Subacute level of Care in a Skilled Nursing Facility (SNF) under Medicare Part A Medical Necessity Guideline

Medical Necessity Guideline (MNG) Title: Subacute level of Care in a Skilled Nursing Facility (SNF) under Medicare Part A		
MNG #: 087	**☒ SCO ☒ One Care** **☒ MA Medicare Premier** **☒ MA Medicare Value** **☒ RI Medicare Preferred** **☒ RI Medicare Value** **☒ RI Medicare Maximum**	**Prior Authorization Needed?** **☒ Yes (always required)** **☐ Yes (only in certain situations. See this MNG for details)** **☐ No**
Clinical: ☐	**Operational: ☐**	**Informational: ☐**
Benefit Type: **☒ Medicare** **☐ Medicaid**	**Approval Date:** 10/14/2021;	**Effective Date:** 2/06/2022;
Last Revised Date: 5/30/2022; 5/19/23	**Next Annual Review Date:** 10/14/2022; 5/30/2023; 5/19/24	**Retire Date:**

OVERVIEW: Subacute nursing and rehabilitation services: services, furnished pursuant to physician orders, for members that are in a Skilled Nursing Facility and covered by Medicare Part A, that:

• Require the skills of qualified technical or professional health personnel such as registered nurses, licensed practical nurses, physical therapists, occupational therapists, and speech-language pathologists or audiologists.

• Must be provided directly by or under the general supervision of these skilled nursing or skilled rehabilitation personnel to assure the safety of the patient and to achieve the medically desired result.

and

• Require a short term, goal-oriented treatment plan including complex skilled nursing care and/or high intensity level skilled rehabilitation.

NOTE: Subacute care is generally more intensive than traditional nursing facility care and less intense than acute care.

DEFINITIONS:
SNF: Skilled Nursing Facility
MD: Medical Director
NP: Nurse Practitioner
PT: Physical Therapy
OT: Occupational Therapy
ST: Speech Therapy
LOC: Level of Care
CAH: Critical Access Hospital

Subacute level of Care in a Skilled Nursing Facility (SNF) under Medicare Part A Medical Necessity Guideline

MDS: Minimum Data Set

DECISION GUIDELINES:

Clinical Coverage Criteria:

Commonwealth Care Alliance (CCA) follows applicable Medicare and Medicaid regulations and uses InterQual Smart Sheets, when available, to review prior authorization requests for medical necessity. This Medical Necessity Guideline (MNG) applies to all CCA Products unless a more expansive and applicable CMS National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), or state-specific medical necessity guideline exists.

Clinical Coverage Criteria: Subacute skilled nursing and rehabilitation services may be covered and authorized in a SNF if the following conditions are met: To be considered reasonable and necessary, the services must meet Medicare guidelines. The guidelines for coverage of subacute skilled services include:

1. 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 *Medicare Benefit Policy Manual*, chapter 8, "Coverage of Extended (SNF) Care Services Under Hospital Insurance", §§30.2 - 30.4); are ordered by a physician and the services are rendered for a condition for which the patient received inpatient hospital services or for a condition that arose while receiving care in a SNF for a condition for which he received inpatient hospital services;

2. The patient requires these skilled services on a daily basis (see §30.6); and

3. 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.)

4. 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.

5. There has been a determination by the care team that a short term, goal oriented treatment plan is necessary; patient care needs requiring subacute skilled nursing care and/or skilled rehabilitation; the patient requires a greater number of MD/NP visits, skilled nursing care hours for frequent assessment, or rehabilitation services than are normally provided at a basic skilled level of care; there is active management of the treatment plan by the care team to stabilize the patient.

Determination of Need:

If the inherent complexity of a service prescribed for a patient is such that it can be performed safely and/or effectively only by or under the general supervision of skilled nursing or skilled rehabilitation personnel, the service is a skilled service

Subacute level of Care in a Skilled Nursing Facility (SNF) under Medicare Part A Medical Necessity Guideline

The clinician considers the nature of the service and the skills required for safe and effective delivery of that service in deciding whether a service is a skilled service. While a patient's particular medical condition is a valid factor in deciding if skilled services are needed, a patient's diagnosis or prognosis should never be the sole factor in deciding that a service is not skilled

Some examples of complex medical conditions that may require subacute skilled nursing or rehabilitative care:

- Presence of serious injury or illness that requires inpatient treatment but not acute hospital care
- Ventilator Program
- Complex Respiratory Care and Treatments
- Specialized Infusion Therapy
- Brain Injury Rehabilitation
- High Intensity Stroke
- High Intensity Orthopedic Program
- Specialized Post-Surgical Recovery Programs
- Complex pain management

Direct Skilled Nursing Services to Patients

Nursing services are considered skilled when they are so inherently complex that they can be safely and effectively performed only by, or under the supervision of, a registered nurse or, when provided by regulation, a licensed practical (vocational) nurse. (See 42CFR §409.32) If all other requirements for coverage under the SNF benefit are met, skilled nursing services are covered when an individualized assessment of the patient's clinical condition demonstrates that the specialized judgment, knowledge, and skills of a registered nurse or, when provided by regulation, a licensed practical (vocational) nurse are necessary. Skilled nursing services would be covered where such skilled nursing services are necessary to maintain the patient's current condition or prevent or slow further deterioration so long as the beneficiary requires skilled care for the services to be safely and effectively provided, and all other requirements for coverage under the SNF benefit are met. Coverage does not turn on the presence or absence of an individual's potential for improvement from nursing care, but rather on the beneficiary's need for skilled care.

A condition that would not ordinarily require skilled nursing services may nevertheless require them under certain circumstances. In such instances, skilled nursing care is necessary only when (a) the particular patient's special medical complications require the skills of a registered nurse or, when provided by regulation, a licensed practical nurse to perform a type of service that would otherwise be considered non-skilled; or (b) the needed services are of such complexity that the skills of a registered nurse or, when provided by regulation, a licensed practical nurse are required to furnish the services.

Rehabilitation Therapy services may or may not be present as part of the Subacute level plan of care, but if present, the patient must have the ability to participate in this level of therapy intensity, or level of care will be subject to change. If combined skilled rehabilitation hours are less than 2 or more hours, 6 or 7 times per week, the member must qualify for subacute level of care based upon skilled nursing and restorative care needs.

Subacute level of Care in a Skilled Nursing Facility (SNF) under Medicare Part A Medical Necessity Guideline

Direct Skilled Therapy Services to Patients

This includes skilled physical therapy, occupational therapy, and speech/language pathology therapy.

Coverage for such skilled therapy services is not dependent on the presence or absence of a beneficiary's potential for improvement from therapy services, but rather on the beneficiary's need for skilled care. Therapy services are considered skilled when they are so inherently complex that they can be safely and effectively performed only by, or under the supervision of, a qualified therapist. (See 42CFR §409.32) These skilled services may be necessary to improve the patient's current condition, to maintain the patient's current condition, or to prevent or slow further deterioration of the patient's condition.

If all other requirements for coverage under the SNF benefit are met, such skilled therapy services are covered when an individualized assessment of the patient's clinical condition demonstrates that the specialized judgment, knowledge, and skills of a qualified therapist are necessary for the performance of the rehabilitation services.

1. The services must be directly and specifically related to an active written treatment plan that is based upon an initial evaluation performed by a qualified therapist after admission to the SNF and prior to the start of therapy services in the SNF that is approved by the physician after any needed consultation with the qualified therapist. In those cases where a beneficiary is discharged during the SNF stay and later readmitted, an initial evaluation must be performed upon readmission to the SNF, prior to the start of therapy services in the SNF;

2. The services must be provided with the expectation, based on the assessment made by the physician of the patient's restoration potential, that the condition of the patient will improve materially in a reasonable and generally predictable period of time; or, the services must be necessary for the establishment of a safe and effective maintenance program; or, the services must require the skills of a qualified therapist for the performance of a safe and effective maintenance program.

3. The services must be considered under accepted standards of medical practice to be specific and effective treatment for the patient's condition; and,

4. The services must be reasonable and necessary for the treatment of the patient's condition; this includes the requirement that the amount, frequency, and duration of the services must be reasonable.

5. Combined Rehabilitation therapy services (PT, OT, ST), direct care daily, must be provided for 2 or more hours, 6 or 7 times per week, as part of a treatment plan that is goal oriented, measurable, and designed to promote recovery (dependent upon Patient's individual condition).

LIMITATIONS/EXCLUSIONS:

If any of the criteria is not met, a stay in a SNF for subacute level of care, even though it might include the delivery of some skilled services, may not be covered.

Subacute level of Care in a Skilled Nursing Facility (SNF) under Medicare Part A Medical Necessity Guideline

For CCA to render payment for skilled services provided to a beneficiary during a SNF Part A stay, the facility must complete an MDS.

Subacute skilled nursing services or skilled rehabilitation services (or a combination of these services) must be needed and provided on a "daily basis," i.e., on essentially a 7-days-a-week basis. A patient whose inpatient stay is based solely on the need for skilled rehabilitation services would meet the "daily basis" requirement when they need and receive those services on at least 6 days a week. (If therapy services are provided less than 6 days a week, the "daily" requirement would not be met.)

Covered SNF services include post-hospital SNF services for which benefits are provided under Part A other than the following:

• Physician services, physician assistant services, nurse practitioner and clinical nurse specialist services, certified mid-wife services, qualified psychologist services, certified registered nurse anesthetist services, certain dialysis-related services, erythropoietin (EPO) for certain dialysis patients, hospice care related to a terminal condition, ambulance trips that convey a beneficiary to the SNF for admission or from the SNF following discharge, ambulance transportation related to dialysis services, certain services involving chemotherapy and its administration, radioisotope services, and certain customized prosthetic devices

Certain additional outpatient hospital services (along with ambulance transportation that convey a beneficiary to a hospital or CAH to receive the additional services) are excluded from coverage and are billed separately. The additional services are:

- Blood products used in blood transfusions
- Dialysis
- Hospice Service
- Modified barium swallow
- MRI/CT scan
- Orthotic or prosthetic equipment
- Physician extenders
- Professional charges for services rendered by physicians
- Radiation therapy/chemotherapy
- Specialized/customized DME (typical high-priced DME items that are excluded):
- CPM machine
- Respiratory assist device
- Ventilator
- Non-powered advanced pressure reduction overlay
- Powered pressure reducing Air Mattress
- Powered air flotation bed – loss air therapy
- Special wheelchairs

- Total parenteral nutrition (TPN)
- Transportation (ambulance or chair van) excluded only for the following services:
- Cardiac catheterizations
- Chemotherapy services
- Computerized axial tomography
- Dialysis
- Magnetic resonance imaging
- Ambulatory surgery involving use of operating room
- Emergency services
- Radiation therapy
- Angiography
- Lymphatic and venous procedures
- Ultrasound
- Ventilator
- Authorized IV Insertion by contracted providers.
- Wound Vacuums

A service is not considered a skilled nursing service merely because it is performed by or under the direct supervision of a nurse. If a service can be safely and effectively performed (or self-administered) by an unskilled person, the service cannot be regarded as a skilled nursing service although a nurse actually provides the service. Similarly, the unavailability of a competent person to provide a nonskilled service, regardless of the importance of the service to the patient, does not make it a skilled service when a nurse provides the service.

For rehabilitation intervention, there must be factors present in the member's condition that indicate the member's potential for functional improvement and the ability to actively participate in the rehabilitation plan of care, or level of care will be subject to change. A member who requires therapy solely to maintain function is not considered an appropriate subacute level of care patient.

Subacute days shall be limited to 100 days per benefit period. In the infrequent situation where the patient has been discharged from the hospital to his or her home more than 60 days before he or she is ready to begin a course of deferred care in a SNF, a new spell of illness begins with the day the beneficiary enters the SNF thereby generating another 100 days of extended care benefits (see Pub. 100-01, Medicare General Information, Eligibility, and Entitlement Manual, Chapter 3, section 10.4.1). Another qualifying hospital stay would not be required, providing the care furnished

is clearly related to a hospital stay in the previous spell of illness and represents care for which the need was predicted at the time of discharge from such hospital stay.

Subacute level of Care in a Skilled Nursing Facility (SNF) under Medicare Part A Medical Necessity Guideline

Concurrent Reviews:
Occurs every 7 days by a CCA Clinician conducting weekly collaboration with facility case manager to discuss current plan of care and discharge planning. This will include review of clinical documentation to determine continued need for Subacute Skilled Nursing Facility services under Medicare Part A:

1. 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 Medicare Benefit Policy Manual, chapter 8, "Coverage of Extended (SNF) Care Services Under Hospital Insurance", §§30.2 - 30.4); are ordered by a physician and the services are rendered for a condition for which the patient received inpatient hospital services or for a condition that arose while receiving care in a SNF for a condition for which he received inpatient hospital services;

2. The patient requires these skilled services on a daily basis (see §30.6); and

3. 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.)

4. 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.

5. There has been a determination by the care team that a short term, goal oriented treatment plan is necessary; patient care needs requiring subacute skilled nursing care and/or skilled rehabilitation; the patient requires a greater number of MD/NP visits, skilled nursing care hours for frequent assessment, or rehabilitation services than are normally provided at a basic skilled level of care; there is active management of the treatment plan by the care team to stabilize the patient.

AUTHORIZATION:
The following list(s) of codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this guideline does not signify that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. This Medical Necessity Guideline is subject to all applicable Plan Policies and Guidelines, including requirements for prior authorization and other requirements in Provider's agreement with the Plan (including complying with Plan's Provider Manual specifications).

All level of care determinations prior to, and during a member's admission to an Extended Care Facility are made at the discretion of Commonwealth Care Alliance clinical staff and/or those designated and authorized by Commonwealth Care Alliance to direct member care. Prior authorization is required for all subacute level of care requests. It is expected that the documentation in the patient's medical record will reflect the medical necessity need for the services provided.

Subacute level of Care in a Skilled Nursing Facility (SNF) under Medicare Part A Medical Necessity Guideline

Although the presence of appropriate documentation is not, in and of itself, an element of the definition of a "skilled" service, such documentation serves as the means by which a provider would be able to establish and a clinician would be able to confirm that skilled care is, in fact, needed and received in a given case. The patient's medical record is also expected to provide important communication among all members of the care team regarding the development, course, and outcomes of the skilled observations, assessments, treatment, and training performed. The documentation in the patient's medical record should illustrate the degree to which the patient is accomplishing the goals as outlined in the care plan. In this way, the documentation will serve to demonstrate why a subacute level of care is needed.

REGULATORY NOTES:

Medical Necessity Guidelines are published to provide a better understanding of the basis upon which coverage decisions are made. CCA makes coverage decisions on a case-by-case basis by considering the individual member's health care needs. If at any time an applicable CMS LCD or NCD or state-specific MNG is more expansive than the criteria set forth herein, the NCD, LCD, or state-specific MNG criteria shall supersede these criteria. This MNG references the specific regulations, coverage, limitations, service conditions, and/or prior authorization requirements in the following:

CMS Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 8, "Coverage of Extended (SNF) Care Services Under Hospital Insurance"

RELATED REFERENCES:

N/A

ATTACHMENTS:

EXHIBIT A:	42CFR §409.32
EXHIBIT B	Medicare Benefit Policy Manual, Chapter 1, "Inpatient Hospital Service"

REVISION LOG:

REVISION DATE	DESCRIPTION
12/31/23	Utilization Management Committee approval
5/19/23	Updated link to CFR
05/30/2022	Template changed to include PA requirements and benefit type.

Disclaimer

This Medical Necessity Guideline is not a rigid rule. As with all of CCA's criteria, the fact that a member does not meet these criteria does not, in and of itself, indicate that no coverage can be issued for these services. Providers are advised, however, that if they request services for any member who they know does not meet our criteria, the request should be accompanied by clear and convincing documentation of medical necessity. The preferred type of documentation is the

letter of medical necessity, indicating that a request should be covered either because there is supporting science indicating medical necessity (supporting literature (full text preferred) should be attached to the request), or describing the member's unique clinical circumstances, and describing why this service or supply will be more effective and/or less costly than

another service which would otherwise be covered. Note that both supporting scientific evidence and a description of the member's unique clinical circumstances will generally be required.

APPROVALS:

Jami Lyn Thomas	Director, Transitions of Care
CCA Senior Clinical Lead [Print]	**Title [Print]**
Jami Lyn Thomas	5/19/23
Signature	**Date**
Christopher Ponder	Operations Manager, Transitions of Care
CCA Senior Operational Lead [Print]	**Title [Print]**
	5/19/23
Signature	**Date**
Nazlim Hagmann	Chief Medical Officer
CCA CMO or Designee [Print]	**Title [Print]**
Nazlim Hagmann	5/19/23
Signature	**Date**