

**Policy terminated because Health Choice does not cover long term care.**

**Table of Contents**

1.0 Description of the Procedure, Product, or Service..... 1  
1.1 Definition..... 1  
2.0 Eligible Recipients..... 1  
2.1 General Provisions..... 1  
3.0 When the Procedure, Product, or Service Is Covered..... 1  
3.1 General Criteria..... 1  
3.2 Specific Criteria..... 1  
4.0 When the Procedure, Product, or Service Is Not Covered..... 6  
4.1 General Criteria..... 6  
4.2 Specific Criteria..... 6  
5.0 Requirements for and Limitations on Coverage..... 7  
5.1 Prior Approval..... 7  
5.2 Limitations..... 7  
6.0 Providers Eligible to Bill for the Procedure, Product, or Service..... 8  
7.0 Additional Requirements..... 8  
7.1 Compliance..... 8  
8.0 Policy Implementation/Revision Information..... 8  
Attachment A: Claims-Related Information..... 9  
A. Claim Type..... 9  
B. Diagnosis Codes..... 9  
C. Procedure Code(s)..... 9  
D. Modifiers..... 9  
E. Billing Units..... 9  
F. Place of Service..... 10  
G. Co-payments..... 10  
H. Reimbursement..... 10

## **1.0 Description of the Procedure, Product, or Service**

### **1.1 Definition**

A Skilled nursing facility (SNF) is an institution licensed under applicable state laws and engaged primarily in providing to inpatients, under the supervision of a doctor and a registered professional nurse, skilled nursing care on a 24-hour basis and an inpatient level of rehabilitative services. A hospital inpatient level of care would be required if a SNF were not available, and other alternative levels of care, such as office, outpatient, home, or lesser-than-SNF level of care (i.e., an intermediate care facility [ICF] or rest home) are unable to provide the frequency and/or intensity of services needed.

## **2.0 Eligible Recipients**

### **2.1 General Provisions**

To be eligible, NCHC recipients must be enrolled on the date of service.

**Note:** Most children will be able to get all the services they need under the core (basic) plan of NC Health Choice. A child who qualifies as having special needs may be able to receive additional services not covered by the core plan.

## **3.0 When the Procedure, Product, or Service Is Covered**

### **3.1 General Criteria**

NCHC covers procedures, products, and services related to this policy when they are medically necessary and

- a. the procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the recipient's needs;
- b. the procedure, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available; **AND**
- c. the procedure, product, or service is furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

### **3.2 Specific Criteria**

Charges made to recipients for services received in a skilled nursing facility (SNF) fall into two distinct categories: 1) routine; and 2) ancillary. In providing benefits for services received in an SNF, distinction is made between routine and ancillary charges for purposes for reimbursement. Regardless of the manner in which the services are billed, routine services are not paid as items separate from accommodation charges. However, ancillary charges, if covered, are paid apart from the charge for room accommodation:

- a. Routine services which should be included in the accommodation charge include:
  1. Medical social services
  2. All general nursing services, including administration of oxygen and related medications, handfeeding, incontinency care, tray services, enemas
  3. Items furnished routinely and relatively uniformly to all patients; e.g.; patient gowns, paper tissues, water pitchers, bedpans, deodorant, mouthwash
  4. Items stocked at the nursing station or on the floor in large quantity and distributed individually in small amounts; e.g.; alcohol, applicators, cotton balls, Band-aids, Maalox, aspirin (and other non-legend drugs ordinarily kept on hand), suppositories, tongue depressors
  5. Items which are utilized by individual patients but which are reusable and expected to be available in an institution providing a skilled level of care; e.g. ' ice bags, bed rails, canes, crutches, walkers, wheelchairs, IV poles and pumps, traction equipment, and other durable medical equipment
  6. Special dietary supplements used for tube feeding or oral feeding, such as elemental high nitrogen diet, even if written as prescription items by a physician
- b. To be considered as ancillary charges payable as separate items when billed by an SNF, services must be:
  1. Directly identifiable services provided to an individual at the direction of a physician because of a specified medical need; e.g., physical therapy, speech therapy
  2. Not reusable; e.g. legend drugs, irrigation solutions, IV fluids, oxygen (including medications), disposable catheters; or represent a cost for each use; e.g., sterilization and set-up of reusable catheters.
- c. The following are covered in a SNF:
  1. Daily charges for room and board, up to the semi-private room rate, as outlined above.
  2. Ancillary charges and other services ordinarily covered in a general hospital, as outlined above.
- d. Benefits are provided for post-hospital skilled nursing facility care when **ALL** of the following conditions are met:
  1. the recipient requires medically necessary skilled nursing care on a continuing daily basis as evidenced by the need for the constant nearby presence, on-site availability, and supervision of a skilled (registered or licensed practical) nurse for the purpose of either monitoring and evaluation of the recipient for an unstable medical condition or for the provision or administration of services or procedures that can only be provided by a skilled nurse;
  2. The recipient receives skilled care for any of the conditions for which he received medically-necessary inpatient hospital care, or for a condition which arose while he was in a skilled nursing facility receiving care for such a condition;

3. Such services are medically required to be given on an inpatient basis as evidenced by documentation that the services are being provided and are needed in a frequency [a minimum of every eight (8) hours] and/or an intensity that cannot be provided in the home setting through intermittent Home Health skilled nursing visits and custodial support and assistance; **AND**
  4. The recipient is referred by and remains under the continual care of an attending physician who shall evaluate the recipient through an on-site visit at least once a month
- e. In determining whether services rendered in a SNF constitute covered care, it is necessary to determine whether the individual services are skilled, and whether skilled management of the services provided is needed, and whether the services planned are needed, whether provided or not. Skilled services are medically necessary services that must be licensed by licensed health care professionals in accordance with state law or regulation. The ability to provide skilled services requires the specialized skills of licensed medical personnel. Covered care includes the skills of teaching, restoring, retraining, and intensive skilled nursing procedures as provided by licensed health care professionals. It connotes an active regimen with short and/or long term goals, and requires skilled services for a period of time. Where the inherent complexity of a service prescribed for a patient is such that it can be safely and/or effectively performed only under the direct supervision of licensed health care professionals, the service constitutes skilled service.
- f. The need for, and length of stay in, a skilled nursing facility depends upon the recipient's medical condition and the type, amount, and frequency of skilled nursing services provided.
1. The recipient must require continuous skilled nursing services daily. The fact that a person may require periodic or occasional skilled services would not in itself make a skilled nursing facility admission an eligible benefit.
  2. Skilled services rendered primarily to sustain life or to aid in essentials of daily living such as tube feeding or Foley catheter care may constitute custodial care when the recipient is not under specific treatment to restore his condition to the extent necessary to live outside an institution.
  3. Skilled paramedical services (such as PT, OT, and ST) which can be, and generally are, rendered on an outpatient basis do not qualify an admission for benefits unless the recipient is also receiving one or more other types of skilled care.
- g. Covered care includes the skills of teaching, observation, restoring, retraining, and intensive skilled nursing procedures. It connotes an active regimen with short and/or long-term goals, and requires skilled services for a period of time. Services for an individual who lacks rehabilitation potential are not necessarily non-covered. For example, a terminal cancer patient whose life expectancy is a few months may require skilled services which are covered care.
- h. Assistance needed by the recipient during a period of teaching, either of the recipient or his caretaker, or retraining is covered.

- i. Intramuscular or intravenous medications are generally considered to be skilled services. In general, subcutaneous medications are self-administered or administered by properly instructed family members.
  - 1. intramuscular injections administered over a prolonged period of time, related to a specific illness and the need documented by medical and clinical evidence
  - 2. Injections which can usually be self-administered do not require skilled care; e.g., the well-regulated diabetic who receives daily insulin does not require skilled care for the purpose of receiving his injection.
  - 3. Injections to the brittle diabetic who requires monitoring of blood glucose, observations, and regulation of insulin dosage every 8 hours or more frequently, are skilled services. A "sliding scale insulin" regimen that is stable and unchanging can be administered by the recipient or by a trained family member and is thus not considered skilled services.
- j. Oral medications which may result in hazardous side effects or reactions, must be administered and observed by licensed nurses, and thus constitutes a skilled service until the recipient has demonstrated good and reliable tolerance to the medication;
- k. Where a prolonged regimen of potentially hazardous oral drug therapy is instituted, the need for skilled care can only be presumed during the period in which the routine is being established when changes in dosage or skilled observation may be required
- l. Insertion, replacement, or sterile irrigation of a catheter
- m. Teaching in the immediate post-operative colostomy care 'teaching period' following a newly-created or revised opening. General maintenance of this condition can then usually be performed by the recipient or by a person without professional training, and would not require skilled nursing services.
- n. Dressings or soaks involving sterile technique which cannot be performed by non-medical personnel are considered skilled services.
- o. An active regimen such as bladder and/or bowel training while it is being initiated
- p. The care of a confused or disoriented recipient who is receiving active medical treatment for their mental status may require skilled services during the treatment period.
- q. A recipient's mobility status alone would not determine whether care is covered or non-covered. The level of care required by the medical condition of the recipient and the need for skilled services determines if the care is covered.
- r. The initial regimen of oxygen therapy often must be performed under medical supervision and is covered care;
- s. Restorative nursing procedures constitute skilled services when designed to restore functions lost or reduced by illness or injury, and are a type requiring the presence of nurses; for example, an intensive regimen of PT.
- t. Treatment of extensive decubiti (stage III or higher) or other widespread skin disorders necessitates skilled care.

- u. The therapeutic use of sunlamps, infra-red lamps, whirlpool, diathermy, and similar equipment is covered when the service is specifically ordered by a physician as a part of an active treatment regimen and observation by skilled personnel is required to evaluate the results of treatment
- v. PT constitutes skilled care for the purpose of rehabilitation and/or restoration of function of the recipient when the services:
  - 1. are directly and specifically related to an active written treatment regimen designed by the physician (in consultation with a qualified physical therapist);
  - 2. require the judgment, knowledge, and skills of a qualified physical therapist;
  - 3. are provided with the expectation that the recipient will improve significantly in a reasonable and generally predictable period of time, or establish a safe and effective maintenance program in connection with a specific disease state;
  - 4. are considered by accepted standards of medical practice to be a specific and effective treatment for the recipient's condition; and
  - 5. The provision of PT does not in itself constitute a covered level of care. The recipient must regularly receive one or more other types of skilled care. Also, an inpatient intensity and duration of rehabilitative services shall be provided as evidenced by at least two hours or more of a combination of PT and one other rehabilitative modality, either occupational therapy (OT) or speech therapy (ST). If only PT (or OT or ST) is provided, skilled nursing services of a continuous nature must also be provided to qualify for SNF benefits
- w. Hot packs, hydrocollator, infra-red treatments or whirlpool bath treatments do not ordinarily require a qualified physical therapist, except where the recipient's condition is complicated by circulatory deficiency, open wounds, etc. If such treatment is prerequisite for PT, it is considered a part of that PT.
- x. Gait training and training for a recipient whose ability to walk has been impaired by neurological, muscular, or skeletal abnormality, require the services of a qualified physical therapist.
- y. Ultrasound, shortwave, and microwave diathermy treatments should always be carried out by, or under the supervision of a qualified physical therapist.
- z. Only a qualified physical therapist may perform range of motion tests. Range of motion exercises when they are a part of active treatment of a loss or restriction of mobility and such exercises may be performed safely only by a qualified physical therapist because of their nature or the condition of the recipient. Passive range of motion exercises not related to the restoration of specific loss of function can ordinarily be provided safely by aides or nursing personnel.

The repetitive services required to maintain function, rather than to restore it, do not involve the use of complex and sophisticated physical therapy procedures and do not require the skills of a qualified physical therapist. A qualified physical therapist may be required to establish a maintenance program.

## 4.0 When the Procedure, Product, or Service Is Not Covered

### 4.1 General Criteria

Procedures, products, and services related to this policy are not covered when

- a. the recipient does not meet the eligibility requirements listed in **Section 2.0**;
- b. the recipient does not meet the medical necessity criteria listed in **Section 3.0**;
- c. the procedure, product, or service unnecessarily duplicates another provider's procedure, product, or service; or
- d. the procedure, product, or service is experimental or investigational.

### 4.2 Specific Criteria

- a. At a point in time, a recipient may no longer need skilled nursing services. The primary purpose of the care being furnished the recipient may be to assist with the activities of daily living. Care which assists the individual in meeting his activities of daily living or by doing for or assisting with such activities as bathing, dressing, eating, walking, or taking medication on a regular schedule is non-covered.
- b. Routine servicing of indwelling bladder catheters, such as emptying containers, etc., is not a skilled service and is non-covered
- c. Dressing changes of non-infected post-operative or chronic conditions are not skilled services
- d. Without other medical conditions requiring skilled care, incontinence being treated by the use of methods such as diapers does not require skilled services
- e. Care of a confused or disoriented recipient who no longer receives 'active' treatment but is controlled by medications, and who has no other medical conditions requiring skilled services, is non-covered care.
- f. There are instances where oxygen therapy is non-covered. For example, care of a recipient with emphysema who can be taught to manage oxygen therapy (intermittent positive pressure) would be non-covered after the 'teaching period' had ended.
- g. When a recipient attains their restoration potential, the services required to maintain that level are not skilled services. General supervision of exercises is not a skilled service.
- h. Routine prophylactic and palliative skin care such as bathing, application of lotions, etc., are not skilled services
- i. Routine use of sunlamps, infra-red lamps, whirlpool, diathermy and similar equipment for palliative and comfort purposes is not covered.
- j. Repetitive exercises to improve gait, maintain strength and endurance, or assist the feeble or unstable recipient do not require the skills of a qualified physical therapist.
- k. Intermediate care, custodial care, or domiciliary care (rest home) is not covered.
- l. A non-inclusive list of services that are NOT considered skilled follows:

1. Assistance with activities of daily living, to include bathing, assistance with walking, dressing, feeding, preparation of special diets, eating, continence, toileting, transferring, skin care, enemas, and taking recipient to the doctor's office.
2. Administration of routine oral medications, eye drops, and ointments
3. Routine care of indwelling bladder catheters
4. Routine care of an established colostomy/ileostomy
5. Routine care of incontinent recipient
6. Established gastrostomy tube feedings
7. Established oxygen therapy
8. Care of decubitus ulcers that are not infected or extensive (Stage I/II)
9. Passive range of motion exercises
10. Observation and monitoring of recipients receiving routine care for the above listed nonskilled services.
11. Superficial oropharyngeal or nasotracheal suctioning.
12. Tracheostomy site care for established tracheostomy.
13. Routine measurement of vital signs.

## **5.0 Requirements for and Limitations on Coverage**

### **5.1 Prior Approval**

- a. Prior approval is required for skilled nursing facility benefits.
- b. A letter of medical necessity and plan of treatment signed and dated by the physician must be submitted to DMA's vendor prior to rendering the service.
- c. Documentation must include:
  1. Recipient's NCHC ID and mailing address
  2. Medical diagnosis, including recipient's physical and mental status and the necessity for skilled care
  3. Admission history and physical and discharge summary of the qualifying acute-care facility admission
  4. Specific skilled services required on a continuing daily basis; and
  5. Expected duration of admission

### **5.2 Limitations**

- a. The recipient must have incurred a prior admission to an acute-care facility of not less than three (3) days to qualify for benefits in a skilled nursing facility;
- b. The admission to the skilled nursing facility must occur within 14 calendar days of discharge from the acute-care facility.
- c. Coverage is limited to the period in which the recipient requires skilled nursing or rehabilitative services on a continuing daily basis (up to a maximum of 100 days per fiscal year for the same reason).
- d. Any admission that began prior to the recipient's date of coverage with NCHC is not covered

- e. If the recipient is subject to a 12-month waiting period for pre-existing conditions and remains continuously confined in a skilled nursing facility during that time, there would be no coverage for the confinement at the end of the 12-month waiting period without discharge from the skilled nursing facility, admission to an acute-care facility, and subsequent readmission to the skilled nursing facility as outlined in (a) and (b) above.
- f. Recipients requiring chronic ventilation use (minimum 8 hours a day) are not subject to the 100 days a year limit, as long as they continue to receive and require continuous daily skilled nursing care as defined by policy requirements above.

## 6.0 Providers Eligible to Bill for the Procedure, Product, or Service

To be eligible to bill for procedures, products, and services related to this policy, providers shall

- a. meet NCHC qualifications for participation;
- b. be currently enrolled with NCHC; **AND**
- c. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

## 7.0 Additional Requirements

### 7.1 Compliance

Providers must comply with all applicable federal, state, and local laws and regulations, including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements.

## 8.0 Policy Implementation/Revision Information

**Original Effective Date:** July 1, 2010

**Revision Information:**

Date	Section Revised	Change
July 1, 2010	Throughout	Policy Conversion: Implementation of Session Law 2009-451, <b>Section 10.32 “NC HEALTH CHOICE/PROCEDURES FOR CHANGING MEDICAL POLICY.”</b>
February 29, 2012	Throughout	Policy Termination

## Attachment A: Claims-Related Information

Reimbursement requires compliance with all NCHC guidelines.

### A. Claim Type

Institutional (UB-04/837I transaction)

### B. Diagnosis Codes

Providers must bill the ICD-9-CM diagnosis codes(s) to the highest level of specificity that supports medical necessity.

### C. Procedure Code(s)

CPT codes				
99307	99308	99309	99310	99315
99316	99318			
Revenue codes				
10X	11X	12X	13X	19X
23X	240	249	250	251
252	255	257	258	259
26X	27X	290	299	30X
32X	41X	42X	43X	44X
46X	47X	634	635	636
73X	76X	80X		
Where the 'X' means all codes within a given range: 11X would be 110 through 119 or 110, 111, 112, 113, 114, 115, 116, 117, 118 and 119.				

### D. Modifiers

Providers are required to follow applicable modifier guidelines.

### E. Billing Units

- a. The accommodation charge shall include such routine services as:
  1. medical social services;
  2. all general nursing services, including administration of oxygen and related medications, hand feeding, incontinency care, tray service and enemas;
  3. items furnished routinely and relatively uniformly to all recipients; e.g., recipient gowns, paper tissues, water pitchers, bedpans, deodorant and mouthwash;
  4. items stocked at the nursing station or on the floor in large quantity and distributed individually in small amounts; e.g., alcohol, applicators, cotton balls, Band-aids, Maalox, aspirin (and other non-legend drugs ordinarily kept on hand), suppositories, tongue depressors;
  5. items which are utilized by individual recipients but which are reusable and expected to be available in an institution providing a skilled level of care; e.g., ice bags, bedrails, canes, crutches, walkers, wheelchairs, IV poles and pumps, traction equipment, and other durable medical equipment; and

6. special dietary supplements used for tube feeding or oral feeding, such as elemental high nitrogen diet, even if written as prescription items by a physician.
- b. To be considered as ancillary charges payable as separate items when billed by an SNF, services must be:
  1. Directly identifiable services provided to a recipient at the direction of a physician because of a specific medical need; e.g., PT and ST
  2. Not reusable; e.g. legend drugs, irrigation solutions, IV fluids, oxygen (including medications), disposable catheters; or represent a cost for each use, e.g., sterilization and set-up of reusable catheters.

**F. Place of Service**

Inpatient Hospital, Outpatient Hospital, Nursing Facility, and Office.

**G. Co-payments**

Co-payment(s) may apply to covered prescription drugs and services.

**H. Reimbursement**

Providers must bill their usual and customary charges.