

**MEDICAL ASSOCIATES HEALTH PLANS  
HEALTH CARE SERVICES POLICY AND PROCEDURE MANUAL  
POLICY NUMBER: PP 78**

**POLICY TITLE:** STEP DOWN/SKILLED CARE

**POLICY STATEMENT:**

The definition of “Skilled Care” means medical services (treatment, management, observation and evaluation of care) rendered by registered or licensed practical nurses, physical, occupational, and speech therapists. Patients receiving Skilled Care are usually quite ill and often have been recently hospitalized. In the majority of cases, “Skilled Care” is necessary for only a limited period of time. After that, most patients have recuperated enough to be cared for by “non-skilled” persons such as spouses, children, or other family or relatives. Custodial Care: is care that helps you with usual daily activities like getting in and out of bed, eating, bathing, dressing, and using the bathroom. It may also include care that most people do themselves, like using eye drops, oxygen, and taking care of colostomy or bladder catheters.

Skilled care is a comprehensive, outcome-oriented approach for patients who do not require acute care services such as high-technology or complex diagnostic procedures but continue to require short-term, complex, medical, and rehabilitation interventions provided by a physician-directed interdisciplinary team. Skilled care can be provided in a variety of settings, including skilled nursing facilities, acute hospitals, and specialty hospitals.

Medically necessary services and supplies required during a skilled nursing facility stay are covered when ordered by a physician and only when the patient is considered to have skilled, not long-term chronic care (custodial) needs.

**PURPOSE:**

To assure a timely, efficient and consistent process for prior authorizing skilled care utilizing resources to deliver care in the most appropriate setting and to determine benefits coverage for Health Plans Enrollees.

**PROCEDURE:**

CMS defines processes for coverage of services for Medicare Members

Medicare Skilled:

1. For Medicare Members, prior authorization is required for coverage of services which meet Medicare guidelines for Skilled Care. Medicare members must have a 3 day inpatient stay to qualify for Skilled. Exception: See page 4, # 8, 3<sup>rd</sup> paragraph for WI Mandate. Medicare members can go to any skilled facility.
2. For Commercial members, prior authorization is required utilizing the criteria as set forth in this policy. Commercial members must go to a contracted skilled facility. If contracted facility is full and member needs to go to a non-contracted facility, case manager must negotiate rates. Commercial members must be seen weekly by a practitioner to ensure the skilled criteria are being met.

**MEDICAL ASSOCIATES HEALTH PLANS**  
**HEALTH CARE SERVICES POLICY AND PROCEDURE MANUAL**  
**POLICY NUMBER: PP 78**  
**PAGE 2**

Notification must be received within 48 hours of admission at Health Care Services 1-800-325-7442 or 563-584-3275. The following information is needed when calling for a prior authorization:

- |    |                   |    |                                     |
|----|-------------------|----|-------------------------------------|
| a. | Client Name       | e. | Diagnosis                           |
| b. | Date of Birth     | f. | Skilled services to be administered |
| c. | Date of Admission |    |                                     |
| d. | Physician         |    |                                     |

3. To qualify for a skilled nursing facility, all of the following specific conditions must be met:

The patient must require skilled nursing and/or skilled rehabilitation services on a daily basis. To meet the daily basis requirement, the following frequency is required:

- a. Skilled nursing services or skilled rehabilitation services must be needed and provided seven (7) days a week.
- b. As an exception, if skilled rehabilitation services are not available seven (7) days a week, those services must be needed and provided at least five (5) days a week.
- c. A break of one or two days in the furnishing of rehabilitation services will not preclude coverage if discharge would not be practical for the one or two days during which therapy is suspended (i.e. the physician has postponed therapy sessions because the patient exhibited extreme fatigue).

**Some examples of criteria for skilled care:**

- Frequent medication adjustments.
- Physical Therapy with restorative goals provided at least five (5) days per week by or under the directions of a licensed physical therapist.
- Individualized program includes but is not limited to:  
Strengthening, gait training, transfer techniques, stair climbing techniques, modalities directed towards alleviation of pain or improved function and mobility (range of motion, stretching, ultrasound, diathermy, hot packs, and whirlpool).
- Physical Therapy Modalities utilized include but are not limited to:  
active/passive range of motion, electrical/tactile stimulation, resistive exercises, and strengthening.
- Occupational Therapy with restorative goals for gross/fine motor muscle re-training provided at least five (5) days per week
- Bed activity skills (rolling, sitting, dangling, etc.), dressing and undressing, personal hygiene, and hand activities (use of telephone, writing, etc.).
- Speech Therapist and provided at least five (5) days per week by or under the direction of the therapist to retrain or establish new skills for communication and/or swallowing techniques in a resident exhibiting a reasonable expectation for improvement.
- Decubitus ulcer, pressure ulcer, or extensive skin lesion (Grade 3 or greater) requiring:
  - Daily dressing changes or irrigations using sterile technique.
- Post-Operative wound care requiring daily sterile dressing changes and/or irrigations

**MEDICAL ASSOCIATES HEALTH PLANS**  
**HEALTH CARE SERVICES POLICY AND PROCEDURE MANUAL**  
**POLICY NUMBER: PP 78**  
**PAGE 3**

- Strict isolation
  - “Grade 3” is defined as- “The skin becomes necrotic with exposure of fat”
  - “Grade 2” is defined as “shows redness, edema, and induration at times with epidermal blistering or desquamation.”
  - Naso-Pharyngeal and/or tracheal suctioning frequently required and provided by licensed professional staff.
  - Ventilator required continuously.
  - Daily intermittent catheterizations are performed by licensed professionals.
  - CAPD (Continuous Ambulatory Peritoneal Dialysis) performed by qualified licensed professional staff.
  - Nephrostomy tube or suprapubic catheter present in early post-operative period. Daily dressing changes, stoma care, and evaluation of tube position required.
  - Colostomy/ileostomy/ileoconduit present in early post-operative period. Daily dressing changes, stoma care, and evaluation of stoma required.
  - Nasogastric, gastrostomy, or jejunostomy tube feeding are utilized to maintain nutritional status (oral intake is inadequate to meet nutritional needs). Intake is documented daily.
  - Intravenous medications administered daily.
  - Intramuscular or subcutaneous medications (excluding insulin) are administered daily.
  - Administration of insulin requires frequent (daily) adjustments in dosage as determined by blood glucose levels.
  - Medications that require physician monitoring and frequent lab values (daily) are administered.
4. Individualized teaching and training program Daily skilled services must be ones that, as a practical matter, can only be provided in a SNF, on an inpatient basis. In making a “practical matter” determination, consideration must be given to the patient’s condition and to the availability and feasibility of using more economical alternative facilities and services.
- A. **Patient’s condition:** Inpatient care would be required as a “practical matter” if transporting the patient to and from the nearest facility that furnishes the required daily skilled services would be an excessive physical hardship.
- B. **Economy and efficiency:** Even if the patient’s condition does not preclude transportation, inpatient care might be more efficient and less costly if, for instance, the only alternative is daily transportation by ambulance.
5. The skilled service must be inherently complex that it can only be safely and effectively performed by, or under the supervision of professional or technical personnel.
6. A condition that does not ordinarily require skilled services may require them because of special medical complications. Under those circumstances, a service that is usually non-skilled may be considered skilled because it must be performed or supervised by skilled nursing or rehabilitation personnel.

**MEDICAL ASSOCIATES HEALTH PLANS**  
**HEALTH CARE SERVICES POLICY AND PROCEDURE MANUAL**  
**POLICY NUMBER: PP 78**  
**PAGE 4**

7. The restoration potential of a patient is not the deciding factor in determining whether skilled services are needed. Even if full recovery or medical improvement is not possible, a patient may need skilled services to prevent further deterioration or preserve current capabilities.
8. The Utilization Review Case Manager from Medical Associates Health Plan (MAHP) will review at a **minimum** of weekly to determine if the client is still meeting criteria for skilled care, either inpatient or in a skilled facility (i.e., nursing home).
  - If criteria for Medicare are met, MAHP will pay after Medicare.
  - If Medicare criteria are not met, MAHP will not cover. Documentation of all review decisions i.e. meeting or not meeting criteria with supporting remarks is entered into the information system. MAHP will send out a denial notice using the “Notice of Medicare Non-Coverage” (NOMNC). If the service is requested prior to obtaining the service (preservice) the “Notice Denial of Medicare Coverage” (NDMC) is sent to the member.

If a physician transfers a Medicare member to skilled without prior approval and the patient does not qualify for skilled, the health plan will pay until the member is notified they no longer qualify for skilled through a NOMNC.

The state of Wisconsin has mandated all Medicare eligible individuals from the State of Wisconsin who have MAHP coverage are eligible for 30 days of skilled coverage even though they do not have a 3-day (consecutive) hospital stay prior to a skilled admission. These individuals must meet MAHP criteria for skilled care which includes weekly physician visits to certify continued need for skilled care. MAHP is responsible for payment. Claims should be submitted to MAHP.

9. For Medicare Part B qualifying skilled rehabilitative therapy: Facilities are requested to perform the following:
  - Fax “Initial Evaluation” form to MAHP Health Care Services Department at 563-585-1545.
  - Fax copy of signed physician order
  - Fax copy of treatment plan when it has been completed
  - Fax copy of signed treatment plan once physician’s signature has been obtained
  - A new treatment plan is required every 30 days
  - Fax date of discharge
  - For record purposes, MAHP requests all information be faxed rather than phoned
10. Commercial (Non-Medicare) Skilled: Skilled coverage for MAHP Commercial population is subject to MAHP criteria. Notification of review decisions to the member is performed according to established procedures. Reviews will be a minimum of weekly with documentation of meeting criteria entered into the information system. This is to assure the member continues to meet skilled criteria

**MEDICAL ASSOCIATES HEALTH PLANS**  
**HEALTH CARE SERVICES POLICY AND PROCEDURE MANUAL**  
**POLICY NUMBER: PP 78**  
**PAGE 5**

11. UR Review for Skilled Nursing Facility: Nursing will monitor and document the progress of the Skilled Medicare and Commercial Members. Assessments are made at a minimum of weekly dependent on the progress of the member. Discharge planning will be documented in the Amisys system.

**Discharge Criteria**

- Presenting symptoms are under control and appear manageable at a lower level of care.
- Member is non-participating in treatment program or unable to actively participate in the therapy program.
- Member has reached maximum expected goals or has failed to show improvement in the last three days.

**EXCLUSIONS:**

1. Long Term Chronic Care: Long Term chronic care (custodial care) services which do not require the skills of qualified technical or professional personnel are not skilled services and are not separately covered. Long Term chronic care services include but are not limited to:
  - a. Administration of routine oral medications, eye drops, and ointments.
  - b. General maintenance care of colostomy and ileostomy.
  - c. Routine services to maintain satisfactory functioning of indwelling bladder catheters.
  - d. Changes of dressings for no infected postoperative or chronic condition.
  - e. Prophylactic and palliative skin care, including bathing and application of creams, or treatment of minor skin problems.
  - f. Routine care of the incontinent patient, including use of diapers and protective sheets.
  - g. General maintenance in connection with plaster cast.
  - h. Routine care in connection with braces and similar devices.
  - i. Use of heat as a palliative and comfort measure, such as whirlpool and hydrocollator.
  - j. Routine administration of medical gases after a regimen of therapy has been established.
  - k. Assistance in dressing, eating and going to the toilet.
  - l. Periodic turning and positioning in bed.
  - m. General supervision of exercises which have been taught to the patient, including maintenance programs which are not related to a specific loss of function.
  - n. 24 hr supervision for exit seeking behavior.
  
2. Wisconsin Medicare enrollees who have coverage for Non-Medicare Approved Care:  
If Medicare does not approve care in the Skilled Nursing Facility, you will be covered for 30 days for the services outlined per spell of illness above if they meet the following conditions:
  - a. You receive Skilled Nursing Care as determined by MAHP.
  - b. The stay is certified as Medically Necessary by the attending physician, and is recertified as Medically Necessary every 7 days.
  - c. Member must meet the skilled criteria as defined in this policy.

**MEDICAL ASSOCIATES HEALTH PLANS  
HEALTH CARE SERVICES POLICY AND PROCEDURE MANUAL  
POLICY NUMBER: PP 78  
PAGE 6**

---

Judy Riniker, R.N.  
Manager of Health Care Services/Quality Improvement

---

Date

---

Mary Leary, R.N.  
Director of Health Care Services/Quality Improvement

---

Date

Attachments: NDMC (Notice of Denial of Medical Coverage)  
NOMNC (Notice of Medicare Non-Coverage)

Original:	07/00	Reviewed:	03/04	Revised:	12/07	Revised:	01/12
Revised:	05/01	Reviewed:	03/05	Revised:	02/09		
Reviewed:	03/02	Reviewed:	03/06	Reviewed:	02/10		
Reviewed:	03/03	Reviewed:	03/07	Revised:	02/11		

**Notice of Denial of Medical Coverage**

---

**Date:**

**Member number:**

**Beneficiary's name:**

---

We have denied coverage of the following medical services or items that you or your physician requested:

---

---

---

---

---

---

We denied this request because:

---

---

---

---

---

---

**What If I Don't Agree With This Decision?**

**You have the right to appeal.** File your appeal in writing within 60 calendar days after the date of this notice. We can give you more time if you have a good reason for missing the deadline.

**Who May File An Appeal?**

You or your treating physician may file an appeal. Or you may name a relative, friend, advocate, attorney, doctor (other than your treating physician), or someone else to act as your representative. Others also already may be authorized under State law to act for you.

You can call us at: \_\_\_\_\_ to learn how to name your representative.

If you have a hearing or speech impairment, please call us at TTY \_\_\_\_\_.

If you want someone to act for you, you and your representative must sign, date, and send us a statement naming that person to act for you.

**There are two kinds of appeals you can file:**

**Standard (30 days)** - You can ask for a standard appeal. We must give you a decision no later than 30 days after we get your appeal. (We may extend this time by up to 14 days if you request an extension, or if we need additional information and the extension benefits you.)

**Fast (72 hour review)** - You can ask for a fast appeal if you or your doctor believe that your health could be seriously harmed by waiting up to 30 days for a decision. We must decide on a fast appeal no later than 72 hours after we get your appeal. (We may extend this time by up to 14 days if you request an extension, or if we need additional information and the extension benefits you.)

- **If any doctor** asks for a fast appeal for you, or supports you in asking for one, and the doctor indicates that waiting for 30 days could seriously harm your health, **we will automatically give you a fast appeal.**
- If you ask for a fast appeal without support from a doctor, we will decide if your health requires a fast appeal. We will notify you if we do not give you a fast appeal, and we will decide your appeal within 30 days.

**What do I include with my appeal?**

Your written request should include: your name, address, member number, reasons for appealing, and any evidence you wish to attach. You may send in supporting medical records, doctors' letters, or other information that explains why we should provide the service. Call your doctor if you need this information to help you with your appeal. You may send in this information or present this information in person.

**How Do I File An Appeal?**

**For a Standard Appeal:** Mail or deliver your written appeal to the address below:

**For a Fast Appeal:** Contact us by telephone or fax:

**What Happens Next?**

If you appeal, we will review our decision. After we review our decision, if any of the services you requested are still denied, Medicare will provide you with a new and impartial review of your case by a reviewer outside of your Medicare health plan. If you disagree with that decision, you will have further appeal rights. You will be notified of those appeal rights if this happens.

**Contact Information:**

If you need information or help, call **us** at:  
Toll Free:  
TTY:

**Other Resources to Help You:**

Medicare Rights Center:  
Toll Free: 1-888-HMO-9050  
Elder Care Locator  
Toll Free: 1-800-677-1116  
1-800-MEDICARE (1-800-633-4227)  
TTY: 1-877-486-2048

**A {Insert provider contact information here}  
Notice of Medicare Non-Coverage**

*Patient name:*

*Patient number:*

**The Effective Date Coverage of Your Current {insert type}  
Services Will End: {insert effective date}**

- 
- Your Medicare health plan and/or provider have determined that Medicare probably will not pay for your current {insert type} services after the effective date indicated above.
  - You may have to pay for any services you receive after the above date.
- 

**Your Right to Appeal This Decision**

- You have the right to an immediate, independent medical review (appeal) of the decision to end Medicare coverage of these services. Your services will continue during the appeal.
  - If you choose to appeal, the independent reviewer will ask for your opinion. The reviewer also will look at your medical records and/or other relevant information. You do not have to prepare anything in writing, but you have the right to do so if you wish.
  - If you choose to appeal, you and the independent reviewer will each receive a copy of the detailed explanation about why your coverage for services should not continue. You will receive this detailed notice only after you request an appeal.
  - If you choose to appeal, and the independent reviewer agrees services should no longer be covered after the effective date indicated above, neither Medicare nor your plan will pay for these services after that date.
  - If you stop services no later than the effective date indicated above, you will avoid financial liability.
- 

**How to Ask For an Immediate Appeal**

- You must make your request to your Quality Improvement Organization (also known as a QIO). A QIO is the independent reviewer authorized by Medicare to review the decision to end these services.
- Your request for an immediate appeal should be made as soon as possible, but no later than noon of the day before the effective date indicated above.
- The QIO will notify you of its decision as soon as possible, generally no later than the effective date of this notice.
- Call your QIO at: {insert name and number of QIO} to appeal, or if you have questions.

**See the back of this notice for more information.**

**MEDICAL ASSOCIATES HEALTH PLANS  
HEALTH CARE SERVICES POLICY AND PROCEDURE MANUAL  
POLICY NUMBER: PP 78  
PAGE 10**

Form CMS 10095-NOMNC (Exp. 10/31/2013)

OMB approval 0938-0910

**MEDICAL ASSOCIATES HEALTH PLANS  
HEALTH CARE SERVICES POLICY AND PROCEDURE MANUAL  
POLICY NUMBER: PP 78  
PAGE 11**

Other Appeal Rights:

- If you miss the deadline for requesting an immediate appeal with the QIO, you still may request an expedited appeal from your Medicare Health plan. If your request does not meet the criteria for an expedited review, your plan will review the decision under its rules for standard appeals. Please see your Evidence of Coverage for more information.
- Contact your plan or 1-800-MEDICARE (1-800-633-4227), or TTY: 1-877-486-2048 for more information about the appeals process.

---

Plan Contact Information:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Additional Information (Optional):

---

Please sign below to indicate you have received this notice.

I have been notified that coverage of my services will end on the effective date indicated on this notice and that I may appeal this decision by contacting my QIO.

\_\_\_\_\_  
Signature of Patient or Representative

\_\_\_\_\_  
Date