	Home w/o services	Home with Skilled Care	Skilled nursing Facility	Inpatient Rehabilitation Facility	Long Term Acute Care Facility
Level of Need	Patient is independent in all areas Patient can safely navigate their home and community	Patient is deemed homebound with physician order present - Help with personal care, pt/ot/slp, social services, on-call services **Homebound:** Patient demonstrates a taxing effort to leave the home unassisted	Patient is in need of on-going daily skilled service daily skilled nursing needs and physician order. - Need for 24/7 services **ALOS – 15.9 days** See below for wound requirements also consider IV abx for SNF care Always think: Is this a decline? What was PLOF (not a year ago, but recently – if patient went to 3 SNFs and no improvement wont be auth-ed); is this for a SKILLED need or custodial. (has to be skilled! Otherwise long term care)	Patient needs two disciplines and physician services daily and overnight. - Must be able to participate in 3 hours per day 5 days a week - Treatment is aimed at enabling the patient to return home/community based **ALOS = 10-15 days**	Patient has complex medical needs with functional impairment that cannot be met in a lesser setting. Requires daily physician visits. **EXPECTED LOS is >25 days**
Functional Status	Ambulation - Negotiate community **distances independently** with or without assistive devices or at prior level of function with caregiver support - Able to leave home - Able to use equipment/DME independently - Able to navigate varying levels of terrain with or without assistive device ADLS - Independent IADLS - Independent Other - No cognitive impairment	Ambulation - May/may not be able to walk around home - Because of illness or injury need the aid of supportive devices in order to leave their place of residence - Patient can ambulate "household" distances ADLS - Needs help not dependent - Supervision to dependent with caregiver support IADLS - Min A to Dependent Other - Baseline cognition Examples: - Home PT/OT services - Home RN 1-2 /week for medication management, abx, disease mgmt etc - On-call line for patients	Ambulation - **Unable to walk household distances** (20-40 or 50-70 feet varying definitions) **with less than minimal assistance** - Requiring greater than minimal assistance with ambulation Contact guard/supervision = red flag for denial (min A itself not a reason for SNF) ADLS - Requiring greater than minimal assistance for ADLS IADLS - Min A to Dependent Other - Dysphagia/choking risk - Bowel/bladder dysfunction Custodial Care does NOT meet for SNF (i.e. help with walking, bathing, dressing, feeding, diet, medications). RT needs also doesn't qualify SEE RED FLAGS on back!!	Ambulation - Min A to dependent - Transfers may be difficult min A to dependent IADLS - Min A to Dependent Other - Cognition : communication disorders, aphasia, memory - Dysphagia - Bowel/bladder dysfunction Expectation is to improve within 10 days **KEY = Has to have medical needs (need physician daily = medically complex cases – see back)**	Ambulation - Significant impairment - Requires an acute hospital stay beyond the typical 4-7 day LOS to address acute medical issues ADLs - Max A to dependent - Typical patient scenario for our hospital: - New trach patients on vent (studies have shown when referred to LTACH right after trach the weaning is quicker) ** If referred several weeks after trach placement then insurance less likely to approve due to less benefit at this stage ** There are vent facilities that can do similar things as LTACH level and closer to us that DC – also they can take care of difficult RT needs (i.e. suctioning frequent)
Medical Management Required	- Independent with medication, wound care, transportation, medication, treatment (i.e. dialysis, chemo), primary care doctor	- General physician supervision at least **once a month** - Intermittent skilled service need **(pt/ot/slp/rn**) - Homebound patient - May require medical management, assistance with wound management	- Condition is expected to improve in a reasonable and predictable period - IV abx, IT- feedings, naso/trach, catheters, medicated dressings, stage 3+ wounds, ostomies - Therapy that required the skill of a qualified pt/ot/slp Poor Cognitive baseline does NOT meet for SNF then CM to address.	- 3+ hours daily therapy - Rehab physician 3X/week (some state daily) - Active medical management of comorbidities	Capabilities: - Line placement (PICC, central, permacath) - IV drips inclu pressors - HD, PD, TPN, tube feeds - PT/OT/SLP - Would vac therapy, complex wound needs - Hiflo, BiPAP, trach vent mgmg, bronch, CTube - 24/7 RT services

Further Clarifications for SNF:

- **SNF Admissions to often require medical director review by insurance** – sepsis admit with min. assist or less (i.e. contact guard or supervision) ; unilateral knee replacement without co-morbidities. Multiple SNF admissions within the last 90 days, any descriptions of : max assist, dependent transfers or ADLs or total assistance, minimal assistance and current functional status at baseline OR prior level of functioning, or contact guard assistance, stand by assist, modified independent, or supervision ; amputation with prior level of functioning custodial due to lower functional status ; refusal to participate with pt/ot ; services provided by family member can be given
- **Methods for overturn on SNF denials** :
    - **high PLOF with decline** (clarify i.e. min assist or lower but the patient was independent prior and lives alone – needs short stay)
    - **Specific need** (i.e. cannot do stairs has at home and lives alone – needs stairs training and then can dc back, unable to get to bathroom without assist and lives alone)
    - Clarifying **if family present** and what the dc plan would be (i.e. family NOT present so short stay will get them indep OR family is present and chronic patient they think might be better with SNF but if no improvement family prepared to take them home in current state – do they work etc?)
    - **Participation (**pain is too high and they did not participate with therapy – RED FLAG – we need therapy to come back repeat notes when fully participating in evalv and gait tested etc. If they couldn't not perform all that then don't submit for auth they cannot make a determination = denial. Also – dementia patient – if they cannot follow commands they wont be approved. Last – how motivated are they – emphasize the want to return home to independence when present)
    - **High Needs** (sometimes denial for patient high levels of assistance but at baseline the family able to take care because they can transfer to wheelchair – now they cannot and family cannot take them! They need some rehab to get back to that baseline even though it's a high needs patient at baseline)
    - **Assist Device (** is it new? This should be a factor as well not always as they can go with a walker but this plus some decline can consider)
    - **Know your levels of care! –** sometimes they will say they can go to ALF if the family cannot care. That's not what we are asking. We are asking for skilled to get them to X place. However also recognize if they are at functional baseline – then it is custodial and they should not be approve for SNF nor should we be going down this path.
- **Remember** – Payor can see all prior SNF stays, what the pt/ot notes are from that stay. We need to use recent PLOF not " a year ago they were independent but since then multiple hospital and SNF stays – this means new baseline and may need long term care at this point". Hospital does not always have the ability to view this.
- **Wound Care Skillable for SNF** – think: packing, wound vac , wounds stage 3 or 4, dressing changes >1-2x/day (consider if patient or family can complete), wounds on perineal, ischial or coccyx with incontinence, open wounds with extensive tunneling or undermining, LOCATION matters for the patients ability to actual perform the wound care (i.e. complex sacral wound care exceeding once a day)
- **Don't forget**: Need SNF for new peg/trach/device/iv abx – you don't need pt/ot on top of that. This is skilled need.

Further Clarification for ACUTE: (lower overturn chance on p2p than SNF)

- Most Often denied due to " not meeting the requirements of daily physician visits" – very difficult to fight this – rarely ever overturned! See diagnosis below that do require daily physician. Outside of thing sometimes rarely will get approved on need for pain titration (IV meds) or some other complex medical need that might be beyond a SNF. i.e. it doesn't matter if they are motivate and can tolerate and need 3+ hours if they don't have the medical physician oversight need the denial is difficult to fight.
- Second top denial reason – initially needed it but improved based on recent pt/ot/slp notes and now no longer meeting intensity required
- They are not aware of all the needs (i.e. somebody with minimal pt needs but has some and has OT and speech needs – don't forget to mention the SLP needs for the patient – sometimes this is overlooked)
- Too LOW functioning – I.e high needs patient they do not think will improve. In this case have therapy come back or demonstrate the improvement the patient has
- Often will approve SNF when denied when performing P2P – always DUAL plan and have a SNF ready for submitting will get auto-approval.
- Other reason denied – not participating well or not working to goal of independent
    - On p2p need to clarify how motivated they are and what living situation will be on discharge
- DIAGNOSIS: (CMS list quick and dirty – when not on the list I feel often goes to medical director review)
    - Stroke, spinal cord injury, amputation, hip fracture (use to be now varied) , brain injury, neuro condition (MS flare, motor neuro disease, polyneuropathy, muscular dystrophy, parkinsons- sometimes need to demonstrate ACUTE issue that will improve)
    - Other: congenital deformity, multiple major trauma, burns, polyarticular disease (think severe not regular OA more like sever joint deformity los ROM atrophy muscle), vasculitis, keep or hip replacement during acute stay that meets one ore more: b/l knee, or b/l hip ; BMI>50, 85 year or older)

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