Priority Health

MEDICAL POLICY
No. 91332-R5

NON-ACUTE INPATIENT SERVICES

Effective Date: August 27, 2019	**Review Dates: 1/93, 12/99, 12/01, 12/02, 11/03, 11/04, 10/05, 10/06, 10/07, 10/08, 10/09, 10/10, 10/11, 10/12, 10/13, 11/14, 11/15, 11/16, 8/17, 8/18, 8/19, 8/20, 8/21, 8/22, 8/23, 8/24**
Date of Origin: June 30, 1988	**Status: Current**

I. POLICY/ CRITERIA

A. Skilled rehabilitative services are a covered benefit as defined below and limited by the member contract when the services are primarily restorative in nature. The member's condition, the complexity, type of services, and the availability and feasibility of using a more economical alternative facility and service, including home-based services, are considered in coverage determinations.

Admission to and services provided in a Skilled Nursing, Subacute, or Rehabilitation Facility are not covered if the necessary care or therapies can be provided safely in the home.

When recovery or further meaningful improvement is not possible, skilled care may be needed to prevent deterioration of the patient's condition. Skilled care in this circumstance is considered custodial care and is not covered.

Skilled nursing and/or rehabilitative services must be:

1. Primarily restorative and rehabilitative in nature.
2. Must be needed on a daily (5-7 days/week) basis, and as a practical matter, the care can only be provided in a skilled nursing or hospital facility on an inpatient basis.
3. Furnished pursuant to a physician's order.
4. Require the skills of technical or professional personnel (where the inherent complexity of the service permits it to be provided by a technically knowledgeable person only).
5. Provided directly by or under the direction of such personnel and be reasonably expected to result in a meaningful improvement in the member's ability to perform functional day-to-day activities that are significant in the member's life roles within 60 days of initiation of the therapy.

B. Members who qualify for skilled, rehabilitative care are eligible for the following services while confined to a Skilled Nursing, Subacute, and Rehabilitation Facility:

1. Nursing care provided 24 hours a day by or under the supervision of a registered professional nurse.
2. Room and board in connection with such nursing care (private room covered only when medically indicated).

3. Physical, occupational, or speech therapy (when billed through the nursing facility).
4. Medical social services.
5. Drugs, biologicals, supplies, appliances, and equipment (for use in the facility and billed by the SNF).
6. Medical services provided by an intern or resident in training.
7. Diagnostic or therapeutic services.
8. Such other services necessary for the health of the patient as are generally provided by skilled nursing facilities.

C. Therapy is covered if it can be reasonably expected to result in a meaningful improvement in the member's ability to perform functional day-to-day activities that are significant in the member's life roles within 60 days of initiation of the therapy. Therapy that does not meet these goals is not covered.

D. Examples of Covered and Non-covered Services

The following are provided as examples of covered and non-covered services. They are not intended to be comprehensive nor are they intended to provide a justification for placement in a skilled nursing or other rehabilitation facility.

1. Examples of covered skilled nursing services include:
    a. Application of dressings involving prescription medications and aseptic techniques.
    b. Insertion and sterile irrigation and replacement of catheters.
    c. Intravenous, intramuscular, or subcutaneous injections (self-administered injections, ex: insulin, do not require skilled services).
    d. Overall management and evaluation of a complex care plan.
    e. Observation and assessment of the member's changing condition.
    f. Patient education services to teach self-maintenance or self-administration of care.
    g. Nasopharyngeal and tracheotomy aspiration.
    h. New intravenous, Levine tube or gastrostomy feedings to teach member or nonmedical caregiver appropriate maintenance plan.
    i. Treatment of extensive decubitus ulcers or other widespread skin disorder.
2. Examples of covered skilled rehabilitative services include (where the need is documented by a referring provider):
    a. Services to develop and manage a patient care plan, including tests and measurements of range of motion, strength, balance, coordination, endurance, functional ability, activities of daily living, perceptual deficits, speech and language or hearing disorders.
    b. Therapeutic exercises or activities which, because of the type of exercise or the condition of the member's, must be performed by or under the supervision of a qualified physical therapist or occupational therapist to ensure the safety of the patient and the effectiveness of the treatment.

c. Hydrocollator, paraffin baths, and whirlpool where the member's condition is complicated by circulatory deficiency, desensitization, open wounds, fractures, etc.
d. Services of a speech pathologist or audiologist when necessary to restore function.

3. Examples of non-covered services include but are not limited to:
   a. Administration of routine medications, eye drops, and ointments.
   b. Assistance in dressing, eating, and going to the bathroom.
   c. Changes of dressings for noninfected postoperative or chronic conditions.
   d. Custodial care.
   e. General maintenance care of colostomy and ileostomy.
   f. Routine services to maintain satisfactory functioning of indwelling bladder catheters.
   g. General maintenance care in connection with a plaster cast.
   h. General supervision of exercises which have been taught to the patient, including the carrying out of maintenance programs through the performance of repetition exercises to improve gait, maintain strength or endurance.
   i. Periodic turning and repositioning in bed.
   j. Prophylactic and palliative skin care, including bathing and application of creams or treatment of minor skin problems.
   k. Routine care of incontinent patients, including use of diapers and protective sheets.
   l. Routine care in connection with braces and similar devices.
   m. Use of heat as a palliative and comfort measure, such as whirlpool and hydrocollator.
   n. Routine administration of medical gases after a regimen of therapy has been established.

E. Prior Authorization Requirements

All skilled services in a Skilled Nursing, Subacute, or Rehabilitation Facility must be authorized.

II. MEDICAL NECESSITY REVIEW

Prior authorization for certain drug, services, and procedures may or may not be required. In cases where prior authorization is required, providers will submit a request demonstrating that a drug, service, or procedure is medically necessary. For more information, please refer to the Priority Health Provider Manual.

III. APPLICATION TO PRODUCTS

Coverage is subject to member's specific benefits. Group specific policy will supersede this policy when applicable.

- **HMO/EPO:** ***This policy applies to insured HMO/EPO plans.***
- **POS:** ***This policy applies to insured POS plans.***
- **PPO:** ***This policy applies to insured PPO plans. Consult individual plan documents as state mandated benefits may apply. If there is a conflict between this policy and a plan document, the provisions of the plan document will govern.***
- **ASO:** ***For self-funded plans, consult individual plan documents. If there is a conflict between this policy and a self-funded plan document, the provisions of the plan document will govern.***
- **INDIVIDUAL:** ***For individual policies, consult the individual insurance policy. If there is a conflict between this medical policy and the individual insurance policy document, the provisions of the individual insurance policy will govern.***
- **MEDICARE:** ***Coverage is determined by the Centers for Medicare and Medicaid Services (CMS) and/or the Evidence of Coverage (EOC); if a coverage determination has not been adopted by CMS, this policy applies.***
- **MEDICAID/HEALTHY MICHIGAN PLAN:** ***For Medicaid/Healthy Michigan Plan members, this policy will apply. Coverage is based on medical necessity criteria being met and the appropriate code(s) from the coding section of this policy being included on the Michigan Medicaid Fee Schedule located at: http://www.michigan.gov/mdch/0,1607,7-132-2945_42542_42543_42546_42551-159815--,00.html. If there is a discrepancy between this policy and the Michigan Medicaid Provider Manual located at: http://www.michigan.gov/mdch/0,1607,7-132-2945_5100-87572--,00.html, the Michigan Medicaid Provider Manual will govern. If there is a discrepancy or lack of guidance in the Michigan Medicaid Provider Manual, the Priority Health contract with Michigan Medicaid will govern. For Medical Supplies/DME/Prosthetics and Orthotics, please refer to the Michigan Medicaid Fee Schedule to verify coverage.***

Special Notes:

This policy does not apply to substance abuse or alcoholism rehabilitation services or treatment facilities.

This policy was previously titled "Skilled Nursing Facility"

IV. BACKGROUND

1. **Long Term Acute Care (LTAC)**: Medical care provided to patients that meet acute care criteria and that require hospitalization for a period of time generally greater than 25 days. This environment provides the patient with daily physician visits, a critical care and medical/surgical experienced nursing staff, a complete respiratory department (24 hours a day, 7 days a week), an in-house rehab department, case management, and social services, an in-house pharmacy, radiology, an operating room, an ICU, and a complete healthcare system designed to meet the needs of high acuity patients. Care provided in a LTAC is covered at the in-patient LTAC benefit. Examples of patient needs meeting LTAC criteria:
   - Long term IV therapies (3 weeks or longer)

- Ventilation/Pulmonary Care
- Hemo or Peritoneal Dialysis
- Post CVA
- Low Tolerance Rehab
- Wound Care
- Complicated Infectious Process

2. **Skilled Nursing, Subacute and Rehabilitation Facility Care:** Care and treatment, including therapy, and room and board in semi-private accommodations, are covered at a Skilled Nursing, Subacute, or Rehabilitation Facility when Priority Health has approved a treatment plan in advance. The treatment plan will be approved based on our determination of Medical/Clinical Necessity and appropriateness.

3. **Custodial and Maintenance Care:** Any care a member receives (if, in Priority Health's opinion), he/she has reached the maximum level of mental and/or physical function and will not improve significantly more. Custodial and maintenance care includes room and board, therapies, nursing care, home health aides and personal care designed to help in the activities of daily living, and home care and adult day care that the member receives, or could receive, from family members.

4. **Residential or Assisted Living:** Non-skilled care received in a home or facility on a temporary or permanent basis are not covered. Examples of such care include room and board, health care aides, and personal care designed to help you in activities of daily living or to keep you from continuing unhealthy activities.

V. CODING INFORMATION

There are no specific codes that define this policy. See content. Confer with health management or network development staff.
