Skilled Nursing Facility (SNF) Services Under Medicare Part A
Medical Necessity Guideline

Medical Necessity Guideline (MNG) Title: Skilled Nursing Facility (SNF) Services Under Medicare Part A		
MNG #: 086	**☒ 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; 6/13/2024;
Last Revised Date: 5/30/2022; 5/25/23; 6/13/2024;	**Next Annual Review Date:** 10/14/2022; 5/30/2023; 5/25/24; 6/13/2025;	**Retire Date:**

OVERVIEW:
Skilled nursing and/or skilled rehabilitation services are furnished pursuant to physician orders, for members that are in a Skilled Nursing Facility and covered by Medicare Part A. These services 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, 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. 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:
Skilled Nursing Facility (SNF) - As defined by CMS (§201.1), an institution or a distinct part of an institution, such as a skilled nursing home or rehabilitation center, which has a transfer agreement in effect with one or more participating hospitals.

Direct Skilled Service (for the purposes of this MNG, may be otherwise referred to as Skilled Service, Skilled Nursing Service or Skilled Rehabilitation Service) - The inherent complexity of a service prescribed for a patient is such that it can be performed safely and effectively, and observed, only by or under the general supervision of skilled nursing or skilled rehabilitation personnel (42CFR § 409.32). Examples of direct skilled nursing services include: the administration of intravenous feedings and intramuscular injections, the insertion of suprapubic catheters. Skilled rehabilitation services concurrent with the management of a patient's care plan include tests and measurements of range of motion, strength, balance, coordination, endurance, and functional ability. Any complications and special services involved must be documented by physicians' orders and notes, as well as nursing or therapy notes.

Reasonable and Necessary (per Medicare):
- Furnished in accordance with accepted standards of medical practice for the diagnosis or treatment of the patient's condition or to improve the function of a malformed body member; and

- Furnished in a setting appropriate to the patient's medical needs and condition; and
- Ordered and furnished by qualified personnel; and
- One that meets, but does not exceed, the patient's medical need; and
- At least as beneficial as an existing and available medically appropriate alternative.

Critical Access Hospital (CAH) – As defined by CMS, "health clinics or centers (as defined by the State) that previously operated as a hospital before being downsized to a health clinic or center", which provide limited outpatient and inpatient hospital services to people in rural areas.

Minimum Data Set (MDS) – A tool for implementing standardized assessment and for facilitating care management in nursing homes and non-critical access hospital swing beds.

Practical Matter – Medicare language to describe the consideration of economy and efficiency in determining whether the skilled services to a member can only be provided/delivered on an inpatient basis in a SNF. 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; or
- 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.

DECISION GUIDELINES:

Clinical Coverage Criteria:

Skilled services include nursing, physical therapy, occupational therapy, and speech/language pathology therapy, and may be covered and authorized in a SNF, if the following conditions are met:

1. The beneficiary must be receiving skilled care; and
2. The services must be considered reasonable and necessary, i.e., the services 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); and
3. The patient requires *skilled nursing services on a daily basis (see §30.6), or *skilled therapy services five days per week; and
4. 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; and
5. An individualized assessment of the member's clinical condition demonstrates that the specialized judgment, knowledge, and skills of a registered nurse or therapist are necessary for the delivery of the nursing or rehabilitation

services; and

6. 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:
        - 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); and
        - 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.

* 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.

Documentation Requirements:

1. The services prescribed/ordered 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.
2. Admission to a Medicare-certified SNF within 30 days of hospital discharge
3. Skilled nursing or skilled therapy services are ordered/prescribed by a physician, and the services are rendered for a condition:
    - For which the member received inpatient hospital services; or
    - That arose while receiving care in a SNF for a condition for which the member received inpatient hospital services.
4. Services prescribed/ordered are:
    - Skilled nursing seven days per week; or
    - Skilled therapy five days per week.
5. The necessary documentation is:
    - Supportive of the need for skilled care and that the care is reasonable and necessary; and
    - Includes all documentation to support daily skilled care for nursing and/or therapy.
6. 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:
    - The beneficiary'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
    - 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.

7. 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).
8. If all other requirements for coverage of skilled therapy services under the SNF benefit are met, required submitted documentation includes all of the following:
    - An individualized assessment of the patient's clinical condition demonstrating that the specialized judgment, knowledge, and skills of a qualified therapist are necessary for the performance of the rehabilitation service; and
    - 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 are approved by the physician after any needed consultation with the qualified physical therapist. In those cases where a beneficiary member 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. The services are directly and specifically related to the treatment plan; and
    - The services must be provided with the expectation, based on the assessment made by the physician of the member's restoration potential, that the condition of the member 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.

NOTE: 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)

LIMITATIONS/EXCLUSIONS:

1. The facility must complete an MDS for skilled services provided to a member during a SNF Part A stay.
2. 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.
3. The member 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 said member was previously treated in the hospital.
4. 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 (see 30.6).
5. If skilled therapy services are provided less than 5 days a week, the "daily" requirement would not be met (see 30.6).
6. The member **refuses skilled therapy services.
7. The services are not considered, under accepted standards of medical practice, to be for the member's condition.
8. The services are not reasonable and necessary (i.e., specific and effective) for the treatment of the member's condition, illness, or injury, i.e., the individual's particular medical needs, including the amount, frequency, and duration of the services.
9. 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.

10. 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).
11. 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.
12. 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.

NOTE: 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, marriage and family therapist services, mental health counselor 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.

NOTE: 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 (See **www.cms.gov/files/document/general-explanation-major-categories-skilled-nursing-facility-snf-consolidated-billing.pdf**)

NOTE: Certain supportive or Personal Care Services are not considered skilled services unless rendered under circumstances detailed in §§30.2.

**If a member has been refusing rehabilitation services, a shorter timeframe may be approved with documentation of member's participation.

REVISION LOG:

REVISION DATE	DESCRIPTION
6/13/24	Medical Policy Committee approval
12/31/23	Utilization Management Committee approval
5/25/23	No Changes implemented
05/30/2022	Template changed to include PA requirements and benefit type.

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References:
Medicare Skilled Nursing Facility Manual
9/28/2000
www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R367snf.pdf

Code of Federal Regulations Chapter 42
4/25/2024
https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-409/subpart-D/section-409.32

Medicare Benefit Policy Manual Chapter 8 - Coverage of Extended Care (SNF) Services Under Hospital Insurance
10/5/2023
www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/bp102c08pdf.pdf

Medicare Benefit Policy Manual Chapter 3 - Duration of Covered Inpatient Services
10/4/2019
www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/bp102c03pdf.pdf

Nursing Facility Manual for MassHealth Providers: The Nursing Facility Manual guides nursing facility providers to the regulations and the administrative and billing instructions they need.
https://www.mass.gov/lists/nursing-facility-manual-for-masshealth-providers

General Explanation of the Major Categories for Skilled Nursing Facility (SNF) Consolidated Billing
www.cms.gov/files/document/general-explanation-major-categories-skilled-nursing-facility-snf-consolidated-billing.pdf

Disclaimer
Commonwealth Care Alliance (CCA) follows applicable Medicare 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.

APPROVALS:

David Mello		**Senior Medical Director Utilization Review and Medical Policy**
CCA Senior Clinical Lead [Print]		**Title [Print]**
David Mello		**6/13/24**
Signature		**Date**

Nazlim Hagmann		**Chief Medical Officer**
CCA CMO or Designee [Print]		**Title [Print]**
Nazlim Hagmann		**6/13/24**
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