

	Prior Authorization Guide: Skilled Nursing Facility Care	Applies to members enrolled in the following My Choice Wisconsin health plan products: Partnership and SSI Managed Care
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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. Skilled Nursing Facility (SNF) services are medically necessary services provided by a certified nursing home to an inpatient and prescribed by a physician in a written plan of care. The following are basic conditions that must always be met before services can be provided by a SNF:

- The member is an active member of My Choice Wisconsin's SSI or Partnership Medicaid programs.
- Medicaid is the appropriate payer.
- A physician certifies at the time the member is admitted to a nursing home or that SNF services are needed.
- 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.
- **For Rehabilitative Stays-** A nursing home shall provide either skilled nursing services or skilled rehabilitation services on a 7-day-a-week basis. If, however, skilled rehabilitation services are not available on a 7-day-a-week basis, the nursing home would meet the requirement in the case of a member whose inpatient stay is based solely on the need for skilled rehabilitation services if the member needs and receives these services on at least 5 days a week.
- **For Long Term Care/Custodial Care Stays-** In determining whether the services needed by a member can only be provided in a skilled nursing facility on an inpatient basis, consideration shall be given to the member's condition and to the availability and feasibility of using more economical alternative facilities and services. The availability of capable and willing family or the feasibility of obtaining other supportive services 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.
- **For Members enrolled in Hospice-** When a resident of a Skilled Nursing Facility (SNF) elects to receive hospice care services, the hospice must contract with that facility to provide the member's room and board and the hospice assumes responsibility for the management of the individual's hospice care.

My Choice Wisconsin will reimburse the SNF 95 percent of the nursing home's current rate for each date of service (DOS) on which room and board is provided. Room and board for an SNF resident is not reimbursed for the same DOS as inpatient respite or general inpatient care.

Created 9.2019

UM Committee Approval: 9.27.2019

Reviewed Date:

Updated: 1/20/2020, 10/1/2020

- **Services for members with a head injury-** A treatment program for members with a head injury must be approved by Division of Medicaid Services (DMS) based on established criteria for admission, continuing stay, discharge, and other program requirements as determined by DMS. Treatment program and rates must be appropriate and receive prior approval from the DMS Nursing Home Policy and Rate Setting Section. Facilities interested in the program requirements and information about treatment of head injuries should contact the following address:

Section Chief
Division of Medicaid Services
Bureau of Long-Term Care Financing
Nursing Home Policy and Rate Setting Section
P.O. Box 7851
Madison, WI 53701-7851

Additional Considerations:

Services included in daily rate- The costs of all routine, day-to-day health care services and materials provided to members by a nursing home shall be reimbursed within the daily rate determined for MA in accordance with s. 49.45 (6m), Stats. The services included in the daily rate are:

- Nursing services
- Special care services, including activity therapy, recreation, social services, and religious services
- Supportive services, including dietary, housekeeping, maintenance, and institutional and personal laundry services (excluding personal dry cleaning services)
- Administrative and other indirect services
- Fuel and utilities
- Physical plant, including depreciation, insurance, and interest on plant
- Property taxes
- Medicaid covered Over-The-Counter drugs and all diabetic supplies
- Services for members with developmental disabilities
- DME and disposable medical supplies as covered in the DME Index and Disposable Medical Supplies Index
- Enteral Nutrition products
- Indirect services provided by independent providers of service (Examples include services performed by a pharmacist reviewing prescription services for a facility and services performed by an occupational therapist developing an activity program for a facility.)
- Personal comfort items, medical supplies and special care supplies. These are items reasonably associated with normal and routine nursing home services which are listed in the nursing home payment formula. If a member specifically requests a brand name which the nursing home does not routinely supply and for which there is no equivalent or close substitute included in the daily rate, the member, after having been informed in advance that the equivalent or close substitute is not available without charge, will be expected to pay for that brand item at cost out of personal funds.

Services separately billable include:

- Influenza and pneumonia immunizations
- Laboratory and radiology services
- Therapies (i.e., OT, PT, and SLP)
- Certain DME — Labeled as "Not In Rate" in the "In NH Facility Rate?" column of the ForwardHealth DME Index and Maximum Fee Schedules
- Certain DMS — Have an "N" in the "In NH Rate" column of the Wisconsin Medicaid Index of Disposable Medical Supplies

Created 9.2019

UM Committee Approval: 9.27.2019

Reviewed Date:

Updated: 1/20/2020, 10/1/2020

Covered services that are provided to a nursing home member by an independent provider of service (e.g., a dentist outside of the nursing home), is only reimbursed when claimed by the independent provider under the independent provider's NPI or billing provider number. Medicaid enrollment and program requirements for that provider type apply.

Bedhold coverage- Bedhold is covered for:

- All hospital leaves of absence up through 15 days (consecutive) per hospitalization; there is no limit on the number of stays per year.
- All leaves for physician approved therapeutic visits (overnight visits for one or more nights by a member with relatives or friends). The plan of care must include the rationale for and the anticipated goals of the leave, as well as any limitations on the frequency or duration of leaves.
- All leaves for therapeutic rehabilitative programs meeting the criteria under Wis. Admin. Code § [DHS 101.03\(165\)](#)

The first day that the member leaves the nursing home, regardless of the time of day, is the first day the member is considered absent. The day the member returns to the nursing home does not count as a bedhold day, regardless of the time of day they return. A staff member designated by the administrator (e.g., social service director or nursing service director) must document the member's absence in the member's records and approve each individual leave based on physician order(s).

Bedhold payments will only be made if the nursing home meets the requirements of the qualifying criteria. My Choice Wisconsin follows the bedhold requirements set forth by Forward Health that are communicated in [Methods of Implementation For Wisconsin Medicaid Nursing Home Payment Rates Memos](#).

Administrative Discharge- Members cannot be administratively discharged from the nursing home unless all the following have occurred:

- The member remains in the hospital longer than 15 days.
- No agreements have been made to hold the bed through payments by the member, family, or guardian.
- The member and either the legal representative or family have been given a 30-day notice of involuntary discharge according to the federal requirements for discharge under 42 CFR 483.12.

Requesting prior authorization:

- Complete the [Inpatient Admission 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. Concurrent review intervals may be extended by My Choice Wisconsin based upon the needs of the individual member.

Exclusions:

SNF stays covered under a member's Medicare coverage including the Partnership-Medicare and Dual Advantage programs are addressed in the Medicare Skilled Nursing Facility Prior Authorization Guide.

If a SSI member is in a nursing home 90 days or longer, the member shall be disenrolled from My Choice Wisconsin's SSI Managed Care program. In the event the member transfers from the nursing home to a hospital and back to the nursing home, the applicable 90 day period shall run continuously from the first

Created 9.2019

UM Committee Approval: 9.27.2019

Reviewed Date:

Updated: 1/20/2020, 10/1/2020

admission to the nursing home and shall include any days in the hospital. My Choice Wisconsin will notify Maximus of all stays that are expected to exceed 90 days.

Private rooms shall not be a covered service within the daily rate reimbursed to a nursing home, except where required under s. [DHS 132.51 \(2\) \(b\)](#). However, if a member or the member's legal representative chooses a private room with full knowledge and acceptance of the financial liability, the member may reimburse the nursing home for a private room if the following conditions are met:

1. At the time of admission, the member or legal representative is informed of the personal financial liability encumbered if the member chooses a private room;
2. Pursuant to s. [DHS 132.31 \(1\) \(d\)](#), the member or legal representative documents the private room choice in writing;
3. The member or legal representative is personally liable for no more than the difference between the nursing home's private pay rate for a semi-private room and the private room rate; and
4. Pursuant to s. [DHS 132.31 \(1\) \(d\)](#), if at any time the differential rate determined under subd. 3. changes, the member or legal representative shall be notified by the nursing home administrator within 15 days and a new consent agreement shall be reached.

Definitions: None

References: [Forward Health Provider Handbook](#)

Created 9.2019

UM Committee Approval: 9.27.2019

Reviewed Date:

Updated: 1/20/2020, 10/1/2020