POLICY AND PROCEDURE

POLICY NAME: LTC (Long Term Care) Skilled Nursing Criteria	**POLICY ID:** LT.UM.08
BUSINESS UNIT: Sunshine State Health Plan	**FUNCTIONAL AREA:** Utilization Management, Long Term Care (LTC)
EFFECTIVE DATE: 05/01/2014	**PRODUCT(S):** LTC
REVIEWED/REVISED DATE: 10/26/2014, 3/11/2015, 3/2016,5/2017,3/2018, 2/2,020, 01/2021, 10/2021, 10/2022,10/2023	
REGULATOR MOST RECENT APPROVAL DATE(S): Please refer to system of record – Archer	

PURPOSE:
To establish clinical criteria on which to review requests for skilled nursing services for Sunshine Health's Long Term Care (LTC) line of business. This applies for members residing in a home and community-based environment. The goal of the skilled nursing services is to provide these services in the home to address the member's cognitive or functional deficits which may be a result of their medical conditions. The services will assist in maintaining the member in their home and community environment, in a safe manner, to avoid the risk for nursing home placement.

SCOPE:
Sunshine Health Utilization and Long Term Care (LTC) Case Management Departments.

DEFINITIONS:

POLICY:
Sunshine Health shall ensure the provision of the following covered services, including those covered under s. 409.98(1) through (19), F.S. In addition to this section, Sunshine Health shall ensure the provision of the covered services specified in the Agency for Health Care Administration contract number FP060 with the Plan.

DESCRIPTION OF BENEFITS:
The following is a description of the LTC covered skilled nursing services covered by this policy:

- Attendant Care Services – Hands –on care, of both a supportive and health-related nature, specific to the needs of a medically stable, physically handicapped individual. Supportive services are those which substitute for the absence, loss, diminution or impairment of a physical or cognitive function. This service may include skilled or nursing care to the extent permitted by state law. Housekeeping activities which are incidental to the performance of care may be also furnished as part of this activity. This service can be provided when the member's mental or physical condition requires assistance with medically related needs. The services must be provided in the member's home. These services cannot be used at the same time as Personal Care or Adult Companion services.

    - Intermittent and Skilled Nursing –The scope and nature of these services do not differ from skilled nursing furnished under the Sate Plan. This service includes the home health benefit available under the Medicaid state plan as well as expanded nursing services coverage under the ACHA contract and applicable waiver. Services listed in the plan of care that are with the Scope of Florida's Nurse Practice Act and are provided by a registered professional nurse, or a licensed practical or vocational nurse under the supervision by a registered professional nurse, licensed to practice in the state. Skilled nursing services shall be listed in the member's plan of care and are provided on an intermittent basis to members who either do not require continuous nursing supervision or whose need is predictable.

    - Caregiver Training – Training and counseling services for individuals who provide unpaid support, training, companionship or supervision. The individual is defined as any person, family member, neighbor, friend, companion or co-worker who provides uncompensated care, training, guidance, companionship or support. This service may not be provided to train paid caregivers. Training includes instruction about treatment regimens and other services included in the plan of care, use of equipment specified in the plan of care, and includes updates as necessary to safely maintain in the home. Counseling is to be aimed at assisting the unpaid caregiver in meeting the needs of the member. The limit for individual or group caregiver training/support is four (4) hours per day with a maximum of 20 hours per month.

- Medication Administration - This service is assistance provided to the member for self-administration of medications, whether in the home or a facility, and includes taking medication from where it is stored and delivering it to the member, removing the prescribed amount of medication from the container and placing it in the member's hand or another container; helping the member by lifting the container to their mouth; applying topical medications; and keeping a record of when a member receives assistance with self-administration of the their medications.

- Medication Management – This service is a review by a licensed nurse of all prescriptions and over-the-counter medications taken by the member, in conjunction with the member's physician. The purpose of the review is to assess whether the member's medication is accurate, valid, non-duplicative and correct for the diagnosis; that therapeutic doses and administration are at an optimal level; that there is appropriate laboratory monitoring and follow-up taking place; and that drug interactions, allergies and contraindications are being assessed and prevented.

- Nutritional Assessment/Risk Reduction Services – An assessment, hands-on care and guidance to caregivers and members with respect to planning and preparing nutritionally appropriate meals. This service teaches caregivers and members to follow dietary specifications that are essential to the member's health and physical functioning, to prepare and eat nutritionally appropriate meals and promote better health through improved nutrition. This service may include instructions on shopping for quality food and food preparation. The services can be provided in the member's home, at a health professional's office or other location.

- Respiratory Therapy – Treatment of conditions that interfere with respiratory functions or other deficiencies of the cardiopulmonary system. Services include evaluation and treatment related to pulmonary dysfunction.

PROCEDURE:
Skilled nursing service benefits must be authorized by Sunshine Health and be appropriate for the member.

When the member's physician identifies which skilled nursing services are appropriate for the member, the physician will follow the Sunshine Health prior authorization process to request a prior authorization as outlined in the Timeliness of UM Decisions and Notifications policy FL.UM.05.00

All requests will be prior authorized and reviewed for medical necessity as outlined in the Medical Necessity Review and Continuity of Care (COC) policy FL.UM.02.01 and Use of Clinical Criteria policy FL.UM.02

A. Identification of Member Potential Need for Skilled Nursing Services

1. Initial assessment:

The LTC Care Coordinators are responsible to develop a person-centered care plan and complete an assessment of new LTC members to determine the medical necessity of covered benefits which may meet the member's needs. Both the Department of Elder Affairs Comprehensive Assessment Form 701B and the LTC Supplemental Assessment are completed face to face at the orientation visit and following the timelines established by the Florida Agency for Health Care Administration. At the initial visit, the LTC Care Coordinator completes the 701B and LTC Supplemental Assessments and assists the member in establishing personal goals for community integration while developing the member's person centered care plan. This information is utilized to identify the specific services and amount of services which addresses the member's needs to maintain them in the least restrictive environment in a safe manner and to support their desired goals. The LTC Care Coordinator educates and assists member in obtaining the necessary prescription and medical records which are faxed directly to the Utilization Management Prior Authorization department. If the member already has the documentation to give to the LTC Care Coordinator at the time of the visit, then the LTC Care Coordinator will upload the documents into the member's electronic record (chart) and forward the request to the Utilization Management Prior Authorization department. The LTC Care Coordinator refers the request to the LTC Utilization Management (UM) team. The Utilization Management reviewers access the member record including the member's person centered care plan, the Department of Elder Affairs Comprehensive Assessment Form 701B, the LTC Supplemental Assessment, and the prescription and medical records to complete a thorough clinical review to make

the appropriate determination for member's care that is in line with and supportive of the member's personal goals that are noted on the person centered care plan.

2. Ongoing assessment:
The LTC Care Coordinator reassesses the member's functional, cognitive, and social needs and informal supports at every contact. This information is used to identify changes in the member's status and if modifications to the type of service(s) and/or amount of service(s) in place should be considered and evaluated based on medical necessity of the service(s).

3. Annual assessment:
On an annual basis, the LTC care coordinator will complete an updated Department of Elder Affairs Comprehensive Assessment Form 701B and the LTC Supplemental Assessment on an enrolled LTC member. This information is used to identify changes in the member's goals and member's status and if modifications to the member's goal and to the type of service(s) and/or amount of service(s) in place should be considered and evaluated based on medical necessity of the service(s) and to be supportive of member's goal.

4. Physician identification:
At any time, a physician or other health care professional who is treating the member may identify that the member may benefit from skilled nursing services. The treating physician or other health care professional can contact Sunshine Health to request a prior authorization of a skilled nursing service.

B. Medical Necessity Determination

If the request for skilled nursing services has not been initiated by the member's treating physician or other healthcare professional and the LTC Care Coordinator identifies the potential need, the LTC Care Coordinator will refer the member to their physician for evaluation and recommendation. The physician will ascertain the member's need based on medical necessity. The physician will submit to Sunshine Health the request and clinical supporting information for a prior authorization review. Sunshine Health will respond to the physician requests within the timelines as outlined in the Timeliness of UM Decisions and Notifications FL.UM.05.00 policy.

The following criteria are used in the order below:

- Most recently available written/electronic version of McKesson's *InterQual* Level of Care and Care Planning Criteria for Pediatric Acute, Adult Acute, Long-Term Acute Care, Rehabilitation, Subacute/SNF, Home Care, Durable Medical Equipment, Imaging, and Adult and Pediatric Procedures, Outpatient Rehab and Chiropractor.
- Medical Necessity Review and Continuity of Care policy FL.UM.02.01
- FL Medicaid Home Health Visit Services Coverage Policy and the FL Medicaid Home Health Visit Services Fee Schedule.
- Other applicable skilled nursing Centene clinical policies
- Current AHCA Medicaid Contract
- Department of Elder Affairs Comprehensive 701B Assessment and LTC Supplemental Assessment
- Medicare National Coverage Determinations when applicable.

To assist in determining the medical necessity of any skilled nursing services, the clinical criteria established in this policy will be applied. Any decision to deny, reduce, suspend or terminate services must be made by a Sunshine Health Medical Director as outlined in the policy Medical Necessity Review and Continuity of Care policy FL.UM.02.01.

C. Referral and Authorization Process

Sunshine Health has timeframes in place for practitioners and providers to notify Sunshine Health of a service request and for Sunshine Health to make utilization management (UM) decisions and notifications to the enrollee, practitioner, and provider in a timely manner. See policy Timeliness of UM Decisions and Notifications Policy FL.UM.05.00

The Sunshine Health UM staff will process requests for authorizations regarding skilled nursing services for LTC members and make decisions following a standardized process and time period. (See Timeliness of UM Decisions and Notifications Policy FL.UM.05.00)

All requests for LTC skilled nursing services will be reviewed against criteria indicated in this policy. If the requested skilled nursing services meet the criteria, the services will be approved and an authorization communicated back to the requesting provider and member. If the request does not meet the established criteria, the request will be sent to a Sunshine Health Medical Director for review. If services are reduced, denied, terminated, or suspended by the Medical Director, communication of the denial will be sent to the requesting and servicing providers, primary care physician and the member. See Timeliness of UM Decisions and Notifications FL.UM.05.00

- The time and date of receipt for any request for review of a service is documented in the Sunshine Health clinical management system. For fax requests, the receipt date and time of authorization request in the clinical management system.
- If the request was sent via fax, the date/time of the request field must be reconciled to the date/time stamp on the fax
- If the request was received via Filenet/ CDMS, the date/ time of the line item request field must be reconciled to match the “Received by Centene” date/ time stamp on the document.

D. Coordination of Benefits

The COB to include Medicare
Determination of who is responsible to pay for services for a comprehensive member which is a member enrolled in the Long Term Care (LTC) product and also in a Managed Medical Assistance (MMA) product is made by identifying the type of service requested. For any service identified as a mixed service, the LTC product is responsible for payment of those services, regardless if the MMA plan is Sunshine Health. Mixed services include:

- Skilled nursing services- Attendant care requests are built under LTC. Private Duty Nursing requests for member’s under 21 years of age are built under member/s MMA/CMS account
- Durable Medical Equipment (DME)
- Therapies in the home (physical therapy, speech therapy, respiratory therapy, occupation therapy, and respiratory therapy)
- Hospice
- Transportation (only for LTC benefits)

The LTC care coordinator will coordinate all LTC covered mixed services with the applicable vendor(s) and in collaboration with the applicable MMA plan. The LTC care coordinator team will follow up with member to verify that services are received and to address any issues with the delivery and or vendor.

REFERENCES:

Agency for Healthcare Administration, Standard Contract FP060
FL Medicaid Home Health Visit Services Coverage Policy
FL Medicaid Home Health Visit Services Fee Schedule See http://ahca.myflorida.com/medicaid/review/Specific/59G-4-130_Home_Health_Visit_Services_Coverage_Policy.pdf

FL.UM.01 - Utilization Management Program Description
FL.UM.02 - Use of Clinical Criteria
FL.UM.02.01 – Medical Necessity Review and Continuity of Care
FL.UM.05.00 - Timeliness of UM Decisions and Notifications
CP.MP.54 - Hospice Clinical Coverage
Chapter 395 or Chapter 400, F.S.
CP.MP.71 - Long Term Care Placement Criteria

ATTACHMENTS: N/A

ROLES & RESPONSIBILITIES: N/A

REGULATORY REPORTING REQUIREMENTS: State review and approval required for any substantial changes and upon request.

REVISION LOG

REVISION TYPE	REVISION SUMMARY	DATE APPROVED & PUBLISHED
New Policy	New Policy	10/26/2014
Annual Review	Removed Hospice in the Description of Benefits Section; Added Aged and Disabled Adult Waiver Provider handbook in the reference section; Added UM Committee approval date.	3/11/2015
Annual Review	Annual Review; modified Fax Service software application	03/2016
Annual Review	Annual review; added definition of attendant care services; added definition of Nutritional Assessment/Risk Reduction; removed skilled services only covered for LTC members eligible or pending eligibility; removed retired policy FL.UM.02.02; added reference to Use of Clinical Criteria FL.UM.02; updated LTC case manager to care coordinator; updated title of AHCA handbook to FL Medicaid Home Health List of Services Coverage Policy; added reference to FL.UM.02.01 Medical Necessity Review.	05/16/2017
Annual Review	Revised to add reference to current contract language requirements	03/2018
Annual Review	Updated Medical Necessity determination, changed policy reference to FL.UM.05.00 and removed policy reference FL.UM.01.05	02/2020
Annual Review	Integration review done by Medical Affairs. Updated policy approval flow.	
Annual Review & Integrated Policy	Integrated Policy	10/01/2021
Annual Review	Added Verbiage to Coordination of Benefits: “Attendant care requests are built under LTC. Private Duty Nursing	10/05/2022

	requests for member's under 21 years of age are built under member/s MMA/CMS account"	
Annual Review	Updated policy ID Updated Footer with policy ID and name	10/2023

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in RSA Archer, the Company's P&P management software, is considered equivalent to a signature.