Clinical Specialty Placement

A. Bariatric

Service Goal: To establish a placement and level of care to reimburse skilled nursing facilities for high resource needs and special DME equipment.

1. Placement Criteria

   Must meet all the following:

   a. BMI equal to or greater than 40

   b. UAT level of care is equal to or greater than 2 (moderate assist with ADL)

   c. Must have impaired mobility requiring assistance of at least two

   d. Formal nutritional evaluation/plan by Registered Dietitian documented with monthly review/update

   e. Monthly weights documented

   f. If member is diabetic; quarterly A1C documented, if not diabetic; annual A1C documented

   g. Member, member's family, friends and facility staff be provided documented counsel regarding the necessity of member adhering to the limitations of the Registered Dietitian nutritional plan

B. Hemodialysis

Service Goal: To establish a placement and level of care to reimburse skilled nursing facilities for members with high acuity and specialized in-house hemodialysis needs.

1. Placement Criteria

   Member requires hemodialysis and meets one or more of the following:

   a. Member is unable to sit up for more than four (4) hours at a time.

      i. If member has a wound or wounds that prohibits outpatient hemodialysis

      ii. If member must use a Hoyer lift for transfers not accommodated by local outpatient hemodialysis center.

C. Respiratory

Service Goal: To provide skilled nursing care, residential care, supervision and respiratory care for persons who need nursing services on a twenty-four (24) hour basis, but who do not require hospital care under the daily direction of a physician.

1. Placement Criteria

   a. The member must require no less than three (3) of the listed therapies in a twenty-four (24) hour period performed by the facility licensed staff:

      i. Aerosol therapy, heat, cool mist FIO2 28% or greater

      ii. Chest physical therapies – percussion and postural drainage

      iii. CPAP/BIPAP continuous or during sleep or a pressure supported only setting on a ventilator without a frequency/respiration rate

iv. Trach care twice a day and as needed

v. Tracheal suctioning on an average of 6 times per day

vi. High flow oxygen therapy for trach weaning

D. Ventilator Dependent

Service Goal: To provide skilled nursing care, residential care, supervision and respiratory care to members who are dependent on mechanical ventilation to sustain life, need nursing services on a twenty-four (24) hour basis, but who do not require hospital care under the daily direction of a physician.

1. Placement Criteria
    a. Requires mechanical ventilation for six (6) hours or greater per day to sustain life.
    b. Weaning from the ventilator is in progress when the member requires less than six (6) hours of mechanical ventilation.
    c. Acceptable setting modes of Mechanical Ventilation
        i. Assist control (AC) or Pressure Regulated Volume Control (PRVC)
        ii. Spontaneous Intermittent Mandatory Ventilation (SIMV)
        iii. Please note: All other setting modes do not meet the criteria for Mechanical Ventilation unless weaning is in progress.
        iv. AVAPS for weaning, CO2 retention, and transition to decannulation. Cannot have a diagnosis of sleep apnea.

E. Sub-Acute Care

Service Goal: To establish a sub-acute level of care to reimburse skilled nursing facilities for members with a higher acuity level than is typical for skilled level of care.

Please note:

- All Sub-Acute Care requests for members with:
    - DSNP B-UFC members utilize Prior Authorization Department for authorization
    - Long Term Care (LTC) covered only members utilize the following 194 placement process.

1. Placement Criteria
    a. Sub-Acute Care is a category of skilled care. A sub-acute care member is a member who has an acuity level that requires which requires skilled nursing care hours that exceed the minimum standards of the Arizona Department of Health Services. The sub-acute member does not need acute care and is able to be managed medically in a licensed skilled nursing care facility. The members have medical or nursing needs that require a nursing assessment, judgment and management by a Registered Nurse on an on-going basis.
    b. The sub-acute member must need one or more of the following:
        i. Nasotracheal or tracheal suctioning by licensed personnel more than two times per eight (8) hour shift.

ii. Multiple complex treatments ordered by the member's medical provider to be performed by registered nursing staff more than two times per eight (8) hour shift. (A complex treatment is one that requires at least twenty (20) minutes.

iii. Intravenous infusions and/or medications that may or may not require an infusion pump and are administered more frequently than one time per twenty-four (24) hour period.

iv. Unstable or severe medical problems that require changes in the therapeutic regimen as ordered by the medical provider.

v. Total Parenteral Nutrition (TPN)

vi. Complex Wound Care:

- Multiple wounds
- Flaps for multiple wounds
- Stage III and/or IV Decubitus
- Non-healing surgical wounds

Behavioral Health Specialty Placement

F. Behavioral Health

Service Goal: To ensure the provision of residential care for members in need of a protective environment for nursing facility care.

1. Placement Criteria

a. All criteria must be met before admission to a SNF Behavioral Unit:

b. The member presents with signs and symptoms of a psychiatric disorder which is consistent with a DSM-5 diagnosis. This behavioral health condition requires a 24-hour nursing care and therapeutic milieu with on-site behavioral health therapy and on-site or on-call psychiatric consultation.

c. Observed evidenced of moderate functional impairment of developmentally appropriate self-care or self-regulation as evidenced by either:

i. Documentation of recent occurrence(s) of suicidal/homicidal ideation without plan or intent, and the inability of the member and support system to carry out a safety plan; or

ii. Documentation of disturbance of mood, thought, or behavior that clearly impair daily functioning, persist in the absence of stressors, and impair recovery from the presenting problem.

d. Outpatient behavioral health services have been attempted and/or do not meet the treatment needs of the member, and there is documentation of a failure to respond or an inability to be safely managed in a less restrictive level of care.

e. The admission is not used primarily and therefore clinically inappropriate as:

i. An alternative to detention, incarceration, or to ensure community safety in a member exhibiting primarily delinquent/antisocial behavior; or

ii. The equivalent of safe housing;

iii. An alternative to parent(s)/guardian(s) or another agencies' capacity to provide for the member; or

iv. A behavioral health intervention when other less restrictive alternatives are available and meet the member's treatment needs.

f. Current medical conditions are documented requiring a level of skilled nursing care that is not available daily in a less restrictive environment including assisted living and available in-home supportive services.

g. Admission: Severity of Need

i. There is clinical evidence that the member has a long-term and/or severe DSM-5 disorder that is amenable to active psychiatric treatment and has a high degree of potential for leading to acute psychiatric hospitalization in the absence of active psychiatric treatment on the behavior unit.

ii. Due to the psychiatric disorder, the member exhibits an inability to adequately care for his/her own physical needs. The family and/or other non-behavior unit support systems are unable to safely fulfill the member's needs.

iii. The member requires supervision 7 days per week/24 hours per day to develop the skills necessary for daily living, to assist with planning and arranging access to a range of educational, therapeutic, and aftercare services, and to develop the adaptive and functional behavior that will allow the member to live outside of a locked behavior unit.

iv. The member's current living environment does not provide the support and access to the therapeutic services necessary for recovery.

h. Documented evidence is present indicating the need for further psychological resources to include:

i. Continued therapeutic treatment that cannot safely be provided on an outpatient basis

ii. Continuation of medication adjustments following an inpatient psychiatric hospitalization

iii. Medication monitoring with frequent laboratory testing is required

iv. Therapies: individual, group, recreational, independent daily living skill building, and social skill building support

i. Behavioral symptoms are documented that are unable to be controlled in a less restrictive environment to include:

i. Combative behavior

ii. Inappropriate sexual behavior

iii. Active hallucinations

iv. Self-harm

j. A preliminary discharge plan of aftercare services and supports has been developed and presented with the request for prior authorization.

2. Discharge Criteria
    a. Member no longer meets placement criteria
3. Review/Summary Preparation
    a. BHP requests the last three (3) months of any that apply:
        i. Progress notes
        ii. Most recent Minimum Data Set (MDS) – Sections C, E, G & H only
        iii. Care Plans
        iv. Member Face Sheet
        v. Any supportive documentation of exhibited behaviors
    b. The BHP will update the 194 reports

G. High Acuity Behavioral Health

Service Goal: To ensure the provision of residential care for members in need of a protective environment for nursing facility behavioral unit.

1. Placement Criteria
    a. The member must meet the following admission criteria:
        i. Must meet all 9 criteria of Behavioral Health Specialty Placement
        ii. Must require higher staffing ratios than Behavioral Health Specialty Placement to achieve the desired outcomes
2. Discharge Criteria
    a. Member no longer meets placement criteria
3. Review/Summary Preparation
    a. BHP requests the last three (3) months of any that apply:
        i. Progress notes
        ii. Most recent Minimum Data Set (MDS) – Sections C, E, G & H only
        iii. Care Plans
        iv. Member Face Sheet
        v. Any supportive documentation of exhibited behaviors
    b. BHP will update the 194 reports.

H. Dementia/Wandering

Service Goal: To ensure the provision of residential care for demented members in need of a protective environment for wandering behavior.

4. Placement Criteria

a. The member must meet the following admission criteria:
    i. The member must have a diagnosis of Dementia (includes Alzheimer's disease), Organic Brain Syndrome (OBS), or other diagnosis affecting their cognitive ability (may include Traumatic Brain Injury aka TBI).
    ii. The member must be identified as:
        - Exhibiting problematic wandering behavior that cannot be managed in a traditional nursing facility or in HCBS, and,
        - There must be documentation that the wandering behavior endangers the member or other residents.
    iii. In a residential setting, it must be documented daily that the member has done one or more of the following:
        - Repeatedly exited through outside doors
        - Frequently wandered into off-limit areas, such as the kitchen, laundry, storage, maintenance, resident rooms and other off-limit areas without responding to redirection.
        - Wandered into other member rooms and was unable to find their way back to their own room.
    iv. In an HCBS setting, it must be documented daily that the member has done one or more of the following:
        - Repeatedly wandered away from home, requiring local police or others to return them
        - Become confused about which house in the neighborhood in theirs
        - The family or other caregiver reports having to lock the member in the house when leaving the member unattended, to prevent them from getting out and lost

5. Discharge Criteria
    a. Member no longer meets placement criteria
6. Review/Summary Preparation
    a. BHP requests the last three (3) months of any that apply:
        i. Nurses progress notes
        ii. Most recent Minimum Data Set (MDS) – Sections C, E, G & H only
        iii. Wandering/Elopement Risk Assessment
        iv. Member Face Sheet
        v. Attendant care provider notes that support any wandering behavior
    b. BHP will update the 194 reports

I. Dementia with Behaviors

Service Goal: To ensure the provision of residential care for members with cognitive impairments in need of a protective environment for significant behaviors.

1. Placement Criteria
    a. The member must meet the following admission criteria:
        i. The member must have a diagnosis of Dementia (includes Alzheimer's disease), Organic Brain Syndrome (OBS), or other diagnosis affecting their cognitive ability (may include Traumatic Brain Injury aka TBI).
        ii. The member must be identified as:
            1. Exhibiting problematic wandering behavior that cannot be managed in a traditional nursing facility or in HCBS, and,
            2. There must be documentation that the wandering behavior endangers the member or other residents.
        iii. In a memory care or dementia unit, it must be documented daily that the member has done one or more of the following:
            1. Repeatedly attempted to exit through the outside door, repeatedly banging on locked door (unable to redirect)
            2. Physical aggression toward other residents
            3. Suicide attempts or other self-injurious behaviors
            4. Throwing things uncontrolled or and unable to redirect
            5. Documentation of yelling continuously for several hours during the day or night despite treatments for pain and non-pharmacological interventions
            6. Repeatedly throwing self out of a wheelchair, out of bed, throwing self to floor, requiring increased staffing for safety concerns
            7. Sexualized behaviors to include documentation of attempts to inappropriately touch other residents
            8. Two documented attempts to step member down from dementia/wandering unit have been attempted and failed causing an exacerbation of symptoms and increased behaviors.
2. Discharge Criteria
    a. The member no longer meets placement criteria.
3. Review/Summary Preparation
    a. BHP requests the last three (3) months of any that apply:
        i. Nurses progress notes
        ii. Most recent Minimum Data Set (MDS) – Sections C, E, G & H only
        iii. Wandering/Elopement Risk Assessment
        iv. Member Face Sheet

v. Attendant care provider notes that support any wandering behavior

b. BHP will update the 194 reports.

J. High Acuity Behavioral Health Placement

Service Goal: To ensure the provision of residential care for members with cognitive impairments in need of a protective environment for significant behaviors.

1. Placement Criteria
    a. The member must meet the following admission criteria:
        i. The member must have a diagnosis of Dementia (includes Alzheimer's disease), Organic Brain Syndrome (OBS), or other diagnosis affecting their cognitive ability (may include Traumatic Brain Injury aka TBI).
        ii. The member must be identified as:
            1. Exhibiting problematic wandering behavior that cannot be managed in a traditional nursing facility or in HCBS, and,
            2. There must be documentation that the wandering behavior endangers the member or other residents.
        iii. In a memory care or dementia unit, it must be documented daily that the member has done one or more of the following:
            1. Repeatedly attempted to exit through the outside door, repeatedly banging on locked door (unable to redirect)
            2. Physical aggression toward other residents
            3. Suicide attempts or other self-injurious behaviors
            4. Throwing things uncontrolled or and unable to redirect
            5. Documentation of yelling continuously for several hours during the day or night despite treatments for pain and non-pharmacological interventions
            6. Repeatedly throwing self out of a wheelchair, out of bed, throwing self to floor, requiring increased staffing for safety concerns
            7. Sexualized behaviors to include documentation of attempts to inappropriately touch other residents
            8. Two documented attempts to step member down from dementia/wandering unit have been attempted and failed causing an exacerbation of symptoms and increased behaviors.
2. Discharge Criteria
    a. The member no longer meets placement criteria.
3. Review/Summary Preparation
    a. BHP requests the last three (3) months of any that apply:
        i. Nurses progress notes
        ii. Most recent Minimum Data Set (MDS) – Sections C, E, G & H only

iii. Wandering/Elopement Risk Assessment

iv. Member Face Sheet

v. Attendant care provider notes that support any wandering behavior

b. BHP will update the 194 reports.