Skilled Nursing Facility Level of Care
Clinical Coverage Criteria

Overview

Skilled care is nursing and rehabilitation services that can only be safely and effectively performed by or under the supervision of licensed healthcare professionals, such as nurses, physical therapists, occupational therapists and speech pathologists.

Skilled nursing facilities focus on restorative and rehabilitative care with the goal of helping patients restore maximum function and regain their independence. Skilled nursing facilities provide subacute rehabilitation, which is less intensive that rehabilitation provided in an inpatient rehabilitation facility. For a patient to qualify for acute inpatient rehabilitation they must be able to tolerate 3 hours of therapy per day (speech-language pathology, occupational therapy, physical therapy) at least 5 days per week. If the patient cannot tolerate this much therapy or no longer requires therapy at this intensive a level, they may be better served at the subacute level.

Policy

This Policy applies to the following Fallon Health products:

☒ Commercial
☒ Medicare Advantage
☒ MassHealth ACO
☒ NaviCare
☒ PACE

Fallon Health follows guidance from the Centers for Medicare and Medicaid Services (CMS) for organization (coverage) determinations for Medicare Advantage plan members. National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Local Coverage Articles (LCAs) and guidance in the Medicare manuals are the basis for coverage determinations. When there is no NCD, LCD, LCA or manual guidance, Fallon Health Clinical Coverage Criteria are used for coverage determinations.

Medicare does not have has an NCD for skilled nursing facility care. National Government Services, Inc. does not have an LCD or LCA for skilled nursing facility care. (MCD search 07-02-2021). Medicare Benefit Policy Manual, Chapter 8 - Coverage of Extended Care (SNF) Services, includes coverage criteria for skilled nursing facility care.

For plan members enrolled in NaviCare and PACE plans, Fallon Health follows Medicare guidance for coverage determinations. In the event that there is no Medicare guidance or if the plan member does not meet medical necessity criteria in Medicare guidance, Fallon Health will follow guidance published by MassHealth. When there is no Medicare or MassHealth guidance, Fallon Health Clinical Coverage Criteria are used for coverage determinations for NaviCare members. Each PACE plan member is assigned to an Interdisciplinary Team. When there is no Medicare or MassHealth guidance, the member's Interdisciplinary Team is responsible for coverage determinations.

Prior authorization is required.

Fallon Health follows the Centers for Medicare and Medicaid (CMS) guidelines for admission to skilled nursing facilities (SNFs).

Manual Link: **Medicare Benefit Policy Manual, Chapter 8 - Coverage of Extended Care (SNF) Services**

Care in a SNF is covered when all of the following criteria are met:

- The patient requires skilled nursing services or skilled rehabilitation services, i.e., services that must be performed by or under the supervision of professional or technical personnel (see §§30.2 - 30.4); are ordered by a physician;
- The patient requires these skilled services on a daily basis (see §30.6); and
- As a practical matter, considering economy and efficiency, the daily skilled services can be provided only on an inpatient basis in a SNF (see §30.7).
- The services delivered are reasonable and necessary for the treatment of a patient's illness or injury, i.e., are consistent with the nature and severity of the individual's illness or injury, the individual's particular medical needs, and accepted standards of medical practice. The services must also be reasonable in terms of duration and quantity.

Commercial members, for which the product is only medical coverage, the social need of a willing and able caregiver or barriers to enter their home are not part of the medical decision criteria.

CMS uses the Patient Driven Payment Model PDPM to help determine need for SNF level of care. If a member does not meet the PDPM, consideration is still given to their needs.

Medical needs

- Intravenous therapy which cannot be arranged as home infusion therapy.
- Intravenous therapy in the hospital would be skilled in the SNF only if daily fluid balance is an active problem.
- Unstable medical condition which requires provider face to face evaluation to adjust treatment plan at least three times a week.
- Respiratory therapy would qualify if the acute admission was due to an exacerbation and they did not return to baseline. If not, the PDPM will be adjusted.

Therapy needs

- Must be due to acute neuromuscular or skeletal change such as stroke, joint replacement, fracture in an extremity. Deconditioning is a self-correcting condition and no randomized controlled trial has shown that daily skilled therapy is required to correct it.
- Cognitively able to retain teaching and make significant progress in scoring in the 18 items that cover self-care, continence, mobility, transfers, communication, and cognition, typically 1 per day.

References

1. Medicare Benefit Policy Manual. Chapter 8 - Coverage of Extended Care (SNF) Services Under Hospital Insurance (Rev. 261, 10-04-19).

Policy history

Origination date:	06/01/2020
Approval(s):	Technology Assessment Committee: 05/27/2020 (policy origination)
	07/10/2021 (Added clarifying language related to Medicare Advantage, NaviCare and PACE under policy section

Not all services mentioned in this policy are covered for all products or employer groups. Coverage is based upon the terms of a member's particular benefit plan which may contain its own specific provisions for coverage and exclusions regardless of medical necessity. Please consult the product's Evidence of Coverage for exclusions or other benefit limitations applicable to this service or supply. If there is any discrepancy between this policy and a member's benefit plan, the provisions of the benefit plan will

govern. However, applicable state mandates take precedence with respect to fully-insured plans and self-funded non-ERISA (e.g., government, school boards, church) plans. Unless otherwise specifically excluded, federal mandates will apply to all plans.