Skilled Nursing Facility Guidelines

Instruction for Use: Skilled Nursing Facilities are certified under Medicare as coverage of extended care services that the medical criteria and guidelines are met. Skilled Nursing Facility (SNF)services are to be provided in accordance with the guidelines established by Medicare.

Preauthorization by the Plan is required.

Basic Requirements for Clinical Appropriateness:

Use of Skilled Nursing Facility level of care may be considered medically necessary when all the following criteria are met:

- The patient must require skilled rehabilitative therapy services and/or skilled nursing care meeting criteria under items A or B below.
- The patient requires these skilled services daily.
- Services must be provided under the supervision of a physician and must be delivered and require the judgement of a qualified and appropriately licensed provider. Examples may include a registered or licensed practical nurse, physical or occupational therapist or speech and language pathologist.
- Services must be directed toward an active treatment regimen for a specific health condition, illness, injury, or disease.
- Services are considered by the Plan to be specific, effective and reasonable treatment for the patient's diagnosis and physical condition.
- Skilled services must be medically necessary at a frequency and intensity that require an inpatient level of care and that cannot be provided in a less-intensive setting (e.g., intermediate care facility, rest home, office, outpatient, or home setting with intermittent skilled services).
- Services must be expected to result in significant and measurable improvement in the patient's medical condition or functional capabilities within a reasonable and defined period of time.

A. Skilled Rehabilitation Services

1. Skilled Nursing Facility level of care is appropriate for skilled rehabilitative therapies when all the following criteria are met:
    a. The patient must be able to participate at least 5 days per week and 60 minutes per day.
    b. 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.

c. There is an expectation that the patient's functional capabilities will improve significantly in a reasonable and predictable period of time.

2. For continuing stay in a skilled nursing facility (for the purpose of skilled rehabilitation) the following criteria must be met in addition to those listed below:
    a. The patient must demonstrate measurable and significant gains in functional status as evaluated on a weekly basis.
    b. Serial weekly progress notes, including objective documentation on a week-to-week basis of the most recent functional status and measured progress toward goals must be provided.

B. Skilled Nursing Services
    1. The need for, and length of stay in, a skilled nursing facility for skilled nursing care depends on the patient's medical condition and the type, amount, and frequency of skilled nursing services provided. The patient must require services that meet the following criteria:
        a. Services can only be provided by a skilled (registered or licensed practical) nurse AND
        b. Services are required at a frequency and / or intensity that cannot be provided in the home setting through intermittent home health skilled nursing visits and custodial support.
        c. Skilled nursing services exist when the patient requires medically necessary skilled nursing care on a continuing daily basis.

    2. Some examples of skilled nursing services that may require placement of the patient in a skilled nursing facility are listed in the Medicare benefit manual.

Policy Guidelines

The need for length of stay in a Skilled Nursing Facility depends upon the patient's medical condition, type, amount, and frequency of skilled nursing services provided. Members may receive medically necessary services in a less intensive care setting (outpatient or home therapy services) when: The patient needs maintenance program or care. Functional maintenance programs are drills, techniques and exercises that preserve the patient's present level of function and prevent regression of that function. Maintenance begins when the therapeutic goals of a treatment plan have been achieved and /or when no further functional progress is apparent or expected to occur.

Maintenance medical care occurs when the patient's condition is stable or predictable; the plan of care does not require a skilled nurse to be in continuous attendance; or the patient, family, or caregivers have been taught the nursing services and have demonstrated the skills and ability to carry out the plan of care.

Services that are not considered to be skilled include but are not limited to the following:

- Assistance with activities of daily living (bathing, walking, dressing, feeding, preparation of special diets, eating, continence, toileting, transferring, skin care, enemas, and taking patients to the doctor's office). Supervision of a patient for safety or fall precautions is not considered a skilled service,
- Routine measurement of vital signs, observation and monitoring of patients receiving routine care for non-skilled services,
- Administration of routine oral medication, eye drops, and ointments,
- Subcutaneous injections such as insulin,
- Routine care of indwelling bladder catheters or established colostomy or ileostomy, gastrostomy tube feedings, tracheostomy site care, oxygen therapy,
- Routine care of an incontinent patient,
- Care of Stage 1 or 2 decubitus ulcer,
- Care of the confused or disoriented patient who is under an established medication regimen,
- Superficial oropharyngeal, nasotracheal, or tracheostomy cannula suctioning.

Medicare Advantage Members

Coverage criteria for Medicare Advantage members can be found in Medicare coverage guidelines in statutes, regulations, National Coverage Determinations (NCD)s, and Local Coverage Determinations (LCD)s. To determine if a National or Local Coverage Determination addresses coverage for a specific service, refer to the Medicare Coverage Database at the following link: https://www.cms.gov/medicare-coverage-database/search.aspx. You may wish to review the Guide to the MCD Search here: https://www.cms.gov/medicare-coverage-database/help/mcd-bene-help.aspx

When coverage criteria are not fully established in applicable Medicare statutes, regulations, NCDs or LCDs, internal coverage criteria will be developed. A summary of evidence, a list of the sources, and an explanation of the rationale that support the adoption of the coverage criteria will be included.

In addition to specific internal coverage criteria policies, the health plan may adopt criteria developed and maintained by other organizations, including a parent organization or health plan.

Licensed Criteria may also be applied to certain services. InterQual Level of Care (LOC) criteria is currently used to support medical necessity and level of care reviews.

In the absence of a specific internal coverage criteria policy, Licensed Criteria, or specific Medicare coverage guidelines as referenced above for Medicare Advantage members, these guidelines will apply. These guidelines will be used by all plans and lines of business unless Federal or State law, contract language, including member or provider contracts, take precedence over this guideline.

Reference Sources:

1. Centers for Medicare and Medicaid Services (CMS). Medicare Benefit Policy Manual, CMS Pub. 100-02, Chap 8 - Coverage of Extended Care (SNF) Services Under Hospital Insurance, (Rev. 10880; Issued: 08/06/2021). Accessed 12-20-2023. https://www.cms.gov/Regulations-and-Guidance/Manuals/Downloads/bp102c08pdf.pdf

2. InterQual Solution: https://www.changehealthcare.com/clinical-decision-support/interqual Last accessed 12-19-2023.

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