Intermittent Skilled Therapy in a Nursing Facility (NF)
Medical Necessity Guideline

Medical Necessity Guideline (MNG) Title: Intermittent Skilled Therapy in a Nursing Facility (NF)		
MNG #: 060	☒ CCA Senior Care Options (HMO D-SNP) (MA) ☒ CCA One Care (Medicare-Medicaid) (MA**)**	**Prior Authorization Needed?** ☐ **Yes (always required)** ☒ **Yes (only in certain situations. See this MNG for details)** ☐ **No**
Benefit Type: ☒ **Medicare** ☐ **Medicaid**	**Approval Date:** 4/1/2021; 1/11/24	**Effective Date:** 06/19/2021; 1/11/24; 1/1/2025
Last Revised Date: 01/06/2022; 6/10/2022; 01/11/2024; 4/11/2024; 5/30/2024; 1/9/2025	**Next Annual Review Date:** 4/1/2022; 1/06/2023; 6/10/2023; 01/11/2025; 4/11/2025; 1/9/2026	**Retire Date:**

OVERVIEW:

Skilled Therapy: The assessment, planning, intervention, and evaluation of goal-oriented rehabilitative services that require the skills of a licensed physical therapist (PT), speech therapist (ST) or occupational therapist (OT) to safely and effectively furnish a recognized therapy the goal of which is to improve an impairment or functional limitation, or to maintain, prevent or slow further deterioration of the functional status for members permanently or temporarily residing in a Nursing Facility (NF) and covered by Medicare Part B. These are intermittent rehabilitative services and members do not require, or meet, medical necessity for skilled level of care.

DECISION GUIDELINES:

The authorizing clinician must determine that the member requires rehabilitative services. The services shall be of such a level of complexity and sophistication, or the condition of the patient shall be such that the services required can only be safely and effectively performed by a qualified clinician, or therapists supervising assistants.

Prior Authorization Requirements:

- **Physical Therapy:** Prior authorization is required after initial **20** physical therapy visits **per calendar year** are exhausted.
- **Occupational Therapy:** Prior authorization is required after initial **20** occupational therapy visits **per calendar year** are exhausted
- **Speech Therapy:** Prior authorization is required after initial **35** speech therapy visits **per calendar year** are exhausted

NOTE: Any PT/OT/ST visits that a member has previously received from another outpatient or nursing facility provider are applied to initial visits allowed. Providers must obtain prior authorization when initial visits allowed have been exhausted.

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Clinical Coverage Criteria:

Intermittent skilled therapy may be covered and authorized in a nursing facility when specific conditions are met. For intermittent skilled therapy to be considered reasonable and necessary, the services must meet Medicare guidelines and must include **all** of the following:

1. Services should be considered accepted standards of medical practice for the specific and effective treatment of the member's condition. The amount, frequency and duration of services must be reasonable under the accepted standards of practice**;** and
2. Services shall be of a level of complexity for the condition of the member that it requires the skills of a therapist to safely and effectively perform the service. A therapy plan of care is developed either by the physician/non-physician practitioner (NPP), or by the physical therapist who will provide the physical therapy services, or the occupational therapist who will provide the occupational therapy services. The plan must be certified by a physician/NPP; and
3. In the case of Rehabilitative therapy, the member's condition has the potential to recover or improve in function in response to therapy, maximum improvement is yet to be attained; and there is an expectation that the anticipated improvement is attainable in a reasonable and generally predictable period of time. Evaluation, re-evaluation and progress documentation must describe objective measurements which shows improvements in function or decrease in severity; and
4. Skilled Therapy may be needed and improvement in the member's condition may occur, even where a chronic or terminal condition exists. In the absence of full or partial recovery, the need for therapy services may be required intermittently to determine the need for assistive equipment or establish a program to maximize function. The deciding factor is that the service requires the skills of a therapist to maintain, prevent or slow further deterioration of the functional status.

Maintenance therapy occurs when the skills of a therapist (as defined by the scope of practice for therapists in each state) are necessary to safely and effectively furnish a recognized therapy service, whose goal is to maintain functional status or to prevent or slow further deterioration in functional status.

1. If the specialized skill, knowledge and judgment of a qualified therapist are required to establish or design a maintenance program to maintain the patient's current condition or to prevent or slow further deterioration, the establishment or design of a maintenance program by a qualified therapist is covered.
2. If skilled therapy services by a qualified therapist are needed to instruct the patient or appropriate caregiver regarding the maintenance program, such instruction is covered.
3. If skilled therapy services are needed for periodic reevaluations or reassessments of the maintenance program, such periodic reevaluations or reassessments are covered.
4. Such skilled care is necessary for the performance of a safe and effective maintenance program only when (a) the therapy procedures required to maintain the patient's current function or to prevent or slow further deterioration are of such complexity and sophistication that the skills of a qualified therapist are required to furnish the therapy procedure or (b) the particular patient's special medical complications require the skills of a qualified therapist to furnish a therapy service required to maintain the patient's current function or to prevent or slow further deterioration, even if the skills of a therapist are not ordinarily needed to perform such therapy procedures.
5. An individualized plan of exercise and activity for patients and their caregiver(s) may be developed by clinicians to

maintain and enhance a patient's progress during the course of skilled therapy, as well as after discharge from therapy services. Such programs are an integral part of therapy from the start of care and should be updated and modified as the patient progresses.

Visits after the initial 20/20/35 PT/OT/ST therapy visits per calendar year are exhausted require all of the following**:**

1. Prior authorizations for all intermittent skilled therapy evaluations and treatment; and
2. Documentation of an in-person assessment of the member by a licensed physical therapist, speech/language therapist, or occupational therapist; and
3. Documentation demonstrating the need for continuing rehabilitative services, including:
    - What goals are to be achieved; and
    - An approximate timeframe in which the goals can be expected to be achieved.
4. A discharge summary for each episode of treatment which summarizes and supports the medical necessity of the entire episode of treatment. (Note: the time indicated in the assessment shall not be considered a limitation; it will, however, guide when additional information may be requested to document the need for continued coverage).

LIMITATIONS/EXCLUSIONS:

1. Intermittent skilled therapy in a nursing facility is not covered under Medicare Part B when member meets Medicare coverage requirements for skilled level of care. A member who needs and is provided skilled rehabilitation services on a "daily basis" meets the requirement for skilled level of care. A member 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 5 days a week. (If therapy services are provided less than 5 days a week, the "daily" requirement would not be met).
2. Services that do not require the professional skills of a therapist to perform, or supervise, are not medically necessary, even if they are performed or supervised by a therapist, physician or NPP. Therefore, if a patient's therapy can proceed safely and effectively through a home exercise program, self-management program, restorative nursing program or caregiver assisted program, payment cannot be made for therapy services.
3. If at any point in the treatment it is determined that the treatment becomes repetitive and does not require the unique skills of a therapist, the services are non-covered.
4. There may be circumstances where the patient, with or without the assistance of an aide or other caregiver, does activities planned by a clinician. Although these activities may be supportive to the patient's treatment, if they can be done by the patient, aides or other caregivers without the active participation of qualified professional/auxiliary personnel, they are considered unskilled.
5. If a patient's limited ability to comprehend instructions, follow directions, or remember skills that are necessary to achieve an increase in function, is so severe as to make functional improvement very unlikely, rehabilitative therapy is not required, and therefore, is not covered. However, limited services in these circumstances may be covered with supportive documentation if the skills of a therapist are required to establish and teach a caregiver a safety or maintenance program.
6. This does not apply to the limited situations where rehabilitative therapy is reasonable and achieving meaningful goals is appropriate, even when a patient does not have the ability to comprehend instructions, follow directions or

remember skills. Examples include sitting and standing balance activities that help a patient recover the ability to sit upright in a seat or wheelchair, or safely transfer from the wheelchair to a toilet.

7. This does not apply to those patients who have the potential to recover abilities to remember or follow directions, and treatment may be aimed at rehabilitating these abilities, such as following a traumatic brain injury.
8. The use of therapy equipment such as therapeutic pools or gym machines alone does not necessarily make the treatment skilled.

REFERENCES:

1. CMS Publication 100-02, *Medicare Benefit Policy Manual*, chapter 15, section 220.2. Accessed December 30, 2024. https://www.cms.gov/medicare/prevention/prevntiongeninfo/downloads/bp102c15.pd f
2. CMS Publication 100-02, *Medicare Benefit Policy Manual*, chapter 8, section 30. Accessed December 30, 2024. https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/bp102c08pdf
Center for Medicare & Medicaid Services Local Coverage Determination (LCD): Outpatient Physical and Occupational Therapy Services (L33631). Accessed December 30, 2024. https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?lcdId=33631&ver=51
3. Centers for Medicare & Medicaid Services Local Coverage Article (LCA): Billing and Coding: Outpatient Physical and Occupational Therapy Services (A56566). Accessed December 30, 2024. https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleId=56566&ver=38

REVISION LOG:

REVISION DATE	DESCRIPTION
1/21/2025	Utilization Management Committee Approval
1/9/2025	Annual Review: Title change – removed “Recommendation for”; Removed MAPD product applicability; Template and references update; Otherwise editorial.
6/25/2024	Utilization Management Committee Approval
4/11/24	Updated to include new PA requirements for Outpatient PT/OT/ST: Effective 2/8/24, PA required after 20/20/35 visits. Language added to limitations section to better define skilled level of care: Intermittent skilled therapy in a nursing facility is not covered under Medicare Part B when member meets Medicare coverage requirements for skilled level of care.
1/11/24	Updated language to clarify intermittent skilled therapy for members permanently or temporarily residing in a nursing facility is not covered under Medicare Part B when member meets Medicare coverage requirements for skilled level of care. Added language requiring a discharge summary for each episode of treatment.
6/10/2022	Template changed to include PA requirements and benefit type. Overview and format updated with numbering. Business owner changed.

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Disclaimer
Commonwealth Care Alliance (CCA) follows applicable Medicare and Medicaid regulations and uses evidence based InterQual© criteria, 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. 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.

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. 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).

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.

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APPROVALS:

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