Medica Central Utilization Management Policy

Policy Name: **Skilled Nursing Facility MP9670 (III-INP.03)**

Effective Date: **07/01/2025**

IMPORTANT INFORMATION – PLEASE READ BEFORE USING THIS POLICY

These services may or may not be covered by all Medica Plans. Coverage is subject to requirements in applicable federal or state laws. Please refer to the member's plan document for other specific coverage information. If there is a difference between this general information and the member's plan document, the member's plan document will be used to determine coverage. With respect to Medicare, Medicaid, and other government programs, this policy will apply unless these programs require different coverage.

Medica may use tools developed by third parties, such as MCG Care Guidelines®, to assist in administering health benefits.Medica utilization management (UM) policies and MCG Care Guidelines are not intended to be used without the independent clinical judgment of a qualified health care provider taking into account the individual circumstances of each member's case. Medica UM policies and MCG Care Guidelines do not constitute the practice of medicine or medical advice. The treating health care providers are solely responsible for diagnosis, treatment, and medical advice.

Members may contact Medica Customer Service at the phone number listed on their member identification card to discuss their benefits more specifically. Providers with questions about this medical policy see Provider Communications for additional information. https://mo-central.medica.com/Providers/SSM-employee-health-plan-for-IL-MO-OK-providers

PURPOSE

To promote consistency between utilization management reviewers by providing the criteria that determines the medical necessity.

MEDICAL NECESSITY CRITERIA

For medical necessity criteria, The Health Plan uses MCG™ Care Guidelines, 28th edition, 2024: *Recovery Facility Care (RFC)*.

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BENEFIT CONSIDERATIONS

1. Prior authorization **is required** for skilled nursing facility (including an extended care facility, and transitional care unit) admissions. Please see the prior authorization list for product specific prior authorization requirements.
2. Patients who meet criteria for skilled nursing facility admission are approved for continued stay based on medical necessity.
3. Coverage may vary according to the terms of the member's plan document.
   Under some contracts, including Medicare, the transfer or admission to the skilled nursing facility must have occurred within 30 calendar days of discharge from a hospital during which the patient was inpatient for not less than three consecutive calendar days, all of which were deemed medically necessary.-
4. Swing bed in Critical Access Hospitals (CAHs) are covered when a patient requires skilled nursing care after an acute hospital stay while there is an active search for an available post-acute bed. Swing bed admissions in Critical Access Hospitals (CAHs) require notification, but not prior authorization.
5. For commercial products, charges to hold a bed during a skilled nursing facility absence, due to hospitalization or any other reason, is not covered. The member may choose to pay the skilled nursing facility privately for the bed-hold.
6. For patients not meeting criteria for skilled nursing facility services, alternative levels of care may be appropriate such as hospice, observational status, or short-term home health services.
7. Court ordered placement in a skilled nursing facility for chemical dependency, substance abuse, or other behavioral health treatments may require coverage according to the terms of the member's plan document.
8. The following services are generally excluded from coverage. Refer to member's plan document for details.
   A. Respite care (sole reason for request)
   B. Custodial care or supportive care.
   C. Routine or maintenance medication administration
9. If the Medical Necessity Criteria and Benefit Considerations are met, The Health Plan will authorize benefits within the clinical criteria and day limits in the member's plan document.
10. If it appears that the Medical Necessity Criteria and Benefit Considerations are not met, the individual's case will be reviewed by the medical director or an external reviewer. Practitioners are advised of the appeal process in their Provider Administrative Manual.

CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS)

- For Medicare members, refer to the following, as applicable at:
  - https://www.cms.gov/medicare-coverage-database/new-search/search.aspx
  - Medicare Benefit Policy Manual. Chapter 8: Coverage of Extended Care (SNF) Services Under Hospital Insurance. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS012673.html

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DOCUMENT HISTORY

Original Effective Date	Created 09/20/2023; Effective 01/01/2024
MPC Endorsement Date(s)	06/19/2024
Began use of MCG™ Care Guidelines	05/01/2024 (28th edition)
MCG Care Guidelines Edition Updates *(The Health Plan Effective Date)*	
Administrative Updates	06/20/2024, 07/01/2025