Skilled Nursing Facility Guidelines

Medicare Advantage Medical Policy # MNG-003
Original Effective Date: 12/27/2023
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Applies to all products administered or underwritten by the Health Plan, unless otherwise provided in the applicable contract. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

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:

When Services May Be Eligible for Coverage

Coverage for eligible medical treatments or procedures, drugs, devices or biological products may be provided only if:

- *Benefits are available in the member's contract/certificate, and*
- *Medical necessity criteria and guidelines are met.*

Based on review of available data, the Health Plan may consider the Use of Skilled Nursing Facility level of care when **ALL** the following criteria are met to be **eligible for coverage****.

Patient Selection Criteria

Coverage eligibility will be 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

- Skilled Nursing Facility level of care is appropriate for skilled rehabilitative therapies when all the following criteria are met:
  - The patient must be able to participate at least 5 days per week and 60 minutes per day.
  - 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.
  - There is an expectation that the patient's functional capabilities will improve significantly in a reasonable and predictable period of time.
- 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:
  - The patient must demonstrate measurable and significant gains in functional status as evaluated on a weekly basis.
  - 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

- 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:
  - Services can only be provided by a skilled (registered or licensed practical) nurse AND
  - 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.
  - Skilled nursing services exist when the patient requires medically necessary skilled nursing care on a continuing daily basis.
- 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.

Rationale/Source

This medical policy was developed through consideration of peer-reviewed medical literature generally recognized by the relevant medical community, U.S. Food and Drug Administration approval status, nationally accepted standards of medical practice and accepted standards of medical practice in this community, technology evaluation centers, reference to federal regulations, other plan medical policies, and accredited national guidelines.

References

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). https://www.cms.gov/Regulations-and-Guidance/Manuals/Downloads/bp102c08pdf.pdf
2. InterQual Solution: https://www.changehealthcare.com/clinical-decision-support/interqual

Policy History

Original Effective Date: 12/27/2023
Current Effective Date: 01/01/2025
12/23/2023 New policy created.
12/27/2023 Utilization Management Committee review and approval. New Policy.
10/15/2024 Policy reviewed and revised.
10/15/2024 Utilization Management Committee review and approval. Reference sources updated.
No substantive changes made.

**Medically Necessary (or “Medical Necessity”) - Healthcare services, treatment, procedures, equipment, drugs, devices, items or supplies that a Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

A. In accordance with nationally accepted standards of medical practice;
B. Clinically appropriate, in terms of type, frequency, extent, level of care, site and duration, and considered effective for the patient's illness, injury or disease; and
C. Not primarily for the personal comfort or convenience of the patient, physician or other healthcare provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, “nationally accepted standards of medical practice” means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of Physicians practicing in relevant clinical areas and any other relevant factors.

NOTICE: If the Patient's health insurance contract contains language that differs from the Health Plan Medical Policy definition noted above, the definition in the health insurance contract will be relied upon for specific coverage determinations.

NOTICE: Medical Policies are scientific based opinions, provided solely for coverage and informational purposes. Medical Policies should not be construed to suggest that the Health Plan recommends, advocates, requires, encourages, or discourages any particular treatment, procedure, or service, or any particular course of treatment, procedure, or service.

NOTICE: Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage.

Medicare Advantage Members

Established 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 may be developed. This policy is to serve as the summary of evidence, a list of resources and an explanation of the rationale that supports the adoption of this internal coverage criteria.