Medical Necessity Guideline

Medical Necessity Guideline (MNG) Title: Skilled Nursing Facility (SNF) Services Under Medicare Part A		
MNG #: 086	**☒ SCO ☒ One Care** **☒ MAPD-MA Medicare Preferred** **☒ MAPD-MA Medicare Value** **☒ MAPD-RI Medicare Preferred** **☒ MAPD-RI Medicare Value** **☒ DSNP-RI Medicare Maximum**	**Prior Authorization Needed?** **☒Yes ☐No**
Clinical: ☐	**Operational: ☐**	**Informational: ☐**
Medicare Benefit: **☒Yes ☐No**	**Approval Date:** 10/14/2021;	**Effective Date:** 2/06/2022;
Last Revised Date:	**Next Annual Review Date:** 10/14/2022; 2/6/2023;	**Retire Date:**

OVERVIEW:

Skilled nursing and/or skilled 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 (vocational) nurses, physical therapists, occupational therapists, and speech-language pathologists or audiologists; and

• 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.

NOTE: "General supervision" requires initial direction and periodic inspection of the actual activity. However, the supervisor need not always be physically present or on the premises when the assistant is performing services.

Skilled care may be necessary to improve a patient's current condition, to maintain the patient's current condition, or to prevent or slow further deterioration of the patient's condition.

DEFINITIONS:

SNF- Skilled Nursing Facility

CAH- Critical Access Hospital

MDS- Minimum Data Set

DECISION GUIDELINES:

Skilled Nursing Facility Level of Care - General

Clinical Coverage Criteria: Skilled 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 skilled services include:

Medical Necessity Guideline

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.

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; e.g., the administration of intravenous feedings and intramuscular injections; the insertion of suprapubic catheters; and ultrasound, shortwave, and microwave therapy treatments.

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

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.

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.

Some examples of direct skilled nursing services are:

- Intravenous or intramuscular injections and intravenous feeding;
- Enteral feeding that comprises at least 26 percent of daily calorie requirements and provides at least 501 milliliters of fluid per day;
- Naso-pharyngeal and tracheotomy aspiration;
- Insertion, sterile irrigation, and replacement of suprapubic catheters;
- Application of dressings involving prescription medications and aseptic techniques (see §30.5 for exception);
- Treatment of decubitus ulcers, of a severity rated at Stage 3 or worse, or a widespread skin disorder (see §30.5 for exception);
- Heat treatments which have been specifically ordered by a physician as part of active treatment and which require observation by skilled nursing personnel to evaluate the patient's progress adequately (see §30.5 for exception);
- Rehabilitation nursing procedures, including the related teaching and adaptive aspects of nursing, that are part of active treatment and require the presence of skilled nursing personnel; e.g., the institution and supervision of bowel and bladder training programs;
- Initial phases of a regimen involving administration of medical gases such as bronchodilator therapy; and
- Care of a colostomy during the early post-operative period in the presence of associated complications. The need for skilled nursing care during this period must be justified and documented in the patient's medical record.

Direct Skilled Therapy Services to Patients-
Include 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 physical 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 services must be provided 1 – 2 hours per day 5 days per week. If member has been refusing rehab approve for a shorter timeframe and request documentation of member's participation.

Services Provided on an Inpatient Basis as a "Practical Matter"

In determining whether the daily skilled care needed by an individual can, as a "practical matter," only be provided in a SNF on an inpatient basis, the clinician considers the individual's physical condition and the availability and feasibility of using more economical alternative facilities or services.
As a "practical matter," daily skilled services can be provided only in a SNF if they are not available on an outpatient basis in the area in which the individual resides or transportation to the closest facility would be:

- An excessive physical hardship;

- Less economical; or

- Less efficient or effective than an inpatient institutional setting.

The availability of capable and willing family or the feasibility of obtaining other assistance for the patient at home should be considered. Even though needed daily skilled services might be available on an outpatient or home care basis, as a practical matter, the care can be furnished only in the SNF if home care would be ineffective because the patient would have insufficient assistance at home to reside there safely.

LIMITATIONS/EXCLUSIONS:

If any one of the four factors is not met, a stay in a SNF, even though it might include the delivery of some skilled services, may not be covered.

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

The member must also have been transferred to a participating SNF within 30 days after discharge from the hospital, unless the exception in §20.2.2 Exceptions to Eligibility Rule for Persons Who Have ESRD applies. In addition, the beneficiary must require SNF care for a condition that was treated during the qualifying hospital stay, or for a condition that arose while in the SNF for treatment of a condition for which the beneficiary was previously treated in the hospital.

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 5 days a week. (If therapy services are provided less than 5 days a week, the "daily" requirement would not be met.) If member has been refusing rehab approve for a shorter timeframe and request documentation of member's participation.

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

Medical Necessity Guideline

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 (please see Hospice Payment Policy)
- 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 wheel chairs
- 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

There must be specific evidence that daily skilled nursing or skilled rehabilitation services are required and received if:

- The primary service needed is oral medication; or

- The patient is capable of independent ambulation, dressing, feeding, and hygiene.

Concurrent Reviews:
Occur 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 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.

Nonskilled Supportive or Personal Care Services

The following services are not skilled services unless rendered under circumstances detailed in §§30.2:

- Administration of routine oral medications, eye drops, and ointments (the fact that patients cannot be relied upon to take such medications themselves or that State law requires all medications to be dispensed by a nurse to institutional patients would not change this service to a skilled service);

- General maintenance care of colostomy and ileostomy;

- Routine services to maintain satisfactory functioning of indwelling bladder catheters (this would include emptying and cleaning containers and clamping the tubing);

- Changes of dressings for uninfected post-operative or chronicconditions;

• Prophylactic and palliative skin care, including bathing and application of creams, or treatment of minor skin problems;

• Routine care of the incontinent patient, including use of diapers and protective sheets;

• General maintenance care in connection with a plaster cast (skilled supervision or observation may be required where the patient has a preexisting skin or circulatory condition or requires adjustment of traction);

• Routine care in connection with braces and similar devices;

• Use of heat as a palliative and comfort measure, such as whirlpool or steam pack;

• Routine administration of medical gases after a regimen of therapy has been established (i.e., administration of medical gases after the patient has been taught how to institute therapy);

• Assistance in dressing, eating, and going to the toilet;

• Periodic turning and positioning in bed; and

• General supervision of exercises, which have been taught to the patient and the performance of repetitious exercises that do not require skilled rehabilitation personnel for their performance. (This includes the actual carrying out of maintenance programs where the performances of repetitive exercises that may be required to maintain function do not necessitate a need for the involvement and services of skilled rehabilitation personnel. It also includes the carrying out of repetitive exercises to improve gait, maintain strength or endurance; passive exercises to maintain range of motion in paralyzed extremities which are not related to a specific loss of function; and assistive walking.) (See Medicare Benefit Policy Manual, Chapter 1, "Inpatient Hospital Services.")

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.

Skilled services 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.

Medical Necessity Guideline

AUTHORIZATION:

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 skilled nursing and skilled rehabilitation services in a SNF. It is expected that the documentation in the patient's medical record will reflect the need for the skilled services provided. 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 skilled service is needed.

REGULATORY NOTES:

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

RELATED REFERENCES:

ATTACHMENTS:

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

REVISION LOG:

REVISION DATE	DESCRIPTION

Disclaimer:

This Medical Necessity Guideline is not a rigid rule. As with all 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:

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