Clinical Policy: Skilled Nursing Visits

Reference Number: TX.CP.MP.538
Last Review Date: 11/22

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

The purpose of this policy is to provide guidelines in processing prior-authorization requests for skilled nursing visits (SNV) and home health aide (HHA) visits.

This policy applies to the following products: STAR, STAR+PLUS, STAR Health, STAR Kids, and CHIP.

Note: for prior authorization requests for SNV related to discharge planning, please refer to TX.UM.02.10 Discharge Planning.

Policy/Criteria

I. It is the policy of Superior HealthPlan that SNV must be prior authorized and are constituted as the following:

A. SNV in limited to skilled nursing procedures performed by a registered nurse (RN) or licensed vocational nurse (LVN) licensed to perform these services under the Texas Nursing Practice Act. These include direct skilled nursing care, parent or guardian caregiver training, and member/caregiver/guardian education, as well as skilled nursing observation, assessment, and evaluation by an RN, provided that a primary physician specifically requests that a nurse visit the member for this purpose and that the physicians order reflects the medical necessity for the visit.

B. For all members, SNV may be provided in the following locations:
   1. Home of the member, parent, guardian, or caregiver
   2. Foster homes
   3. Independent living arrangements

C. SNV are intended to provide skilled nursing care to promote independence and support the member living at home.
   1. SNV may be provided on consecutive days.
   2. Intermittent SNV is defined as less than eight hours per visit and less frequently than daily.
   3. Intermittent SNV may be delivered in interval visits up to 2.5 hours per visit, not to exceed a combined total of three visits per day.
   4. Part-time SNV is defined as less than eight hours per day for any number of days per week.
   5. Part-time SNV may be continuous up to 7.5 hours per day (not to exceed a combined total of three 2.5 hour visits).

D. The fact that the service can be or is taught to the member or to the member's family or friends does not negate the skilled aspect of the service when the service is performed by a nurse. If the service could be performed by the average nonmedical person, the absence of a competent person to perform it does not cause it to be a skilled nursing service. If the nature of a service is such that it can safely and effectively be performed by the average

nonmedical person without the direct supervision of a licensed nurse, the service cannot be regarded as a skilled nursing service.

E. Some services are classified as skilled nursing services based on complexity alone (e.g., intravenous and intramuscular injections or insertion of catheters) and, if reasonable and necessary to the treatment of the member's illness or injury, would be covered on that basis. However, in some cases, the member's condition may cause a service that would ordinarily be considered unskilled to be considered a skilled nursing service. This may occur when the member's condition is such that the service can be safely and effectively provided only by a licensed nurse.

F. A service which, by its nature, requires the skills of a licensed nurse to be provided safely and effectively continues to be a skilled service even if it is taught to the member, the member's family, or other caregivers. When the member needs the skilled nursing care and there is no one trained, able, and/or willing to provide it, the services of a licensed nurse could be reasonable and necessary to the treatment of the illness or injury.

G. Skilled nursing services must be reasonable and necessary to the treatment of the member's illness or injury within the context of the member's unique medical condition. To be considered reasonable and necessary for the treatment of the member's illness or injury, the services must be consistent with the nature and severity of the illness or injury, the member's particular medical needs, and within accepted standards of medical and nursing practice. A member's overall medical condition is a valid factor in deciding whether skilled services are needed. A member's diagnosis should never be the sole factor in deciding whether the service the member needs is either skilled or not skilled. The determination of whether the services are reasonable and necessary should be made in consideration of the primary provider's determination that the services ordered are reasonable and necessary.

H. The services must, therefore, be viewed from the perspective of the condition of the member when the services were ordered and what was, at that time, reasonably expected to be appropriate treatment for the illness or injury throughout the certification period.

I. Skilled nursing care must be provided on a part-time or intermittent basis.

II. It is the policy of Superior HealthPlan that the following documentation is required for a complete **medical necessity** review.

A. A signed physician order or acceptable alternative order less than 90 days old which requests SNV or HHA services at a given frequency and duration. Please refer to *TX.UM.26 Electronic and Verbal Signature Policy* for other acceptable alternative orders.

B. Up-to-date plan of care (POC) - the POC shall be completed by a registered nurse (RN) in a clear and legible format. The POC must include the following information:
   1. Start of care date for home health services, refer to *TX.UM.43 Incomplete Prior Authorization Request.*
   2. All pertinent diagnoses
   3. Mental status
   4. Types of services, including amount, duration, and frequency
   5. Equipment/supplies required
   6. Prognosis

7. Rehabilitation potential
8. Functional limitations
9. Activities permitted
10. Nutritional status and requirements
11. Medications
12. Treatments, including amount and frequency
13. Safety measures to protect against injury

C. List all community or state agency services which the member receives in the home (e.g., primary home care (PHC), community based alternative (CBA), Medically Dependent Children's Program (MDCP).

D. Instructions for timely discharge from nursing services or referral to an outpatient center.

E. Date member was last seen by the physician
   1. For initial home health SNV, the member must be seen by within 30 days of the start of care (SOC).
   2. For recertification/ongoing services, the member must be at least once every six months since the SOC.

F. The type and frequency of visits, supplies, or durable medical equipment (DME) must appear on the POC before the physician signs the orders, and may not be added after the physician has signed the orders.

III. It is the policy of Superior HealthPlan that home health skilled nursing and HHA services are considered medically necessary when the following criteria are met:

- For members 21 years of age and older, home health skilled nursing services are available when the member requires nursing services for an acute condition or an acute exacerbation of a chronic condition which can be treated on an intermittent or part-time basis and typically have an end-point.
- For members 20 years of age or younger, home health skilled nursing services are available when the member requires nursing services for an acute condition, acute exacerbation of a chronic condition, or a chronic condition that can be treated on an intermittent or part-time basis.

Note: *An acute condition is a condition or exacerbation that is anticipated to improve and reach resolution within 60 days.*

A. The nursing services provided are not primarily for the comfort or convenience of the member or custodial in nature;

B. SNV are considered **medically necessary** when criteria are met using InterQual (IQ) subsets:
   1. Home Care Services, Adult – for the review of patients ≥ 18 years of age
   2. Home Care Services, Pediatric – for the review of patients < 18 years of age

IV. Nursing visits for the primary purpose of assessing a member's care needs to develop a POC are considered administrative and are not billable.

V. It is the policy of Superior HealthPlan that home health skilled nursing and HHA services are considered **not medically necessary** if requested primarily to provide the following:

A. Respite care
B. Childcare
C. Activities of daily living for the member
D. Housekeeping services
E. Routine post-operative disease, treatment, or medication teaching after a provider visit
F. Routine disease, treatment, or medication teaching after a provider visit
G. Individualized, comprehensive case management beyond the service coordination required by the Texas Nursing Practice Act
H. SNV will not be approved for the sole purpose of instructing the member on the use of the subcutaneous injection port device. Any necessary instruction must be performed as part of the office visit with the primary provider.

VI. It is the policy of Superior HealthPlan that nursing visits for the purpose of administering medications are **not medically necessary** if one of the following conditions exists:

A. The medication is not considered medically necessary to the treatment of the member's illness or is not approved by the Food and Drug Administration (FDA) or is being used for indications not approved by the FDA.
B. The administration of medication exceeds the therapeutic frequency or duration by accepted standards of medical practice.
C. A medical reason does not prohibit the administration of the medication by mouth.
D. The member, a primary caregiver, a family member, or neighbor have been taught or can be taught to administer subcutaneous (SQ/SC), intramuscular (IM), and intravenous (IV) injections and has demonstrated competency.
E. The medication is a chemotherapeutic agent or blood product SQ/SC, IM, and IV injections.

Background

Definitions

- **Incomplete Information Process**- Notification process for obtaining incomplete information submitted by HH provider to support medical necessity of requested SNV services.
- **Summary Sheet** - Summary of recent health history for initial authorization OR recertification summary to support medical necessity/rationale for extension of SNV services. Include recent hospitalizations, emergency room visits, surgery (may submit a discharge summary), illnesses, changes in condition, changes in medication or treatment, family/caregiver update, other pertinent observations.
- **Skilled Nursing** - means assessments, judgments, interventions, and evaluations of interventions requiring the education, training, and experience of a licensed nurse.

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2021, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT® Codes	Description
N/A	

HCPCS Codes	Description
N/A	

ICD-10-CM Diagnosis Codes that Support Coverage Criteria

ICD-10-CM Code	Description
N/A	

Reviews, Revisions, and Approvals	Date	Approval Date
New Policy	12/13	12/13
Updated verbal order protocol. Change clinical criteria to follow recommended InterQual frequency alone regardless of the duration. Updated InterQual 2014 SNV lists and deleted the adult and pediatric disease management initial subsets. Updated medical director review work process. Removed RS, PCN and SNV under definitions. Updated references and signatories.	12/14	12/14
Removed work process and imbedded in attachment section. Added policy to reference list.	02/15	02/15
Removed work process from policy. Removed product types from purpose. Grammatical changes. Removed requirement that member be homebound to receive Home Health services. Added Home Health SN and HHA Services that will not be prior authorized. Added medication administration limitations for Home Health SN. Added members under age 20 with chronic conditions can also qualify for HH SN. Added POC shall be initiated by a registered nurse (RN) or licensed vocational nurse (LVN).	12/15	12/15

Reviews, Revisions, and Approvals	Date	Approval Date
Added STAR Kids to product type. Removed CHIP Perinate from product type. Grammatical edits. Updated references and signatories. Updated role titles. Added SN visits are considered medically necessary when criteria are met using InterQual subsets for Home Health Services: Adults/Pediatrics.	12/16	12/16
Updated revision date, references, and signatories. Added statement regarding offering a peer-to-peer discussion prior to an adverse determination for Medicaid members under age 21.	12/17	12/17
Annual revision. Updated references and signatories.	11/18	11/18
Updated to new template from TX.UM.10.48 (TX.CP.MP.538 nomenclature implementation). Removed procedure code end date code G0154. Included home health aide services, under the plan of care documentation requirements. Removed LVN from the following statement: "The POC shall be completed by a RN in a clear and legible format." Updated references.	12/19	12/19
Annual review. Updated references.	12/20	12/20
Annual review. Added to Section II B 1, to refer to policy TX.UM.43. Added for clarification purposes to Section II D: nursing services and outpatient center. Removed from section I: *Note: If a request is incomplete and the member is a Medicaid member under age 21, the Incomplete Information Process must be followed per TX.UM.05 Timeliness of UM Decisions and Notifications;* and from Section IV: *NOTE: For Medicaid members under age 21, the opportunity for a peer-to-peer discussion must be offered prior to issuing an adverse determination as outlined in TX.UM.10.35. Physician Peer to Peer Policy.* Section I and II replaced all instances of provider for physician for clarification purposes. Section II, E revised date last seen to include 30 days from SOC and 6 months for ongoing and continued services from SOC. Reformatted sections. Clarified age limitations in section II. Updated references.	11/21	11/21
Annual review. Updated references. In Section III, changed A to a note "*An acute condition is a condition or exacerbation that is anticipated to improve and reach resolution within 60 days".*	11/22	11/22

References

1. HHSC Uniformed Managed Care Manual chapter 3.22

2. Texas Medicaid Provider Procedures Manual Home Health Nursing and Private Duty Nursing Services Handbook 1, 3.2 Skilled Nursing and Home Health Aide Services, October 2022
3. Texas Department of Human Services http://www.dads.state.tx.us/providers/communications/2001/rsc/RSC2001-13.pdf
4. TX.UM.05 Timeliness of UM Decisions and Notifications
5. TX.UM.10.35 Physician Peer to Peer Policy
6. TX.UM.02.10 Discharge Planning
7. TX.UM.26 Electronic and Verbal Signature Policy

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions, and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to

recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members, and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.