toward meeting goals documented at least weekly or more frequently; **AND**
- Medical specialty consultative services, pharmacy and diagnostic services available.

OR,

Member requires any of the following:

Rehabilitation (RUB, RUC, RUA, RVB, RVC, RVA) – Residents satisfying the following **two** conditions

1. Residents receiving physical therapy, occupational therapy, **and/or** speech-language pathology services while a resident; **AND**,
2. Member is receiving more than 8 and a half hours of therapy per week; **OR**,
Member is receiving over 12 hours of therapy with at least 2 disciplines one being 5 days per week and the other being at least 3 days per week.

Sub-Acute Setting (Short-Term) – Level of Care 5 Complex

This subset is for review of patients who require medical and rehab services in a Level V Complex subacute setting for short-term care, such as more medically complex, but not limited to high cost drugs[^], bariatric patient care requiring equipment rentals (such as beds, tables, etc.), Guillian Barre Syndrome, Ventilator dependent patients, catastrophic multiple trauma, severe head injury, etc. These criteria are appropriate to use when the patient is medically stable and the following Patient Status and Program Requirements are met:

[^] See below for section on *High Cost Drugs*.

Patient Status

- Medically stable with medical or surgical comorbidities manageable and not requiring acute medical attention; **AND**
- Requires care that is directly related and reasonable for the presenting condition and/or illness; **AND**
- Expected improvement from medical and rehab intervention within a reasonable and predictable period of time; **AND**
- Patients who require rehabilitative services must exhibit a decline in physical function (compared to prior level of function) in order for the rehab services to be considered medically appropriate. Prior level of function can include: independent, modified independent in the community, supervised or minimum assistance in the community with caregiver support, or long-term resident.

Program Requirements

- Skilled nursing at least 4-5 hours per day and/or skilled therapy up to 4 hours per day at least 5 days per week; **AND**
- Assessment and oversight by a medical practitioner such as a Nurse Practitioner (NP) or Physician Assistant (PA) required ≥ 2 times per week; **AND**
- Interdisciplinary and goal oriented treatment by professional nursing, social worker, or case manager, and rehab therapists with specialized training, education and/or certification; **AND**
- Treatment plan developed within 2 days of admission; **AND**
- Daily documentation of treatment and response to interventions with progress toward meeting goals documented at least weekly or more frequently; **AND**
- Medical specialty consultative services, pharmacy and diagnostic services available.

OR,

Member requires any of the following:

Rehabilitation Plus Extensive Services (RUL, RVX, RUX, RVL, RMX, RML) - Residents satisfying all of the following **three** conditions:

1. Having a minimum activity of daily living (ADL) dependency score of 2 or more meaning member could not fully performed the ADL activity without minimal assistance/help from staff; **AND**,
2. Receiving physical therapy, occupational therapy, and/or speech-language pathology services while a resident; **AND**,

3. While a resident, receiving complex clinical care and have needs involving tracheostomy care, ventilator/respirator, and/or infection isolation.

Inpatient Rehabilitation Facility (IRF)⁷

Exclusions

Inpatient Rehabilitation Facility care **is not considered medically necessary** when any of the following apply:

1. The IRF benefit is not to be used as an alternative to completion of the full course of treatment in the referring hospital. Any member who has not yet completed the full course of treatment in the referring hospital must remain in the referring hospital, with appropriate rehabilitative treatment provided, until they have completed the full course of treatment.
2. "Trial" IRF admissions, during which a member is admitted to an IRF for 3 to 10 days to assess whether or not the member would benefit significantly from treatment in the IRF setting, is not considered reasonable and necessary.
3. Any member requiring only one discipline of therapy.
4. Any member not meeting all 5 of the below criteria **at the time of admission**.

Coverage

In order for Inpatient Rehabilitation Facility care to be considered reasonable and necessary, the documentation in the patient's IRF medical record (which must include the preadmission screening described in section 110.1.1, the post-admission physician evaluation described in section 110.1.2, the overall plan of care described in section 110.1.3, and the admission orders described in section 110.1.4) must demonstrate a reasonable expectation that the following criteria were met at the time of admission to the IRF. Inpatient Rehabilitation Facility admission is **considered medically necessary** when all of the following are met:

NOTE: For complete section verbiage and guidance please refer to the following link [here](#).

1. The member must require the active and ongoing therapeutic intervention of more than one therapy discipline (physical therapy, occupational therapy, speech-language pathology, and/or prosthetics/orthotics), **with one of which** being physical or occupational therapy; **AND**
2. The member must generally require an intensive rehabilitation therapy program, as defined in section 110.2.2. Under current industry standards, this intensive rehabilitation therapy program generally consists of at least 3 hours of therapy per day at least 5 days per week. In certain well-documented cases, this intensive rehabilitation therapy program might instead consist of at least 15 hours of intensive rehabilitation therapy within a 7 consecutive day period, beginning with the date of admission to the IRF; **AND**
3. The member must reasonably be expected to actively participate in, and benefit significantly from, the intensive rehabilitation therapy program that is defined in section 110.2.2 **at the time of admission to the IRF**. The member can only be expected to benefit significantly from the intensive rehabilitation therapy program if the patient's condition and functional status are such that the patient can reasonably be expected to make measurable improvement (that will be of practical value to improve the member's functional capacity or adaptation to impairments) as a result of the rehabilitation treatment, as defined in section 110.3, and if such improvement can be expected to be made within a prescribed period of time. The member need not be expected to achieve complete independence in the domain of self-care nor be expected to return to his or her prior level of functioning in order to meet this standard; **AND**
4. The member must require physician supervision by a rehabilitation physician, defined as a licensed physician with specialized training and experience in inpatient rehabilitation. The requirement for medical supervision means that the rehabilitation physician must conduct face-to-face visits with the patient at least 3 days per week throughout the patient's stay in the IRF to assess the patient both medically and functionally, as well as to modify the course of treatment as needed to maximize the patient's capacity to benefit from the rehabilitation process; **AND**

5. The member must require an intensive and coordinated interdisciplinary approach to providing rehabilitation, as defined in section 110.2.5.##

**** 110.2.2 - Intensive Level of Rehabilitation Services.** A primary distinction between the IRF environment and other rehabilitation settings is the intensity of rehabilitation therapy services provided in an IRF. For this reason, the information in the patient's IRF medical record (especially the required documentation described in section 110.1) must document a reasonable expectation that at the time of admission to the IRF the patient generally required the intensive rehabilitation therapy services that are uniquely provided in IRFs.

Although the intensity of rehabilitation services can be reflected in various ways, the generally-accepted standard by which the intensity of these services is typically demonstrated in IRFs is by the provision of intensive therapies at least 3 hours per day at least 5 days per week. However, this is not the only way that such intensity of services can be demonstrated. The intensity of therapy services provided in IRFs could also be demonstrated by the provision of 15 hours of therapy per week (that is, in a 7-consecutive day period starting from the date of admission). Thus, IRFs may also demonstrate a patient's need for intensive rehabilitation therapy services by showing that the patient required and could reasonably be expected to benefit from at least 15 hours of therapy per week (defined as a 7-consecutive day period starting from the date of admission), as long as the reasons for the patient's need for this program of intensive rehabilitation are well-documented in the patient's IRF medical record and the overall amount of therapy can reasonably be expected to benefit the patient. Many IRF patients will medically benefit from more than 3 hours of therapy per day or more than 15 hours of therapy per week, when all types of therapy are considered. However, the intensity of therapy provided must be reasonable and necessary under section 1862(a)(1)(A) of the Act and must never exceed the patient's level of need or tolerance, or compromise the patient's safety.

The required therapy treatments must begin within 36 hours from midnight of the day of admission to the IRF. Therapy evaluations constitute the beginning of the required therapy services.

^^ 110.3 - Definition of Measurable Improvement. A patient can only be expected to benefit significantly from an intensive rehabilitation therapy program provided in an IRF, as required in section 110.2.3, if the patient's IRF medical record indicates a reasonable expectation that a measurable, practical improvement in the patient's functional condition can be accomplished within a predetermined and reasonable period of time. In general, the goal of IRF treatment is to enable the patient's safe return to the home or community-based environment upon discharge from the IRF. The patient's IRF medical record is expected to indicate both the nature and degree of expected improvement and the expected length of time to achieve the improvement.

110.2.5 - Interdisciplinary Team Approach to the Delivery of Care. An IRF stay will only be considered reasonable and necessary if **at the time of admission** to the IRF the documentation in the patient's IRF medical record indicates a reasonable expectation that the complexity of the patient's nursing, medical management, and rehabilitation needs requires an inpatient stay and an interdisciplinary team approach to the delivery of rehabilitation care.

Interdisciplinary services are those provided by a treatment team in which all of its members participate in a coordinated effort to benefit the patient and the patient's significant others and caregivers. Interdisciplinary services, by definition, cannot be provided by only one discipline. Though individual members of the interdisciplinary team work within their own scopes of practice, each professional is also expected to coordinate his or her efforts with team members of other specialties, as well as with the patient and the patient's significant others and caregivers. The purpose of the interdisciplinary team is to foster frequent, structured, and documented communication among disciplines to establish, prioritize, and achieve treatment goals.

At a minimum, the interdisciplinary team must document participation by professionals from each of the following disciplines:

- A rehabilitation physician with specialized training and experience in rehabilitation services;
- A registered nurse with specialized training or experience in rehabilitation;
- A social worker or a case manager (or both); and
- A licensed or certified therapist from each therapy discipline involved in treating the patient.

Long Term Acute Care (LTAC)

Exclusions

The following conditions can typically be treated in a SNF and are **not considered medically necessary** for LTAC admission:

1. COPD with great than 2 readmissions in the last 6 months; **OR,**
2. A respiratory condition requiring nebulizer treatments every 4 hours; **OR,**
3. Simple hypoxia on room air (o₂ saturations 85%-91%).
4. Most wound care can be treated at a SNF including:
 - Wounds with extensive undermining or tunneling
 - Chronic non-healing or open surgical wounds
 - Wound vacuum assisted devices (wound VAC) for stage IV wounds

- Pre-op optimization
- Wounds on the perineal, ischial or coccyx with incontinence
- Lower extremity wounds including
- Post skin flap or graft
- Recalcitrant wounds
- Post skin flap or graft

Coverage

NOTE: Applies to Members in states with the covered benefits noted in the Member's Benefits package.

Admission to a Long Term Acute Care facility **is considered medically necessary** when the member meets the following criteria:

1. **Medically Complex.** There are few indications that may be medically necessary for LTAC, such as short-bowel syndrome or where continuous suction is not available in SNF or INR, severe pancreatitis, malignancy complications in patients who are not receiving palliative or hospice services, dialysis that cannot be provided in a SNF. Other indications such as CHF, inflammatory bowel disease (IBD), End-Stage Renal Disease (ESRD), recent CNS injury (stroke, SCI or TBI) or hematological disorders can most likely be treated in an alternative level of care (ALOC); **OR**,
2. **Acute respiratory failure (Respiratory Complex).** The top diagnoses include pulmonary edema, acute CHF, COPD and other respiratory conditions. Appropriate conditions include chest tube management, failure of ALOC: such as Requiring trial and initiation of NIPPV , Failed home NIPPV management and adjustment required, Nocturnal ventilation prior to admission requiring increased reliance on mechanical ventilation or NIPPV support, OXYGEN > 50%; **OR**,
3. **Ventilator Weaning.** In order to consider as medically necessary for LTAC for ventilator weaning, WellCare requires 3 failed attempts at weaning as an inpatient for at least 2 weeks for ventilator patients who are expected to require prolonged mechanical ventilation (PMV). The definition of PMV is 21 days of mechanical ventilation for at least 6 hours per day (CMS definition). Patients who are being considered for ventilation weaning must have a formal evaluation of their clinical appropriateness prior to a trial of weaning. For example, patients with a fixed obstruction of their airway due to a malignancy may not be expected to wean and would not be appropriate for LTAC; long-term ventilator patients who have been admitted to the hospital for an acute illness would also not be considered as medically necessary for LTAC. Weaning period begins after intubation & mechanical ventilation as well as tracheostomy insertion & ventilation; **OR**,
4. **Wound Care.** This includes (but is not limited to) complex wound care. The following wound scenarios would be appropriate for medically necessary LTAC admissions:
 - Necrotic wounds requiring multiple and aggressive surgical excisions or debridements (e.g., post-fasciotomies); **OR**
 - Large wound or skin conditions such as affecting > 15 % BSA

HIGH COST DRUGS

Adempas	Farydak	Juxtapid	Privigen	Tasinga
Advate	Ferriprox	Kalydeco	Procysbi	Tetrabenazine
Afinitor	Firazyr	Kuvan	Prolastin-C	Thalomid
Aldurazyme	Gammagard Liquid	Lazanda	Promacta	Thiola
Apokyn	Gamunex-C	Lenvima (24 mg Daily Dose)	Ravicti	Tobi Podhaler
Aralast NP	Gattex	Letairis	Revlimid	Tyvaso Refill
Avastin	Glassia	Linezolid	Rituxan	Valchlor
Benefix	Gleevec	Leukine	Sabril	Velcade
Bexarotene	Harvoni	Lynparza	Samsca	Viekira Pak
Bosulif	Herceptin	Mekinist	Serostim	Votrient
Advate	Hettioz	Myalept	Simponi	Vpriv
Cimzia Starter Kit	HP Acthar	Naglazyme	Soliris	Xalkori
Cinryze		Neulasta	Sovaldi	Xenazine

Cubicin	Humira Pen (Crohn's Disease)	Neupogen	Sprycel	Xtandi
Cuprimine	Ibrance	Nexavar	Stelara	Xyrem
Daklinza	Iclusig	Ofez	Stivarga	Zelboraf
Daraprim	Ilaris	Olysio	Subsys	Zemaira
Dificid	Imbruvica	Opdivo	Supprelin LA	Zolinza
Disperz	Increlex	Orenitram	Sutent	Zydelig
Elaprase	Inlyta	Orkambi	Syprine	Zykadia
Eloctate	Jadenu	Opsumit	Tafinlar	Zytiga
Erivedge	Jakafi	Pomalyst	Targretin	Zyvox
Esbriet				
Exjade				

CODING^{9,10}

CMS DATA: SNF PER DIEM PPS

The Balanced Budget Act of 1997 mandates the implementation of a **per diem** prospective payment system (PPS) for skilled nursing facilities (SNFs) covering **all** costs (routine, ancillary and capital) related to the services furnished to beneficiaries under Part A of the Medicare program.

SNF Consolidated Billing requirements

Congress then enacted the Balanced Budget Act of 1997 (BBA), Public Law 105-33, Section 4432(b), and it contains a Consolidated Billing (CB) requirement for SNFs. Under the CB requirement, **an SNF itself must submit all Medicare claims for the services that its residents receive** (except for specifically excluded services below).

Excluded Services

There are a number of services that are excluded from SNF CB. These services are outside the PPS bundle, and they remain separately billable to Part B when furnished to an SNF resident by an outside supplier. However, bills for these excluded services, when furnished to SNF residents, must contain the SNF's Medicare provider number. Services that are categorically excluded from SNF CB are the following:

- Physicians' services furnished to SNF residents. These services are not subject to CB and, thus, are still billed separately to the Part B carrier.
 - Many physician services include both a professional and a technical component, and the technical component is subject to CB. **The technical component of physician services must be billed to and reimbursed by the SNF.**
 - Section 1888(e)(2)(A)(ii) of the Social Security Act specifies that **physical, occupational, and speech-language therapy services are subject to CB**, regardless of whether they are furnished by (or under the supervision of) a physician or other health care professional.
- Physician assistants working under a physician's supervision;
- Nurse practitioners and clinical nurse specialists working in collaboration with a physician;
- Certified nurse-midwives;
- Qualified psychologists;
- Certified registered nurse anesthetists;
- Services described in Section 1861(s)(2)(F) of the Social Security Act (i.e., Part B coverage of home dialysis supplies and equipment, self-care home dialysis support services, and institutional dialysis services and supplies);
- Services described in Section 1861(s)(2)(O) of the Social Security Act, i.e., Part B coverage of Epoetin Alfa (EPO, trade name Epogen) for certain dialysis patients. Note: Darbepoetin Alfa (DPA, trade name Aranesp) is now excluded on the same basis as EPO;
- Hospice care related to a resident's terminal condition;
- An ambulance trip that conveys a beneficiary to the SNF for the initial admission, or from the SNF following a final discharge.

Related Bill Type

- 21X SNF inpatient services
- 18X Hospital swing bed (SB)

Related Place of Service Codes (POS)

31 Skilled Nursing Facility - Covered Stay

A facility which primarily 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

32 Nursing Facility —Not Covered under Medicare Part A; Covered by Medicaid for services provided in a nursing home licensed and certified by the state survey agency as a Medicaid Nursing Facility (Refer to Individual State Medicaid Manual).

A facility which primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled or sick persons or, on a regular basis, health-related care services above the level of custodial care to other than mentally retarded individuals.

Related Revenue Codes

- 0022 Claim is paid under SNF PPS.
- 0191 Hemodynamically Stable, No Comorbidities, Does not require rehab, short stay anticipated (3-5 days)
- 0192 Hemodynamically Stable, Non-Complex Comorbidities, Requires Rehab, Skilled Nursing, Assessments of body systems 1-2X/day
- 0193 Hemodynamically Stable, Complex Comorbidities, Requires Rehab, Skilled Nursing, Assessments of body system 2-3X/day Trach care/Suction
- 0194 Hemodynamically Stable, Complex Comorbidities Requires Rehab, Skilled Nursing, Assessments of body system 3-4X/day (Non-Vent. Dependent)
- 0199 Hemodynamically Stable, Complex Comorbidities Requires Rehab, Skilled Nursing, Assessments of body system q4-6Hr (Vent. Dependent)

Occurrence Code

- 50 Assessment date for each assessment period represented on the claim with revenue code 0022.

For New York State Long Term Care Nursing Home / Custodial Level of Care ONLY ¹²

- 100 Custodial bed
- 121 Custodial Specialty: TBI bed
- 123 Custodial Specialty: Pediatric Bed
- 124 Custodial Specialty: Neurobehavioral bed
- 160 Custodial Specialty: AIDS bed
- 169 Custodial Specialty: Ventilator Dependent bed
- 183 Leave of Absence – Other (Bed Hold)
- 185 Leave of Absence – Nursing Home for Hospitalization (Bed Hold)
- 189 Therapeutic leave (authorized by medical professional)
- 663 Respite bed
- 658 Room and Board – (Hospice)

HIPPS. The **Health Insurance Prospective Payment System (HIPPS)** rate code consists of the three-character resource utilization group (RUG) code that is obtained from the “Grouper” software program followed by a 2-digit assessment indicator (AI) that specifies the type of assessment associated with the RUG code obtained from the Grouper.

Specific Uses of HIPPS Codes - Skilled Nursing Facility Prospective Payment System

Effective October 1, 2010, under the skilled nursing facility prospective payment system (SNF PPS), a case-mix adjusted payment for varying numbers of days of SNF care is made using one of 66 Resource Utilization Groups, Version IV (RUG-IV). On claims to Medicare and other payers these RUG-IVs are represented as the first three positions of HIPPS codes.

NOTE: Providers may view the valid RUG-III codes and AI's used under the previous version RUG-III system, termed 9/30/2010, in Chapter 6 of the RAI Version 2.0 Manual at http://www.cms.gov/NursingHomeQualityInits/20_NHQIMDS20.asp#TopOfPage (°CMS, 2013).

HIPPS codes are determined based on assessments made using the Minimum Data Set (MDS). Grouper software run at a skilled nursing facility or swing bed hospital uses specific data elements from the MDS to assign beneficiaries to a RUG IV code. The Grouper outputs the RUG IV code, which must be combined with the Assessment Indicator to create the HIPPS code. The HIPPS code is then entered on the claim. The following scheme has been developed to create distinct 5-position, alphanumeric SNF HIPPS codes:

The first, second and third positions of the code represent the RUG-IV case mix group. If the MDS assessment was not performed appropriately, these positions may instead carry a default value. The valid values for these positions are as follows:

RUG-IV GROUP CODES

- Rehabilitation Plus Extensive Services:** RUX, RUL, RVX, RVL, RHX, RHL, RMX, RML, RLX
- Rehabilitation:** RUA, RUB, RUC, RVA, RVB, RVC, RHA, RHB, RHC, RMA, RMB, RMC, RLA, RLB
- Extensive Services:** ES3, ES2, ES1
- Special Care High:** HE2, HE1, HD2, HD1, HC2, HC1, HB2, HB1
- Special Care Low:** LE2, LE1, LD2, LD1, LC2, LC1, LB2, LB1
- Clinically Complex:** CE2, CE1, CD2, CD1, CC2, CC1, CB2, CB1, CA2, CA1
- Behavioral Symptoms and Cognitive Performance:** BB2, BB1, BA2, BA1
- Reduced Physical Function:** PE2, PE1, PD2, PD1, PC2, PC1, PB2, PB1, PA2, PA1
- Default:** AAA

The fourth and fifth positions of the code represent an assessment indicator (AI), identifying the reason and timeframe for the completion of the MDS. These positions may be numeric or alphabetical. Valid values for RUG-IV billing are available for download from Chapter 6 of the Resident Assessment Instrument (RAI) Version 3.0 Manual at: http://www.cms.gov/NursingHomeQualityInits/45_NHQIMDS30TrainingMaterials.asp

HIPPS codes created using the SNF structure are only valid on claim lines reporting revenue code 0022.

Nebraska Only – RUG III Crosswalk for SNF

NE MLTC LOC	Index Code	Criteria/Description	Index Value
REHABILITATION			
163	RAD	Rehabilitation/ADL = 17-18	1.66
162	RAC	Rehabilitation/ADL = 14-16	1.31
161	RAB	Rehabilitation/ADL = 9-13	1.24
160	RAA	Rehabilitation/ADL = 4-8	1.07
EXTENSIVE SERVICES			
172	SE3	Extensive Services 3/ADL >6	2.1
171	SE2	Extensive Services 2/ADL >6	1.79
170	SE1	Extensive Services 1/ADL >6	1.54
SPECIAL CARE			
152	SSC	Special Care/ADL = 17-18	1.44
151	SSB	Special Care/ADL = 15-16	1.33
150	SSZ	Special Care/ADL = 4-14	1.28
CLINICALLY COMPLEX			
145	CC2	Clinically Complex w/Depression/ADL = 17-18	1.42
144	CC1	Clinically Complex/ADL = 17-18	1.25
143	CB2	Clinically Complex w/Depression/ADL = 12-16	1.15
142	CB1	Clinically Complex/ADL = 12-16	1.07
141	CA2	Clinically Complex w/Depression/ADL = 4-11	1.06
140	CA1	Clinically Complex/ADL = 4-11	0.95
IMPAIRED COGNITION			
133	IB2	Cognitive Impairment with Nursing Rehab/ADL = 6-10	0.88

132	IB1	Cognitive Impairment/ADL = 6-10	0.85
131	IA2	Cognitive Impairment with Nursing Rehab/ADL = 4-5	0.72
130	IA1	Cognitive Impairment/ADL = 4-5	0.67
BEHAVIOR PROBLEMS			
123	BB2	Behavior Problem w/Nursing Rehab/ADL= 6-10	0.86
122	BB1	Behavior Problem/ADL = 6-10	0.82
131	BA2	Behavior Problem w/Nursing Rehab/ADL= 4-5	0.71
120	BA1	Behavior Problem/ADL = 4-5	0.6
REDUCED PHYSICAL FUNCTION			
115	PE2	Physical Function w/Nursing Rehab/ADL=16-18	1
114	PE1	Physical Function/ADL = 16-18	0.97
113	PD2	Physical Function w/Nursing Rehab/ADL = 11-15	0.91
112	PD1	Physical Function/ADL = 11-15	0.89
111	PC2	Physical Function w/Nursing Rehab/ADL = 9-10	0.83
110	PC1	Physical Function/ADL = 9-10	0.81
104	PB2	Physical Function w/Nursing Rehab/ADL = 6-8	0.65
103	PB1	Physical Function/ADL = 6-8	waiver - not covered
102	PA2	Physical Function w/Nursing Rehab/ADL = 4-5	0.62
101	PA1	Physical Function/ADL = 4-5	waiver - not covered
OTHER			
180	STS	Short Term Stay	0.59

Related CPT® E&M Codes

Nursing Facility Services

- 99304** Initial nursing facility care, per day, for the evaluation and management of a patient, which requires these 3 key components: A detailed or comprehensive history; A detailed or comprehensive examination; and Medical decision making that is straightforward or of low complexity.
- 99305** Initial nursing facility care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity.
- 99306** Initial nursing facility care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity.
- 99307** Subsequent nursing facility care, per day for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A problem focused interval history; A problem focused examination; Straightforward medical decision making.
- 99308** Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of low complexity.
- 99309** Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of moderate complexity.
- 99310** Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A comprehensive interval history; A comprehensive examination; Medical decision making of high complexity.
- 99315** Nursing facility discharge day management; 30 minutes or less
- 99316** Nursing facility discharge day management; more than 30 minutes
- 99318** Evaluation and management of patient involving an annual nursing facility assessment, which requires these 3 key components: A detailed interval history; A comprehensive examination; and Medical decision making that is of low to moderate complexity.

Related CPT ®*Speech and Physical Therapy Codes

- 92507** Individual Treatment of speech, language, voice, communication, and/or auditory processing disorder
- 92508** Group, 2 or more - Treatment of speech, language, voice, communication, and/or auditory processing disorder

- 92521 Evaluation of speech fluency (eg, stuttering, cluttering)
- 92522 Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria);
- 92523 Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria); with evaluation of language comprehension and expression (eg, receptive and expressive language)
- 92524 Behavioral and qualitative analysis of voice and resonance
- 92526 Treatment of swallowing dysfunction and/or oral function for feeding
- 92597 Evaluation for use and or fitting of voice prosthetic device to supplement oral speech
- 92609 Therapeutic services for the use of speech-generating device including programming and modification
- 97161 Physical therapy evaluation: low complexity
- 97162 Physical therapy evaluation: moderate complexity
- 97163 Physical therapy evaluation: high complexity
- 97164 Re-evaluation of physical therapy established plan of care
- 91765 Occupational therapy evaluation, low complexity
- 97166 Occupational therapy evaluation, moderate complexity
- 97167 Occupational therapy evaluation, high complexity
- 97168 Re-evaluation of occupational therapy established plan of care
- 97532 Development of cognitive skills to improve attention, memory, problem solving (includes compensatory training), direct (one-on-one) patient contact, each 15 minutes
- 97533 Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one to one) patient contact by the provider, each 15 minutes **
- 97535 Self-care/home management training (eg, activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact by provider, each 15 minutes **
- 97537 Community/work integration training (eg, shopping, transportation, money management, avocational activities and/or work environment/modification analysis, work task analysis, use of assistive technology device/adaptive equipment), direct one-on-one contact by provider, each 15 minutes **
- 97542 Wheelchair management (eg, assessment, fitting, training), each 15 minutes

** These codes are not covered in the Nebraska market.

Orthotic Management and Prosthetic Management

- 97760 Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(s), lower extremity(s) and/or trunk, each 15 minutes
- 97761 Prosthetic training, upper and/or lower extremity(s), each 15 minutes
- 97762 Checkout for orthotic/prosthetic use, established patient, each 15 minutes

HCPCS®* Codes – No applicable codes.

ICD-10-PCS Codes – No applicable codes.

ICD-10-CM Diagnosis Codes – This list may not be all inclusive

Care in a skilled nursing facility (SNF) is covered if all four factors outlined above have been met.

- I50.1 Left ventricular failure, unspecified
- I50.21 Acute systolic (congestive) heart failure
- I50.23 Acute on chronic systolic (congestive) heart failure
- I50.31 Acute diastolic (congestive) heart failure
- I50.33 Acute on chronic diastolic (congestive) heart failure
- I50.41 Acute combined systolic (congestive) and diastolic (congestive) heart failure
- I50.43 Acute on chronic combined systolic (congestive) and diastolic (congestive) heart failure
- I50.811 Acute right heart failure
- I50.813 Acute on chronic right heart failure
- J44.0 Chronic obstructive pulmonary disease with acute lower respiratory infection
- J44.1 Chronic obstructive pulmonary disease with (acute) exacerbation
- J81.0 - J81.1 Pulmonary edema
- K85.00 - K85.92 Acute pancreatitis
- K91.2 Postsurgical malabsorption, not elsewhere classified

Coding information is provided for informational purposes only. The inclusion or omission of a CPT, HCPCS, or ICD-10 code does not imply member coverage or provider reimbursement. Consult the member's benefits that are in place at time of service to determine coverage (or non-coverage) as well as applicable federal / state laws.

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MEDICAL POLICY COMMITTEE HISTORY AND REVISIONS

Date	Action
2/1/2018	• Approved by MPC. Kentucky Medicare included in the policy as it was previously omitted.
12/7/2017	• Approved by MPC. Included information on RUG scoring.
11/2/2017	• Approved by MPC. Removed "Rehabilitation" from title; updated CMS language, leveling included for every SNF review.
9/7/2017	• Approved by MPC. Clarified NE verbiage and coding.
1/12/2017	• Approved by MPC. Inclusion of note in Coding section re: non-coverage of codes for Nebraska.
4/7/2016	• Approved by MPC. Clarified language re: coverage.
1/7/2016	• Approved by MPC. Added <i>Covered Services Summary</i> and section on <i>High Cost Drugs</i> .
10/17/2015	• Approved by MPC. New.