



Medicare Part C Medical Coverage Policy

Skilled Care Services

Origination: June 30, 1988

Review Date: February 21, 2018

Next Review: February, 2020

DESCRIPTION OF PROCEDURE OR SERVICE

Skilled Care Services include home health care and skilled nursing facility (SNF), or skilled unit (SNU), or sub-acute facility or unit care that is covered when medically necessary and prior approved by the Plan. Skilled nursing and/or skilled rehabilitation services are those services furnished pursuant to physician orders that:

- Require the skills of qualified technical or professional health personnel such as registered nurses, licensed practical (vocational) nurses, physical therapists, occupational therapists, and/or speech pathologists or audiologists; and
- 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.

DEFINITIONS:

- 1) **Improvement Standard:** While the expectation of improvement may be reasonable when evaluating a goal in which restoring prior capability was anticipated, the Plan recognizes that even if there is no improvement, skilled care may still be required to prevent or slow deterioration and maintain the member at the maximum practical level of function. The RESTORATION POTENTIAL of the individual is NOT the deciding factor in determining whether skilled services are needed. Thus, coverage does not depend on restorative potential, but on whether skilled care is required, along with the reasonableness and necessity of the services themselves. Conversely, coverage would not be available in a situation where the beneficiary's care needs can be addressed safely and effectively through the use of non-skilled personnel.
- 2) **Maintenance Therapy** denotes a repetitive activity necessary to maintain function usually provided by certified nursing assistants. In rehabilitation, maintenance therapy may be skilled when specialized knowledge and judgment of a qualified therapist is required to design and establish a maintenance program based on an initial evaluation and periodic reassessment of the member's needs and is consistent with the member's capacity for tolerance. (An Example would be a Parkinson's patient, who may need a licensed therapist to determine what type of exercises will best contribute to his or her maintenance of present functioning.) Physical Therapy should anticipate a "Maintenance program" and incorporate this into the plan of care.
- 3) **Custodial Care** is excluded except in the case of Hospice. Custodial care is the type of care that is designed essentially to assist the individual in meeting the activities of daily living or services that constitute personal care; i.e., help with walking, getting out

of bed, assistance with bathing, dressing, feeding, toileting, preparation for special diets, or supervision with medication.

- 4) Place of residence** is wherever the member makes his or her home. This may be his or her dwelling, an apartment, a relative's home, a home for the aged, or some other type of institution. The member may have two homes, as long as the home bound rule applies.

An institution may **not** be considered a member's residence if the institution is a hospital or skilled nursing facility and meets the definition of such per Medicare. To meet this definition, the hospital must be providing diagnostic and therapeutic services for medical diagnosis, treatment and care of the injured, disabled or sick per the Social Security Act, Section 1861 (e)(1). A skilled nursing facility must be primarily engaged in providing skilled nursing care and related services for residents who require medical or nursing care, or rehabilitative services for the injured, disabled or sick per the Social Security Act, Section 1819 (a). The only exception is when the services involve equipment that cannot be made readily available to the member in the place of residence.

The member may also attend a state licensed "Adult Day Care Centers" on a regular basis and still be considered home bound. (See Special Note).

5) "Part time or Intermittent" Home Health Care

CMS defines intermittent as skilled nursing care that is either provided or needed on fewer than 7 days each week, or less than 8 hours each day for periods of 21 days or less (with extensions in exceptional circumstances when the need for additional care is finite and predictable.) A person expected to need more or less full-time skilled nursing care over an extended period of time, i.e., a member who requires institutionalization, would usually not qualify for home health benefits.

POLICY STATEMENT

Coverage will be provided for skilled care services when it is determined to be medically necessary, as outlined below in the guidelines and medical criteria.

BENEFIT APPLICATION

Please refer to the member's individual Evidence of Coverage (EOC) for benefit determination. Coverage will be approved according to the EOC. Limitations if criteria are met.

Coverage decisions for members will be made in accordance with:

- The Centers for Medicare & Medicaid Services (CMS) national coverage decisions;
- General coverage guidelines included in original Medicare manuals unless superseded by operational policy letters or regulations; and
- Written coverage decisions of local Medicare carriers and intermediaries with jurisdiction for claims in the geographic area in which services are covered.

Benefit payments are subject to contractual obligations of the Plan. If there is a conflict between the general policy guidelines contained in the Medical Coverage Policy Manual and the terms of the member's particular Evidence of Coverage (EOC), the EOC always governs the determination of benefits.

I. HOME HEALTH CARE

Home health care services and/or supplies are covered when a patient's condition restricts the ability of the individual to leave home.

An individual does not have to be bedridden to be considered confined to the home; however the following criteria need to be met for the member to be considered homebound.

Criteria A (1 or 2) and B (1 and 2) is met as follows:

A: Criteria 1 or 2:

1. Members will be considered to be homebound if they have a condition due to an illness or injury that restricts their ability to leave their place of residence except with the aid of supportive devices such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the assistance of another person; **OR**
2. Have a condition such that leaving the home is medically contraindicated.

AND

B: Criteria 1 and 2:

1. There must exist a normal inability to leave the home.
- AND**
2. Leaving the home must require a considerable and taxing effort.

Members are allowed to take occasional absences from the home for non-medical purposes. Examples include a trip to the barber, attendance at a family event, or other infrequent and unique events.

If the member does in fact leave the home, the member may nevertheless be considered homebound if the absences from the home are infrequent or for periods of relatively short duration, or are attributable to the need to receive health care treatment. Absences attributable to the need to receive health care treatment include, but are not limited to:

- Attendance at adult day centers to receive medical care;
- Services received at hospitals, skilled nursing facilities, or rehabilitation centers when they involve equipment too cumbersome to bring to the home.
- Ongoing receipt of outpatient kidney dialysis; or
- The receipt of outpatient chemotherapy or radiation therapy.

Covered Home Health Services

Home health services that may be authorized for coverage are as follows:

1. Part-time or intermittent skilled nursing care;

2. Part-time or intermittent home health aide services;
3. Physical therapy;
4. Speech-language pathology;
5. Occupational therapy;
6. Medical social services;
7. Medical supplies, while receiving skilled care

Skilled Services:

Nursing

1. Observation and assessment of the member's condition when only the specialized skills of a medical professional can determine member's status;
2. Management and evaluation of a member care plan where underlying conditions or complications require that only a registered nurse can ensure that essential non-skilled care is achieving its purpose;
3. Teaching and training activities which require the skills or knowledge of a registered nurse;
4. Direct skilled nursing services to members.

Therapy Services:

The plan must include therapy treatment goals which pertain directly to the member's illness or injury. The plan must include the expected duration of therapy services. The plan must describe a course of treatment which is consistent with the qualified therapist's assessment of the patient's function.

Physical Therapy:

1. Assessment of rehabilitation needs and potential;
2. Develop/implement a physical therapy program;
3. Therapeutic exercises;
4. Gait training;
5. Range of motion;
6. Maintenance therapy to ensure the safety of the member or the effectiveness of the program;
7. Ultrasound, short-wave, and microwave diathermy treatments;
8. Hot packs, infra-red treatments, paraffin baths and whirlpool baths;
9. Wound care provided by physical therapists within the scope of the State Practice Act.

Occupational Therapy:

- A. Assessment by a qualified therapist, planning, implementing, and supervision of therapeutic programs such as:
 - 1. Selecting and teaching task oriented therapeutic activities designed to restore physical function;
 - 2. Planning, implementing, and supervising therapeutic tasks and activities designed to restore sensory-integrative function;
 - 3. Teaching compensatory techniques to improve the level of independence in the activities of daily living;
 - 4. The designing, fabricating, and fitting of orthotic and self-help devices;
 - 5. Vocational and prevocational assessment and training that is directed toward the restoration of function in the activities of daily living lost due to illness or injury.

Speech-Language Pathology;

- 1. Assessment of rehabilitation needs;
- 2. Services directed towards specific speech/voice production as a result of an illness or injury;
- 3. Service can only be provided by a speech-language pathologist (SLP) and it is reasonably expected that the service will improve the member's ability to independently carry out any one or combination of communicative activities of daily living;
- 4. Services of a SLP to establish a hierarchy of speech-voice-language communication tasks and cueing that directs a member toward speech-language communication goals in the plan of care;
- 5. The services of a SLP to train the member, family, or other caregivers to augment the speech-language communication, treatment, or to establish an effective maintenance program;
- 6. The services of a SLP to assist members with aphasia in rehabilitation of speech and language skills;
- 7. The services of a SLP to assist members with voice disorders to develop proper control of the vocal and respiratory systems for correct voice production.

NOTE: For criteria for home speech therapy requests, refer to the medical coverage policy: Speech Language Pathology.

Home Health Aide Services:

The reason for the visits by the home health aide must be to provide hands-on personal care to the member or provide services needed to maintain the member's health or to facilitate treatment of the member's illness or injury. The physician's order should indicate the frequency of the home health aide services required by the member. These services may include but are not limited to:

1. Personal Care (in conjunction with skilled care services only):
 - a. Bathing, dressing, grooming, caring for hair, nail, and oral hygiene which are needed to facilitate treatment or to prevent deterioration of the member's health, changing the bed linens of an incontinent member, shaving, deodorant application, skin care with lotions and/or powder, foot care, and ear care;

And

- b. Feeding, assistance with elimination (including enemas unless the skills of a licensed nurse are required due to the member's condition, routine catheter care and routine colostomy care), assistance with ambulation, changing position in bed, assistance with transfers.
2. Simple dressing changes that do not require the skills of a licensed nurse;
3. Assistance with medications which are ordinarily self-administered and do not require the skills of a licensed nurse to be provided safely and effectively;
4. Assistance with activities that are directly supportive of skilled therapy services but do not require the skills of a therapist to be safely and effectively performed, such as routine maintenance exercises and repetitive practice of functional communication skills to support speech-language pathology services;

Medical Social Worker Services:

1. The services of these professionals are necessary to resolve social or emotional problems that are expected to be an impediment to the effective treatment of the member's medical condition or rate of recovery;

And

2. The plan of care indicates how the required services necessitate the skills of a qualified social worker or a social work assistant to be performed safely and effectively.

Home Infusion Therapy:

The Plan provides coverage of medically necessary infusion therapy when prescribed by a physician and member is confined to the home. Services may be authorized in lieu of hospitalization or admission to a skilled nursing facility to ensure safe and effective medication administration in the treatment of illness or injury. Coverage of medically necessary supplies and services are included.

INDICATIONS FOR COVERAGE:

To qualify for the home health benefit (includes covered services listed above), a member must meet the following requirements:

1. Be confined to the home (see I. A and B for homebound criteria);

And

2. Under the care of a physician;

And

3. Receive services under a plan of care established and periodically reviewed by a physician;

And

4. Require a skilled service on an intermittent basis such as skilled nursing care, physical therapy, or speech-language pathology;

And

5. Have had a face-to-face encounter with a physician or Non-Physician Practitioner (NPP)

Or

6. Has a continuing need for occupational therapy.

The Plan follows Original Medicare home health guidelines in that venipuncture for the purposes of obtaining a blood sample can no longer be the sole reason for home health eligibility. The Plan will authorize coverage of medically necessary venipunctures, but this service does not qualify the member for additional benefits such as coverage of home health aides.

WHEN COVERAGE WILL NOT BE APPROVED

Home Care Services that are **not** covered for Blue Medicare HMO/ Blue Medicare PPO members include:

1. Services or supplies not specified in the home care plan approved by a Plan physician;
2. Services provided by a person who ordinarily resides in the member's home or is a member of the member's family;
3. Homemaker services;
4. Home care for chronic conditions requiring long periods of care or observation that can be safely provided in the member's home by a person without medical training;
5. Custodial care.

II. SKILLED NURSING FACILITY and SKILLED REHABILITATION SERVICES

A skilled nursing facility (SNF) or skilled nursing unit (SNU) provides inpatient skilled nursing care twenty-four (24) hours a day, seven (7) days a week, under the supervision of a registered

nurse, and/or skilled rehabilitative services at least five (5) days per week. These services are directed toward, and supportive of, restoring physical function and abilities that have been lost due to recent medical conditions where there is a reasonable expectation of partial or complete restoration of physical function.

Services at an SNF/SNU for a member without restorative potential would be eligible for coverage if the services have been determined to be skilled, and not custodial in nature. Such coverage depends not on the beneficiary's restoration potential, but on whether skilled care is required, along with the reasonableness and necessity of the services themselves. Such services must be under the direction of a physician, and supported by a treatment plan approved in advance by the Plan. Specific contract benefit limits would apply.

INDICATIONS FOR COVERAGE:

Care in a SNF/SNU is covered if **all** of the following are met:

1. The complexity of the service 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; are ordered by a physician and are rendered for a condition for which the member may or may not have received inpatient hospital services or for a condition that arose while receiving care in a SNF for a condition for which he/she received inpatient hospital services;

And

2. The member requires these skilled services on a daily basis meaning the member needs and receives the services at least five (5) days a week;

And

3. The services must be reasonable and necessary for the treatment of a member's illness or injury, i.e., be 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.

To Note:

- A service that is "non-skilled" may be considered skilled when, because of special (acute) medical complications, its performance or supervision, or the observation of the member requires the use of skilled nursing or skilled rehabilitative personnel.
- The restorative potential is not the deciding factor in determining whether skilled services are needed. Even when full recovery or medical improvement is not possible, skilled care may be needed to prevent, to the extent possible, deterioration of the member's condition and if those alternatives would adversely affect the member's medical condition when considering care alternatives.

If any one of these *factors is not met*, a stay in a SNF or SNU, even though it might include the delivery of some skilled services, is not covered. (For example, authorization for a SNF level of care would not be appropriate if a member needs intermittent rather than daily skilled service.)

LIMITATIONS

Pre-certification and case review is required for Blue Medicare HMO/ Blue Medicare PPO members. The medical necessity for continued stay should be reevaluated at a frequency appropriate for each individual case.

Skilled Nursing Facility Care is covered for up to 100 days per benefit period. See the member's E.O.C.

WHEN COVERAGE WILL NOT BE APPROVED

Respite care and custodial care are excluded from coverage.

Any non-skilled level of care.

The Plan follows Original Medicare's guidelines and definitions for coverage of Skilled Care Services (e.g., spell of illness/benefit period, homebound status, part time, intermittent) for Blue Medicare HMO/ Blue Medicare PPO members.

APPLICABLE CODES/Physician Documentation Information for Skilled Care Services

This policy may apply to the following codes. Inclusion of a code in the section does not guarantee reimbursement.

No applicable codes for this policy since the organization determinations are based on the service and not the code.

The Plan may request medical records for determination of medical necessity. When medical records are requested, letters of support and/or explanation are often useful, but are not sufficient documentation unless all specific information needed to make a medical necessity determination is included.

SPECIAL NOTES:

Per Medicare, the member can receive services at Adult Day Care Center or like institutions if the need for DME is too cumbersome for the home. The Benefit's Improvement and Protection Act (BIPA) of 2001 amended the "home bound rule" and allows for absences of the member from the home attributable to the need to receive health care treatment, including regular absences for the purpose of participating in therapeutic, psychosocial or medical treatment in a licensed adult day care program. Absences as such do not disqualify a member considered to be confined to his home. The Home Health Agency is still responsible for the care plan.

References:

1. Pub 100-2 Medicare Benefit Policy Manual Chapter 8- Coverage of Extended Care (SNF) Services Under Hospital Insurance (10/26/12); Issued 05-16-08; Accessed via the internet at www.cms.gov; Manuals/IOM on 2/12/18.
2. Pub 100-2 Medicare Benefit Policy Manual Chapter 7- Home Health Services (2012); issue (Rev. 139, 05/06/2011); Accessed via www.cms.gov; on 02/12/2018.
Jimmo Versus Sebelius Settlement Agreement Fact Sheet; accessed via CMS site at <http://www.cms.gov>.
3. CMS Pub 100-04 Medicare Claims Processing, Transmittal 1562, Prothrombin Time (PT/INR) Monitoring for Home Anticoagulation Management.
4. Medicare Local Coverage Determination for Skilled Nursing Care- Teaching and Training: Alzheimer's disease and Behavioral Disturbances – Palmetto GBA Part A/B (L34562); Effective date 10/01/2015. Accessed via cms.gov/medicare-coverage-database/ 2/12/18.

5. Medicare Benefit Manual; Chapter 7 Rev. 208, section 30.1.1; Updated clarification of “confined to home”; viewed at www.cms.gov; effective date 5/11/2015; viewed on 02/12/18.
6. Medicare MLN Matters Article – MM1436 Certifying Patients for the Medicare Home Health Benefit, viewed via <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1436.pdf> 2/12/18.

Policy Implementation/Update Information:

- Revision Date: February 2009: Included CMS definition of “Part time or Intermittent” Home Health Care; removed specific examples listed.
- Revision Date: April 12, 2011: Updated language under Indications for Coverage – Home Infusion Therapy to indicate that member must be confined to the home to obtain services, as referenced in current CMS guidelines. Applicable codes: see section; updated the reference section.
- Revision Date: 08/21/2013; updated policy with definitions regarding restorative potential, maintenance and custodial care. Minor edits to improve clarity as appropriate, Clarified “Place of Residence”.
- Revision Date: 11/20.2013: Updated Medicare’s definition of Home Bound
- Revision Date: 5/20/2015: Under section – Indications For Coverage, Item B, added 2nd bullet:
“Services received at hospitals, skilled nursing facilities, or rehabilitation centers when they involve equipment too cumbersome to bring to the home”; as referenced in the Medicare Benefit Manual, Ch. 7. October 29, 2015 updated LCD due to ICD-10 update only.
- Revision Date: February 9, 2016: Indication For Coverage – added item #5 including face-to-face requirement with a physician or NPP as coverage criteria. Formatting changes for policy continuity.
- Revision Date: February 21, 2018: Annual Review. No CMS Updates Minor Revisions only.

Approval Dates:

Medical Coverage Policy Committee: February 21, 2018

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