



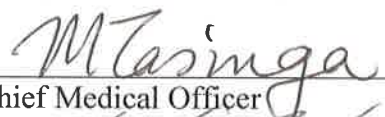
KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS				
POLICY AND PROCEDURES				
SUBJECT: Nursing Facility Services and Long Term Care			POLICY #: 3.42-P	
DEPARTMENT: Utilization Management				
Effective Date: 05/2000	Review/Revised Date: 10/29/2018	DMHC		PAC
		DHCS		QI/UM COMMITTEE
		BOD		FINANCE COMMITTEE



 Douglas A. Hayward
 Chief Executive Officer

Date 10/29/18



 Chief Medical Officer

Date 10/19/18



 Director of Member Services

Date 10/15/18



 Administrative Director of Health Services

Date 10/16/18

POLICY:

Kern Health Systems (KHS) will cover medically necessary Nursing Facility Services provided from the time of admission and up to one month after the month of admission¹ unless deemed short term for completion of medically necessary services and not considered custodial in nature. Provision of Skilled Nursing facility services allow for up to 100 days per benefit period (including any days covered under the prior subscriber contract issued by the plan to the enrollee or enrollee's group) of skilled inpatient services in a skilled nursing facility. The skilled inpatient services must be customarily provided by a skilled nursing facility, and above the level of custodial or intermediate care.

A benefit period begins on the date the enrollee is admitted to a hospital or skilled nursing facility at a skilled level of care. A benefit period ends on the date the enrollee has not been an inpatient in a hospital or skilled nursing facility, receiving a skilled level of care, for 60 consecutive days. A new benefit period can begin only after any existing benefit period ends. A prior three-day stay in an acute care hospital is not required to commence a benefit period.

KHS Members with coverage for Medicare benefits, discharged from an acute care hospital will be allowed to return to a skilled nursing facility (SNF), continuing care retirement community, or multi-level facility, as defined, in which the member resided at least 60 days prior to hospitalization.

KHS members requiring Nursing Facility Services will be identified and placed in a health care facility that provides the level of care most appropriate to the member's medical needs.³ For those Medi-Cal members requiring LTC, KHS will coordinate the member's care and initiate disenrollment per DHCS criteria.

Long Term Care (LTC) services are carved out of KHS' contract with the Department of Health Care Services (DHCS) and therefore are not a covered benefit for Medi-Cal members.

This policy does not apply to members who elect hospice services. Standards for the provision of hospice services are outlined in *KHS Policy and Procedure #3.43-P: Hospice*.

Nursing Facility Services will be provided as outlined in the following statutory, regulatory, and contractual requirements:

- California Health and Safety Code §1367.09
- California Code of Regulations Title 22 §§51118; 51120; 51120.5; 51121; 51123; 51124.5; 51124.6; 51334(l); 51335(j); 51335.5(a); and 51335.6(a)
- DHCS Contract Exhibit A – Attachment 11 17(A)

DEFINITIONS:

Long Term Care⁴	Care in a facility considered custodial and not short term for longer than the month of admission plus one month. Hospice services are not long term care services regardless of the member's expected or actual length of stay in a nursing facility.
Nursing Facility Services	Includes both Intermediate Care Services and Skilled Nursing Facility (SNF) Services.

PROCEDURES:

1.0 ACCESS

Primary Care Practitioners (PCPs) and/or specialists are responsible for identifying KHS members who require Nursing Facility Services. Nursing Facility Services require prior authorization.

Once the member's PCP has determined that the member requires Nursing Facility Services, the PCP must consult with KHS Utilization Management staff to determine the appropriate level of care. Utilization Management staff inform the KHS Chief Medical Officer (CMO) or their designee of the member's need for Nursing Facility Services. If the PCP and the Utilization Management Case Manager disagree regarding level of care, the CMO or their designee and the PCP will discuss on an individualized basis until a mutually agreed upon decision is reached.

Members in need of Nursing Facility Services are placed in a health care facility that provides the level of care most appropriate to the member's medical needs. These health care facilities include skilled nursing facilities, subacute facilities, pediatric subacute facilities, and intermediate care facilities.⁵ As outlined in Section 1.3 of this procedure, KHS Members with coverage for Medicare benefits, discharged from an acute care hospital will be allowed to return to a skilled nursing facility, continuing care retirement community, or multi-level facility, as defined, in which the member resided at least 60 days prior to hospitalization. Preference is given to KHS contract facilities when attempting to secure placement.

If the member is in a contract acute facility, the acute facility's discharge planning staff who are familiar with Medi-Cal criteria, secure placement for the member at a facility providing the appropriate level of care, as authorized by KHS. If the member is an outpatient, a KHS Case Manager works with the PCP's office to secure placement.

1.1 Nursing Facilities

A Nursing Facility is defined as a facility that is licensed as either a skilled nursing facility or an intermediate care facility.⁶ Nursing Facilities meet the requirements outlined in the table below.

Intermediate Care Facility⁷	A facility which is licensed as such by DHCS or is a hospital or skilled nursing facility which meets the standards specified in California Code of Regulations Title 22 §51212 and has been certified by DHCS for participation in the Medi-Cal program.
Skilled Nursing Facility⁸	Any institution, place, building, or agency which is licensed as a skilled nursing facility by DHCS or is a distinct part or unit of a hospital, meets the standard specified in California Code of Regulations Title 22 §51215 (except that the distinct part of a hospital does not need to be licensed as a skilled nursing facility) and has been certified by DHCS for participation as a skilled nursing facility in the Medi-Cal program. Skilled nursing facility shall include the terms “skilled nursing home”, “convalescent hospital”, “nursing home”, or “nursing facility”.

1.2 Levels of Care

The table below describes the different levels of care.

Level of Care	Patient Condition	Facility
Intermediate Care ⁹	<ul style="list-style-type: none"> Requires protective and supportive care, because of mental or physical 	Hospital, skilled nursing facility, or intermediate care facility.

Level of Care	Patient Condition	Facility
	<p>conditions or both, above the level of board and care.</p> <ul style="list-style-type: none"> • Does not require continuous supervision of care by a licensed registered or vocational nurse except for brief spells of illness. • Does not have an illness, injury, or disability for which hospital or skilled nursing facilities are required. 	<p>For members under the age of 65, services may also be provided in a public institution only if the case meets the conditions of CCR Title 22 §51120(b).</p>
<p>Skilled Nursing Facility¹⁰</p>	<ul style="list-style-type: none"> • Requires the continuous availability of skilled nursing care provided by licensed registered or vocation nurses, or the equivalent thereof. • Does not require the full range of health care services provided in a hospital as hospital acute care or hospital extended care 	<p>Skilled nursing facility</p>
<p>Subacute Care¹¹</p>	<ul style="list-style-type: none"> • Requires more intensive licensed nursing care than is provided to the majority of patients in a skilled nursing facility. • Does not require hospital acute care 	<p>Subacute care unit</p>
<p>Pediatric Subacute Care¹²</p>	<ul style="list-style-type: none"> • Under 21 years of age • Does not have a qualifying CCS eligible condition • Uses a medical technology that compensates for the loss of a vital bodily function 	<p>Pediatric subacute care unit</p>

To be eligible for a specific level of care, a member must meet the criteria outlined in Attachment A – *Nursing Facility Services Eligibility Criteria*. This criteria is based

on the definitions set forth in Title 22, CCR, §§51118, 51120, 51120.5; 51121; 51124.5; 51124.6; and the criteria for admission set forth in Title 22, CCR, §§51335; 51335.5; 51335.6; and 51334 and related sections of the *Manual of Criteria for Medi-Cal Authorization* referenced in Title 22, CCR, 51003(e).¹³

1.3 Medicare Member's Return to Previous Facility

Once the member's PCP has determined that the member is ready for hospital discharge and that the medical care needs of the member, including continuity of care, can be met in the previous facility, a KHS Case Manager will coordinate the return of the member to that facility in conjunction with the acute hospital's discharge planning staff, the accepting return LTC facility, and the member.

The receiving facility must agree to abide by KHS standards and terms and conditions, including utilization review, management and administrative procedure, and licensing and certification including the appropriate certification of the facility by the Health Care Financing Authority or other state or federal agencies.¹⁴ The receiving facility must also agree to accept reimbursement from KHS for covered services at either of the following rates¹⁵:

- A. The rate applicable to similar skilled nursing coverage for contracted facilities
- B. Upon mutual agreement, at a rate negotiated in good faith by KHS on an individual, per enrollee, contractual basis.

If a determination not to return the member to the facility is made, the physician must document reasons in the member's medical record and share that written explanation with the member.¹⁶

2.0 PROVISION OF SERVICES

Medically necessary Nursing Facility Services are covered from the time of admission and up to one month after the month of admission¹⁷ unless deemed short term for completion of medically necessary services and not considered custodial in nature.

2.1 Intermediate Care Services

Members who qualify for the Intermediate Care level of care are eligible to receive intermediate care services.

2.2 Skilled Nursing Facility (SNF) Services

Members who qualify for the Skilled Nursing Facility level of care, the Subacute level of care, or the Pediatric Subacute level of care are eligible to receive SNF services. These services are provided as authorized by a skilled nursing facility, subacute care unit, or pediatric subacute care unit as appropriate.

For the Medi-Cal Product, SNF services include¹⁸:

- A. Room and board
- B. Physician and Nursing services
- C. Drugs prescribed by a physician as part of the plan of care in the plan skilled nursing facility in accord with the plan's drug formulary guidelines if they are administered in the skilled nursing facility by medical personnel

- D. Durable medical equipment in accord with the plan's durable medical equipment formulary if skilled nursing facilities ordinarily furnish the equipment
- E. Imaging and laboratory services that skilled nursing facilities ordinarily provide
- F. Medical social services
- G. Blood, blood products, and their administration
- H. Medical supplies
- I. Behavioral health treatment for pervasive developmental disorder or autism
- J. Respiratory therapy

3.0 **CASE MANAGEMENT AND COORDINATION OF CARE**

¹⁹KHS Utilization Management staff assesses the projected length of stay of the member upon admission to a nursing facility.

3.1 **Coordination of Care**

KHS is required to provide coordination of care to beneficiaries who meet medical necessity criteria for LTC, including coordinating placement in an LTC facility that provides the level of care most appropriate to the beneficiary's medical needs for LTC. Coordinating placement in an LTC facility includes coordinating the transfer of the beneficiary to the LTC facility; notifying the beneficiary and his or her family or guardian of the transfer to the LTC facility; assuring the appropriate transfer of medical records to the LTC facility; assuring that continuity of care is not interrupted; and continued provision of all medical necessary covered services to the beneficiary while the beneficiary is enrolled with KHS. The responsibility to coordinate the placement of a beneficiary in an LTC facility is not contingent on the beneficiary's expected length of stay at the LTC facility.

3.2 **Disenrollment of Medi-Cal Members Needing LTC**

If the member will require LTC or custodial care beyond short term medical needs, KHS UM clinical staff (RN, LVN, MD) will submit a disenrollment request to Member Services staff (MSR). Upon MSR notification, the request for disenrollment will be forwarded to DHCS. The request for disenrollment is initiated by sending a facsimile to Maximus at (916) 364-0287 see Attachment B, Disenrollment Request. KHS is responsible for supplying all medically necessary services to the member until disenrollment becomes effective.

Disenrollment is requested on the first business day of the second month following the month of the admission to the facility unless deemed short term for completion of medically necessary services and not considered custodial in nature. Provided that the disenrollment is requested at least 30 days prior to such date, the disenrollment is effective the first day of the third month. If the request was made less than 30 days prior to that date, disenrollment will be effective the first day of the month that begins at least 30 days after submission of the disenrollment request.

The disenrollment request cannot be submitted prior to the beneficiary's placement in the LTC facility. KHS should notify the LTC facility that the disenrollment request has been submitted to DHCS. KHS is required to provide all medically necessary covered services to the beneficiary until the disenrollment is effective.

Upon the disenrollment effective date, KHS coordinates the member's orderly transfer to the Medi-Cal Fee-For-Service program. This includes notifying the member and his or her family or guardian of the disenrollment; coordinating the appropriate transfer of medical records from the KHS contracted provider to the Medi-Cal fee-for-service provider; facilitating uninterrupted continuity of care; and, completion of all administrative work necessary to assure a smooth transfer of responsibility for the member's health care.

KHS Case Managers encourage PCPs to continue to care for the member under fee-for-service in order to preserve continuity of care. If the member's PCP will not continue to follow under fee-for service, KHS Utilization Management Case Managers will work with the PCP and the accepting LTC facility to secure a physician to follow under fee-for-service.

Persons who become eligible for Medi-Cal at the time they are in an LTC facility are not eligible to enroll with KHS. However, there will be cases where a beneficiary in an LTC facility is erroneously enrolled in a MCP. In these instances, KHS will notify their respective contract manager to request immediate disenrollment retroactive to the date of enrollment. Should the plan not discover this enrollment until several months have elapsed and have provided services beyond the LTC, they may either:

1. Notify their contract manager and request retroactive disenrollment to the date of enrollment and advise providers to bill FFS and reimburse KHS for any claims previously paid.
2. Accept responsibility for all contracted services for the first two months and request disenrollment to occur in the third month.

4.0 REIMBURSEMENT

KHS reimburses contract nursing facilities at the appropriate negotiated rate. Non-contract nursing facilities are reimbursed at the appropriate Medi-Cal Fee for Service rate or by completion of a fully executed pre-approved Letter of Agreement. All claims must be submitted in compliance with *KHS Policy and Procedure #6.01-P: Claims Submission and Reimbursement*.

5.0 MONITORING AND REPORTING

KHS is responsible for ensuring that their delegates comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and Dual Plan Letters. These requirements must be communicated by KHS to all delegated entities and subcontractors.

Reports are submitted as outlined in the following table.

Reported To	Report	Due Date	Responsibility
QI/UM Committee	Referral data for nursing facility services and any identified trends	Monthly and quarterly	Administrative Director of Health Services

The QI/UM Committee recommends corrective action, if needed.

ATTACHMENTS:

- **Attachment A - *Nursing Facility Services Eligibility Criteria***
- **Attachment B – *Disenrollment Request form***

REFERENCE:

Revision 2018-09: Policy review by Administrative Director of Health Services as part of Internal Compliance Review of APL 17-006. **Revision 2017/12:** Policy revised to comply with All Plan Letter 17-017.

¹ DHS Contract A-11 17(A)

³ DHS Contract A-11 17(A)

⁴ DHS Contract A-11 17 (A) Paragraph 2

⁵ DHS Contract A-11 17(A) paragraphs 1 and 5

⁶ DHS Contract A-11 17 (A) paragraph 2

⁷CCR Title 22 Section 51120.5

⁸ CCR Title 22 §51118

⁹ CCR Title 22 §51121

¹⁰CCR Title 22 §51120(a)

¹¹ CCR Title 22 §51124 (a) and (b)

¹² CCR Title 22 §51124.5(a) and 51335.5(a)

¹³CCR Title 22 §51124.6(a) and 51135.6(a)

¹⁴ DHS Contract A-11 17 second paragraph

¹⁵ HSC 1367.09(a)(3)

¹⁶ HSC 1367.09(a)(4)

¹⁷ HSC 1367.09(a)(2)

¹⁸ DHS Contract A-11 17(A)

¹⁹CCR Title 22 §51123

²⁰ Benefit list taken from HFAM Model EOC 2006-2007

²¹ DHS Contract A-11 17 third paragraph

²² DHS Contract A -11 17 fourth paragraph

Nursing Facility Services Eligibility Criteria for the Various Levels of Care

Intermediate Care Level of Care (CCR Title 22 Section 51334(l))

In order to qualify for intermediate care services, a patient shall have a medical condition which needs an out-of-home protective living arrangement with 24-hour supervision and skilled nursing care or observation on an ongoing intermittent basis to abate health deterioration. Intermediate care services emphasize care aimed at preventing or delaying acute episodes of physical or mental illness and encouragement of individual patient independence to the extent of his ability. As a guide in determining appropriate placement:

1. The complexity of the patient's medical problems is such that he requires skilled nursing care or observation on an ongoing intermittent basis and 24-hour supervision to meet his health needs.
2. Medications may be mainly supportive or stabilizing but still require professional nurse observation for response and effect on an intermittent basis. Patients on daily injectable medications or regular doses of PRN narcotics may not qualify.
3. Diet may be of a special type, but patient needs little or no assistance in feeding himself.
4. The patient may require minor assistance or supervision in personal care, such as in bathing or dressing.
5. The patient may need encouragement in restorative measures for increasing and strengthening his functional capacity to work toward greater independence.
6. The patient may have some degree of vision, hearing or sensory loss.
7. The patient may have some limitation in movement, but must be ambulatory with or without an assistive device such as a cane, walker, crutches, prosthesis, wheelchair, etc.
8. The patient may need some supervision or assistance in transferring to a wheelchair, but must be able to ambulate the chair independently.
9. The patient may be occasionally incontinent of urine, however, patient who is incontinent of bowels or totally incontinent of urine may qualify for intermediate care service when the patient has been taught and can care for himself.
10. The patient may exhibit some mild confusion or depression; however, his behavior must be stabilized to such an extent that it poses no threat to himself or others.

Skilled Nursing Level of Care (CCR Title 22 Section 51335 (j))

In order to qualify for skilled nursing facility services, a member shall have a medical condition which needs visits by a physician at least every 60 days and constantly available skilled nursing services. The following criteria together with the provisions of section 51124, will assist in determining appropriate placement. These general criteria are not intended to be either all-inclusive or mutually exclusive. In practice, they should be applied as a total package in evaluation of an approved admission.

1. Need for patient observation, evaluation of treatment plans, and updating of medical orders by the responsible physician
2. Need for constantly available skilled nursing services. A patient may qualify for nursing home services if the patient has one or more of the potentially qualifying conditions
 - A. A condition which needs therapeutic procedures. A condition such as the following may weigh in favor of nursing home placement.
 - (1) Dressing of postsurgical wounds, decubiti, leg ulcers, etc. The severity of the lesions and the frequency of dressings will be determining factors in evaluating whether they require nursing home care.
 - (2) Tracheostomy care, nasal catheter maintenance

- (3) Indwelling catheter in conjunction with other conditions. Its presence without a requirement for other skilled nursing care is not a sufficient criterion for nursing home placement.
 - (4) Gastrostomy feeding or other tube feeding
 - (5) Colostomy care for initial or debilitated patients. Facilities shall be required to instruct in self-care, where such is feasible for the patient. Colostomy care alone should not be a reason for continuing nursing home placement.
 - (6) Bladder and bowel training for incontinent patients
- B. A condition which needs patient skilled nursing observation. Patients whose medical condition requires continuous skilled nursing observation of the following may be in a nursing home dependent on the severity of the condition. Observation must, however, be needed at frequent intervals throughout the 24 hours to warrant care in a nursing home:
- (1) Regular observation of blood pressure, pulse, and respiration is indicated by the diagnosis or medication and ordered by the attending physician
 - (2) Regular observation of skin for conditions such as decubiti, edema, color, and turgor
 - (3) Careful measurement of intake and output is indicated by the diagnosis or medication and ordered by the attending physician
- C. The patient needs medications which cannot be self-administered and requires skilled nursing services for administration of the medications. Nursing home placement may be necessary for reasons such as the following:
- (1) Injections administered during more than one nursing shift. If this is the only reason for nursing home placement, consideration should be given to other therapeutic approaches, or the possibility of teaching the patient or a family member to give the injections.
 - (2) Medications prescribed on an as needed basis. This will depend on the nature of the drug and the condition being treated and frequency of need as documented. Many medications are now self-administered on an PRN basis in residential care facilities
 - (3) Use of restricted or dangerous drugs, if required more than during the daytime, requiring close nursing supervision.
 - (4) Use of new medications requiring close observation during initial stabilization for selected patients. Depending upon the circumstances, such patients may also be candidates for intermediate care facilities.
- D. A physical or mental functional limitation.
- (1) Physical limitations. The physical functional incapacity of certain patients may exceed the patient care capability of intermediate care facilities.
 - (a) Bedfast patients
 - (b) Quadriplegics, or other severe paralysis cases. Severe quadriplegics may require such demanding attention (skin care, personal assistance, respiratory embarrassment) as to justify placement in nursing homes.
 - (c) Patients who are unable to feed themselves
 - (2) Mental limitations. Persons with a primary diagnosis of mental illness (including mental retardation), when such patients are severely incapacitated by mental illness or mental retardation. The following criteria are used when considering the type of facility most suitable for the mentally ill and mentally retarded member where care is related to his mental condition:

- (a) The severity of unpredictability of the member's behavior or emotional state
- (b) The intensity of the care, treatment, and services, or skilled observation that his condition requires
- (c) The physical environment of the facility, its equipment, and the qualifications of staff
- (d) The impact of the particular patient on other patients under care in the facility

Subacute Level of Care (CCR Title 22 Section 51124.5)

To be eligible for this level of care a member's condition must meet all of the criteria as provided for in the "Subacute Level of Care Criteria" contained in the *Manual of Criteria for Medi-Cal Authorization* as determined by the attending physician and as approved by KHS.

Pediatric Subacute Level of Care (CCR Title 22 Section 51124.6)

Medical necessity for pediatric subacute care services shall be substantiated by any one of the following items:

1. Tracheostomy with dependence on mechanical ventilation for a minimum of 6 hrs/day
2. Dependence on tracheostomy care requiring suctioning at least every 6 hours, and room mist or oxygen as needed, and dependence on one of the 4 treatment procedures listed in B through E below:
 - A. Dependence on intermittent suctioning at least every 8 hours, and room air mist or oxygen as needed
 - B. Continuous IV Therapy including administration of therapeutic agents necessary for hydration or of IV pharmaceuticals; or IV pharmaceutical administration of more than one agent via peripheral or central line without continuous infusion
 - C. Peritoneal dialysis treatments requiring at least 4 exchanges every 24 hours
 - D. Tube feedings, naso-gastric or gastrostomy tube
 - E. Other medical technologies required continuously which in the opinion of the attending physician and KHS, require the services of a professional nurse
3. Dependence on total parenteral nutrition or other intravenous nutritional support, and dependence on one of the five treatment procedures as listed in 2 above
4. Dependence on skilled nursing care in the administration of any three of the five treatment procedures listed in 2

Medical necessity for pediatric subacute skilled nursing care shall be further substantiated by all of the following conditions:

1. The intensity of medical/skilled nursing care required by the patient shall be such that the continuous availability of a registered nurse in the pediatric subacute unit is medically necessary to meet the member's healthcare needs, and not be any less than the nursing staff ratios specified in CCR Title 22 §51215.8(g) and (i)
2. The medical condition has stabilized such that the immediate availability of the services of an acute care hospital, including daily physician visits, are not medically necessary
3. The intensity of medical/skilled nursing care required by the patient is such that, in the absence of a facility providing pediatric subacute care services, the only other medically necessary inpatient care appropriate to meet the patient's health care needs under the Medi-Cal program is in an acute care licensed hospital bed.

DISENROLLMENT REQUEST FORM

Plan/Agency KERN FAMILY HEALTH CARE

Date _____ HCP # 303

Name/Title _____ Phone _____

Referred to CM _____

ID Number				I: B U	Pers.	Social Security No.	Birthdate			Name		
Proj.	County	Alt Code	Char				Month	Day	Year	Last	First	M.I.

Reason for Disenrollment:

MOVED OUT OF SERVICE AREA

new address _____ date moved _____

INPUT ERROR: BATCH # _____ DATE MAILED: _____

PRIOR CARE: DR.: _____ TEL NO.: _____

diagnosis _____

subscriber name _____ cert # _____ date of enrollment _____

CCS#: _____ GHPP#: _____ EFFECTIVE MO/YR: _____

name of contact person _____ county _____ telephone no. _____

INCARCERATION TO THE YOUTH/ADULT CORRECTIONAL FACILITY

name of facility _____ date of placement _____

OTHER

Action _____

(Requested by)

(Date)

DER MONTH EFFECTIVE:
(Include each month to be disenrolled)

MO(s)/YR: _____

QMC Enrollment: MO(s)/YR: _____

PLAN _____

PH40 _____ PH30 _____

Entered by _____ Date _____