Skilled Nursing Facility Level of Care Guidelines

Applies to the following CarePartners of Connecticut products:

- ☒ CareAdvantage Premier
- ☒ CareAdvantage Prime
- ☒ CareAdvantage Preferred
- ☒ CarePartners Access

The following provides descriptions of levels of care (LOC) available for members in skilled nursing facilities (SNF) and is not to be used to determine medical necessity for admission. CarePartners of Connecticut utilizes nationally recognized nationally recognized medical necessity criteria to determine the appropriateness for admission and the LOC with the facility based on the clinical information presented at the time of admission.

Any disagreements with the member's LOC should be discussed directly with the CarePartners of Connecticut care manager (CM).

Providers should only bill the revenue codes as outlined in their provider agreements and in the Skilled Nursing Facility Payment Policy.

Note: The LOC billed must match the authorized LOC and length of stay.

Level 1A – Skilled Evaluation — Revenue Code 0190

This level of payment is for all members who require a skilled evaluation **only** and is limited to a maximum of five days. An assessment of the member's continued need for skilled care (e.g., Levels 1B or L2) must be made by the end of the third day of the stay. If the assessment determines the member does not meet skilled criteria, the member must receive a Notice of Medicare Noncoverage (NOMNC) 48 hours prior to the first day of noncoverage, in accordance with CMS regulations.

If a member does meet skilled criteria, the level of payment must be adjusted to reflect the appropriate skilled need (e.g., 1B or L2) by the fifth day of the stay.

Skilled Nursing Services

- Skilled nursing available 24 hours/day
- Restorative care
- Nursing interventions/treatments 1-2 times/24 hours, including, but not limited to:
  - Member/caregiver teaching and education (e.g., simple wound care, transfer techniques)
  - IV fluids only
- Skilled assessment (e.g., vital signs, weight, wound therapy, medication effectiveness)

Skilled Rehabilitation Services

- Evaluation only (must be completed within 24 hours of admission)
- Plan of care for restorative care (restorative aide or certified nursing assistant)

Per Diem Inclusions

Per diems include, but are not limited to:

- Skilled nursing care
- Room and board (including enteral feedings)
- Laboratory services
- All medications, including IV
- Medical/surgical supplies
- Oxygen and supplies
- DME (to be used by the member while at the facility, including, but not limited to overlay air mattresses, PAP therapy and bariatric equipment)
- Medical social work

- PT/OT/ST evaluation only
- Basic diagnostic tests (completed at the facility)
- Portable x-ray services

Per Diem Exclusions

- Physician coverage
- Psychiatric evaluations, psychotherapy and psychopharmacology services
- CAPD/hemodialysis
- Customized wheelchairs
- Devices and equipment needed for home placement and use only
- Ambulance transportation
- Respiratory therapy
- PT/OT/ST treatments
- Total parental nutrition (TPN)
- Wound vacuum
- Customized orthotics, prosthetics and orthopedic devices made for individual use

Examples of Diagnoses, Surgeries and Procedures

- Management and evaluation of care plan
- Medically unstable with changes in medication or treatment plan, requiring a daily skilled nursing observation/monitoring/treatment

Level 1/1B – Skilled Nursing and/or Rehabilitation Revenue Code 0191

This level of payment is for members who require skilled care daily for a minimum of 6 days/week.

Skilled Nursing Services

- Skilled nursing services provided for at least 2 hours/day up to 4 hours/day
- Restorative care
- Nursing interventions/treatments 2-4 times/24 hours, which include, but are not limited to:
  - Member/caregiver teaching and education (e.g., medication adherence, ADLs, chronic condition management)
  - Wound management requiring complex dressing and/or equipment
  - Single IV medications 1-2 times/24 hours
  - Bowel and bladder training
  - Assessment and management of chronic diseases and co-morbidities
  - Respiratory treatments (e.g., nebulizer and/or other respiratory treatments)

Skilled Rehabilitation Services

- Skilled rehabilitation services provided for 1-2 hours/day of one or more combined therapies (PT, OT, ST, and/or RT), 6-7 days/week
- For medically complex members who cannot tolerate at least 1 hour/day of skilled rehabilitation services, a combination of restorative nursing care/rehabilitation services >2 hours/day, 6 days/week to support overall care plan
- Restorative care may be used to supplement and/or substitute for rehabilitation hours for members with short-term illness
- If skilled rehabilitation hours are less than the hours documented above, the member must qualify for this level based upon skilled nursing and restorative care needs

Inclusions

Per diems include, but are not limited to:

- Skilled nursing care
- Room and board (including enteral feedings)
- Laboratory services
- All medications, including IV
- Medical/surgical supplies
- Oxygen and supplies

- DME (to be used by the member while at the facility, which include, but are not limited to, overlay air mattresses, PAP therapy and bariatric equipment)
- Medical social work
- PT/OT/ST treatments
- Respiratory therapy
- Basic diagnostic tests (completed at the facility)
- Portable x-ray services

Per Diem Exclusions

- Physician coverage
- Psychiatric evaluations, psychotherapy and psychopharmacology services
- CAPD/hemodialysis
- Customized wheelchairs
- Devices and equipment needed for home placement and use only
- Ambulance transportation
- Total parental nutrition (TPN)
- Wound vacuum
- Customized orthotics, prosthetics and orthopedic devices made for individual use
- High-cost medication (considered on a case-by-case basis)

Examples of Diagnoses, Surgeries and Procedures

- Decompensation of functional status due to chronic illness (e.g., CHF, COPD) or surgery with medical comorbidities that preclude active participation in skilled therapy >2 hours/day
- Rehabilitation potential for clinical/functional improvement

Level 2 – Subacute Nursing and/or Rehabilitation Revenue Code 0192

This level of payment is for members in need of complex nursing care or intense rehabilitation therapies.

Skilled Nursing Services

- Skilled nursing services provided for more than 4 hours/day
- Nursing interventions/treatments 4-6 times/24 hours, which include, but are not limited to:
  - Member/caregiver teaching/education (e.g., new ostomy care, new diabetic with frequent insulin adjustments and teaching, chronic disease care)
  - Wound management requiring complex dressing and equipment
  - Single IV medications 3 times/24 hours or multiple IV medications
  - Bowel and bladder treatment
  - Assessment and management of chronic diseases and co-morbidities
  - Respiratory treatments (e.g., nebulizer and/or other respiratory treatments)

Skilled Rehabilitation Services

- Skilled rehabilitation services provided 2-3 hours/day of a minimum of 2 or more combined therapies (PT, OT, ST, and/or RT), 6-7 days/week
- For medically complex members who cannot tolerate at least 1 hour/day of skilled rehabilitation services, a combination of restorative nursing care/rehabilitation services >2 hours/day, 6 days/week to support overall care plan
- Restorative care may be used to supplement and/or substitute for rehabilitation hours for members with short-term illness
- If skilled rehabilitation hours are less than the hours documented above, the member must qualify for this level based upon skilled nursing and restorative care needs

Per Diem Inclusions

Per diems include, but are not limited to:

- Skilled nursing care
- Room and board (including enteral feedings)
- Laboratory services

- All medications, including IV
- Medical/surgical supplies
- Oxygen and supplies
- DME (to be used by the member while at the facility, including but not limited to, overlay air mattresses, PAP therapy and bariatric equipment)
- Medical social work
- PT/OT/ST treatments
- Respiratory therapy
- Basic diagnostic tests (completed at the facility)
- Portable x-ray services

Per Diem Exclusions

- Physician coverage
- Psychiatric evaluations, psychotherapy and psychopharmacology services
- CAPD/hemodialysis
- Customized wheelchairs
- Devices and equipment needed for home placement and use only
- Ambulance transportation
- Total parental nutrition (TPN)
- Wound vacuum
- Customized orthotics, prosthetics and orthopedic devices made for individual use
- High-cost medication considered on a case-by-case basis

Examples of Diagnoses, Surgeries and Procedures

- New strokes (<30 days) with functional impairment requiring 2 or more disciplines
- New joint replacements able to tolerate minimum of 2.5 hours/day
- Members with high rehabilitation potential with expectation of discharge to community

Level 3 – Ventilator Program Revenue Code 0193

This level of payment is for members who require ventilator management.

Skilled Nursing Services

- Skilled nursing services provided for more than 4 hours/day
- Nursing interventions/treatments 4-6 times/24 hours, which include, but are not limited to:
  - Member/caregiver teaching/education (e.g., new ostomy care, new diabetic with frequent insulin adjustments and teaching, chronic disease care)
  - Wound management requiring complex dressing and equipment
  - Single IV medications 3 times/24 hours or multiple IV medications
  - Bowel and bladder treatment
  - Assessment and management of chronic diseases and comorbidities
  - Respiratory treatments (e.g., nebulizer and/or other respiratory treatments)

Skilled Rehabilitation Services

- Skilled rehabilitation services provided 2-3 hours/day of two or more combined therapies (PT, OT, ST, and/or RT), 6-7 days/week.
- For medically complex members who cannot tolerate at least 1 hour/day of skilled rehabilitation services, a combination of restorative nursing care/rehabilitation services greater than 2 hours/day, 6 days/week to support overall care plan.
- Restorative care may be used to supplement and/or substitute for rehabilitation hours for members with short-term illness.
- If skilled rehabilitation hours are less than the hours documented above, the member must qualify for this level based upon skilled nursing and restorative care needs.

Per Diem Inclusions

Per diems include, but are not limited to:

- Room and board (including enteral feedings)
- Laboratory services
- All medications, including IV
- Medical/surgical supplies
- Oxygen and supplies
- DME (to be used by the member while at the facility, which include, but are not limited to, overlay air mattresses, PAP therapy and bariatric equipment)
- Medical social work
- PT/OT/ST treatments
- Respiratory therapy
- Basic diagnostic tests (completed at the facility)
- Portable x-ray services

Per Diem Exclusions

- Physician coverage
- Psychiatric evaluations, psychotherapy and psychopharmacology services
- CAPD/hemodialysis
- Customized wheelchairs
- Devices and equipment needed for home placement and use only
- Ambulance transportation
- Total parental nutrition (TPN)
- Wound vacuum
- Customized orthotics, prosthetics and orthopedic devices made for individual use
- High cost medication (considered on a case-by-case basis)

Other Requirements for Skilled Admissions

- All exclusions from the per diem rate for DME must be coordinated with the appropriate Care Manager as prior authorization may be required. Refer to the CarePartners of Connecticut Care Management List to determine the appropriate Care Manager.
  Note: DME must be purchased from approved CarePartners of Connecticut participating providers.
- All items and services must be related to the member's diagnosis and treatment and ordered by the PCP.
- With the exception of an emergency, the facility must coordinate with the appropriate CM and utilize a CarePartners of Connecticut participating provider for any services excluded from the per diem. The cost of any nonemergency service not approved will be the responsibility of the ordering facility. Coverage requests for services for members that are not approved are subject to the organization determination process described at 42 CFR 422.566 et seq.
- The SNF will be compensated the contracted per diem rate starting on the day of admission and ending on the evening before day of discharge (the SNF will not bill for day of discharge).
- Level of care will be determined by the CM or delegated care manager (DCM) in collaboration with the facility and must be based on the aggregate medical needs of the member, reflecting the needed intensity of nursing services, rehabilitation and pharmacy administration.
- The CM/DCM must have access to and knowledge of weekly meetings and family meetings, the opportunity to participate in care planning, review of cases with interdisciplinary team, and discharge planning goals, including collaboration on the need for home visits, and the opportunity to develop systems that identify and report changes of condition of subacute and custodial members within 24 hours, or by the following business day.
- At the point of member discharge from the SNF, the provider must send a copy of the discharge summary to the CM/DCM and the member's PCP within seven days of discharge (or the member's post-discharge visit with the PCP, whichever is sooner).
- PT, OT and/or ST will be routinely provided 6-7 days per week, as necessary and in accordance with the terms of this agreement.

Document History

- December 2020: Added applicable CarePartners Access PPO content, effective for dates of service on or after January 1, 2021
- March 2019: Policy reviewed by committee; clarified purpose of document
- January 2019: Document created

Audit and Disclaimer Information

CarePartners of Connecticut reserves the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in this payment policy. If such an audit determines that a provider/facility did not comply with this payment policy, CarePartners of Connecticut will expect the provider/facility to refund all payments related to noncompliance. For more information about CarePartners of Connecticut's audit policies, refer to the CarePartners of Connecticut public Provider website.

This policy provides information on CarePartners of Connecticut claims adjudication processes. As every claim is unique, this policy is neither a guarantee of payment, nor a final indication of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management requirements (when applicable), adherence to plan policies and procedures, and claims editing logic. An authorization is not a guarantee of payment. Claims for services subject to authorization may be reviewed for accuracy and compliance with payment policies.

This policy applies to the CarePartners of Connecticut products identified by the checkboxes on page one. CarePartners of Connecticut reserves the right to amend a payment policy at its discretion.