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 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

Prior authorization is required.

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

- 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.

Level	Total	Rasch	Minutes	Hours	Description
1	18 24 30	0 10 20	498 456 419	> 8 7–8 6–7	Total Assistance
2	36 45	30 35	384 330	6–7 5–6	Maximal Assistance
3	54 63	40 45	276 222	4–5 3–4	Moderate Assistance
4	72 80	50 55	168 120	2–3 2–3	Minimal Assistance
5	90 100	60 65	60 < 60	1–2 < 1	Supervision/Setup
6	108 114 120	70 80 90	0 0 0	0 0 0	Modified Independence
7	126	100	0	0	Complete Independence

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 (new policy)

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. For Medicare and Medicaid members, this policy will apply unless Medicare and Medicaid policies extend coverage beyond this policy.