



Medicare Skilled Nursing Facility (SNF) Prior Authorization Resource

Applies to members enrolled in the following My Choice Wisconsin Medicare health plan products:

**Partnership Dual Eligible,
Dual Advantage**

Coverage rationale:

Skilled care may be necessary to improve a member's current condition, to maintain the member's current condition, or to prevent or slow further deterioration of the member's condition. Care in a Skilled Nursing Facility (SNF) is considered necessary if **all** of the following six factors are met:

1. The member is an active member of My Choice Wisconsin's Partnership Dual Eligible or Dual Advantage program.
2. The member has days remaining within the benefit period or is eligible for a new benefit period. **Benefit Period (Spell of Illness)** is the period of time for measuring the use of hospital insurance benefits. A benefit period begins with the first day (not included in a previous benefit period) on which a member is furnished inpatient hospital or SNF services by a qualified provider. The benefit period ends with the close of a period of 60 consecutive days during which the member was neither an inpatient of a hospital nor an inpatient of a SNF. To determine the 60-consecutive-day period, begin counting with the day on which the individual was discharged. See the [Medicare General Information, Eligibility and Entitlement Manual, Chapter 3, §10.4 Benefit Period \(Spell of Illness\)](#).
3. The member requires daily skilled nursing services or skilled rehabilitation services, i.e., services that must be performed by or under the supervision of professional or technical personnel; are ordered by a physician and the services are rendered for a condition for which the member received inpatient hospital services or for a condition that arose while receiving care in a SNF for a condition for which he received inpatient hospital services. Skilled nursing and/or skilled rehabilitation services are those services, furnished pursuant to physician orders, that:
 - 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 member and to achieve the medically desired result. **NOTE:** "General supervision" requires initial direction and periodic inspection of the actual activity. However, the supervisor need not always be physically present or on the premises when the assistant is performing services.
4. These skilled services are required on a daily basis: Skilled nursing services or rehabilitation services (or a combination of these services) must be needed by the member and provided for the member on a "daily basis," i.e., on essentially a 7-days-a-week basis. A member whose inpatient stay is based solely on the need for skilled rehabilitation services would meet the "daily basis" requirement when they need and receive those services on at least 5 days a week. (If therapy services are provided less than 5 days a week, the "daily" requirement would not be met.) This requirement should not be applied so strictly that it would not be met merely because there is an isolated break of a day or two during which no skilled rehabilitation services are furnished and discharge from the facility would not be practical.
5. As a practical matter, considering economy and efficiency, the daily skilled services can be provided only on an inpatient basis in a SNF.
 - a. In determining whether the daily skilled care needed by an individual can, as a "practical matter," only be provided in a SNF on an inpatient basis, the individual's physical condition and

the availability and feasibility of using more economical alternative facilities or services should be considered.

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

Additional Considerations:

Three-Day Prior Hospitalization the Original Medicare requirement of three (3) consecutive calendar hospital day stay before transferring to a SNF is waived for My Choice Wisconsin Medicare Advantage and Partnership Dual Eligible members.

Benefit Period (Spell of Illness) When a member changes membership (i.e., from one Medicare plan to a My Choice Wisconsin Medicare plan, or from one My Choice Wisconsin Medicare plan to another My Choice Wisconsin Medicare plan) while in the middle of SNF stay, the member does not automatically get a new 100-day benefit. The member continues with the benefit period started with the previous plan and the member must meet all the SNF coverage criteria and requirements to begin a new benefit period.

Medicare SNF Coverage Guidelines-Covered Services under Part A Under SNF Prospective Payment System (PPS), covered SNF services include post-hospital SNF services for which benefits are provided under Part A (the hospital insurance program) and all items and services which, prior to July 1, 1998, had been paid under Part B (the supplementary medical insurance program) but furnished to SNF residents during a Part A covered stay. The following are billed separately:

- a. Physician services, physician assistant services, nurse practitioner and clinical nurse specialist services, certified mid-wife services, qualified psychologist services, certified registered nurse anesthetist services;
- b. Certain dialysis-related services;
- c. Erythropoietin (EPO) for certain dialysis members;
- d. Hospice care related to a terminal condition;
- e. Ambulance trips that convey a member to the SNF for admission or from the SNF following discharge;
- f. Ambulance transportation related to dialysis services;
- g. Certain services involving chemotherapy and its administration;
- h. Radioisotope services;
- i. Certain customized prosthetic devices; and
- j. Certain additional outpatient hospital services (along with ambulance transportation that convey a beneficiary to a hospital or CAH to receive the additional services) are excluded from coverage under SNF PPS and are billed separately. The additional services are:
 - o Cardiac catheterization services;
 - o Computerized axial tomography (CT scans);

- Magnetic resonance imaging (MRIs);
- Radiation therapy;
- Ambulatory surgery involving the use of a hospital operating room;
- Emergency services;
- Angiography services; and
- Lymphatic and venous procedures

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

See the [Medicare Benefit Policy Manual, Chapter 8, §10.2 - Medicare SNF Coverage Guidelines under PPS.](#)

Members who exhaust their SNF benefits while inpatient or in a SNF are entitled to coverage of certain services under Part B. These services and supplies would continue to be covered until a new benefit period begins or they are no longer considered to be medically necessary or reasonably necessary for the diagnosis and treatment of the member's illness/injury. Examples include, but are not limited to:

- Diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests
- X-ray, radium, and radioactive isotope therapy, including materials and services of technicians
- Prosthetic devices (other than dental) which replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices (Example: Accessories and supplies used directly with an enteral or parenteral device (e.g., catheters, filters, extension tubing, infusion bags, pumps, IV poles, needles, syringes, dressings, tape, flushing solutions, volumetric monitors, and parenteral and enteral nutrient solutions)
- Leg, arm, back, and neck braces, trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition;
- Outpatient physical therapy, outpatient speech language pathology services, and outpatient occupational therapy. *Therapy services are payable under the Physician Fee Schedule when furnished by 1) a provider to its outpatients in the member's home; 2) a provider to members who come to the facility's outpatient department; 3) a provider to inpatients of other institutions, or 4) a supplier to patients in the office or in the member's home. Coverage includes therapy services furnished by participating hospitals and SNFs to their inpatients who have exhausted Part A inpatient benefits or who are otherwise not eligible for Part A benefits. Providers of therapy services that have inpatient facilities, other than participating hospitals and SNFs, may not furnish covered therapy services to their own inpatients. However, since the inpatients of one institution may be considered the outpatients of another institution, all providers of therapy services may furnish such services to inpatients of another health facility. See the [Medicare Benefit Policy Manual, Chapter 15, §220.1.4 - Requirement That Services Be Furnished on an Outpatient Basis.](#)*
- Surgical dressings, splints and casts, and other devices used for reduction of fractures and dislocations;
- Physician, Physician Nurse Practitioner or Clinical Nurse Specialist services (usually billed to part B)
- Screening mammography services
- Screening pap smears and pelvic exams;
- Influenza, pneumococcal pneumonia, and hepatitis B vaccines
- Some colorectal screening
- Diabetes self-management (e.g., diabetic supplies and equipment including blood glucose monitors, strips and lancets)
- Prostate screening;
- Ambulance services

- Hemophilia clotting factors
- Epoetin Alfa (EPO) for ESRD beneficiaries when given in conjunction with dialysis.

See the [Medicare Benefit Policy Manual, Chapter 15, §250 - Medical and Other Health Services Furnished to Inpatients of Hospitals and Skilled Nursing Facilities](#). Also see the [Medicare Benefit Policy Manual, Chapter 8, §70 - Medical and Other Health Services Furnished to SNF Patients](#).

Requesting prior authorization:

- Complete the [Skilled Nursing Facility and Long Term Acute Care Prior Authorization Request Form](#)
- Provide clinical documentation to support the SNF care including;
 - a history and physical exam pertinent to the member's care, the skilled services provided,
 - the member's response to the skilled services provided during most recent cares,
 - the plan for future care based on the rationale of prior results,
 - the complexity of the service to be performed, and
 - any other pertinent characteristics of the member.
- Fax to 608-210-4050
- SNF stays are reviewed concurrently every 14 days for medical necessity

Exclusions:

SNF stays covered under a member's Medicaid coverage including Partnership-Medicaid, Family Care or SSI Managed Care are addressed in the Medicaid Skilled Nursing Facility Prior Authorization Guide.

Definitions:

None

References:

[Medicare Benefit Policy Manual, Chapter 8, §10.2 - Medicare SNF Coverage Guidelines under PPS](#).