Skilled Nursing Facility Level of Care
Clinical Coverage Criteria

Description

Skilled care is nursing and rehabilitation services that can only be safely and effectively performed by or under the supervision of licensed healthcare professionals, such as nurses, physical therapists, occupational therapists and speech pathologists.

Skilled nursing facilities focus on restorative and rehabilitative care with the goal of helping patients restore maximum function and regain their independence. Skilled nursing facilities provide subacute rehabilitation, which is less intensive that rehabilitation provided in an inpatient rehabilitation facility. For a patient to qualify for acute inpatient rehabilitation they must be able to tolerate 3 hours of therapy per day (speech-language pathology, occupational therapy, physical therapy) at least 5 days per week. If the patient cannot tolerate this much therapy or no longer requires therapy at this intensive a level, they may be better served at the subacute level.

Policy

This Policy applies to the following Fallon Health products:

☒ Medicare Advantage (Fallon Medicare Plus, Fallon Medicare Plus Central)
☒ MassHealth ACO
☒ NaviCare HMO SNP
☒ NaviCare SCO
☒ PACE (Summit Eldercare PACE, Fallon Health Weinberg PACE)
☒ Community Care

Prior authorization is required.

Medicare Advantage (Fallon Medicare Plus, Fallon Medicare Plus Central)
Fallon Health complies with CMS's national coverage determinations (NCDs), local coverage determinations (LCDs) of Medicare Contractors with jurisdiction for claims in the Plan's service area, and applicable Medicare statutes and regulations when making medical necessity determinations for Medicare Advantage members. When coverage criteria are not fully established in applicable Medicare statutes, regulations, NCDs or LCDs, Fallon Health may create internal coverage criteria under specific circumstances described at § 422.101(b)(6)(i) and (ii).

Medicare statutes and regulations do not have coverage criteria for Medicare does not have has an NCD for skilled nursing facility care. National Government Services, Inc. the Part A/B Medicare Administratitve Contractor with jurisdiction in the Plan's service are does not have an LCD for skilled nursing facility care (Medicare Coverage Database search 04/21/2024).

The **Medicare Benefit Policy Manual, Chapter 8 - Coverage of Extended Care (SNF) Services Under Hospital Insurance,** includes coverage criteria for skilled nursing facility level of care. The Plan follows coverage criteria in the Medicare Benefit Policy Manual, Chapter 8 - Coverage of Extended Care (SNF) Services Under Hospital Insurance, for Fallon Medicare Plus and Fallon Medicare Plus Central members. No prior hospital stay is required.

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Care in a SNF is covered if all of the following four factors are met:

- 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 §§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;
- The patient requires these skilled services on a daily basis (see §30.6); and
- 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.); and
- 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.

If any one of these four factors is not met, a stay in a SNF, even though it might include the delivery of some skilled services, is not covered. For example, payment for a SNF level of care could not be made if a patient needs an intermittent rather than daily skilled service.

CMS uses the Patient Driven Payment Model PDPM to help determine need for SNF level of care. If a member does not meet the PDPM, consideration is still given to their needs.

Note: Fallon Medicare Plus and Plus Central members have coverage for up to 100 days in each benefit period for skilled nursing facility level of care. No prior hospital stay is required.

MassHealth ACO
Fallon Health follows Medical Necessity Guidelines published by MassHealth when making medical necessity determinations for MassHealth members. In the absence of Medical Necessity Guidelines published by MassHealth, Fallon Health may create clinical coverage criteria in accordance with the definition of Medical Necessity in 130 CMR 450.204.

MassHealth has Clinical Eligibility Criteria for nursing facility services in regulations at 130 CMR 456.409.

The Plan follows Clinical Eligibility Criteria in 130 CMR 456.409 when determining medical necessity for nursing facility services for MassHealth ACO members. To be considered clinically eligible for nursing facility services, a member must require one skilled service listed in 130 CMR 456.409(A) daily, or the member must have a medical or mental condition requiring a combination of at least three services from 130 CMR 456.409(B) and (C), including at least one of the nursing services listed in 130 CMR 456.409(C).

MassHealth Standard, CommonHealth and Family Assistance members have coverage for up to 100 days at either a nursing facility, chronic or rehabilitation hospital, or any combination thereof, per Contract Year.

NaviCare HMO SNP, NaviCare SCO
For plan members enrolled in NaviCare, Fallon Health first follow's CMS's national coverage determinations (NCDs), local coverage determinations (LCDs) of Medicare Contractors with jurisdiction for claims in the Plan's service area, and applicable Medicare statutes and regulations when making medical necessity determinations.

When coverage criteria are not fully established in applicable Medicare statutes, regulations, NCDs or LCDs, or if the NaviCare member does not meet coverage criteria in applicable Medicare statutes, regulations, NCDs or LCDs, Fallon Health then follows Medical Necessity Guidelines published by MassHealth when making necessity determinations for NaviCare members.

Note: NaviCare members have coverage for up to 100 days in each benefit period for skilled nursing facility level of care. No prior hospital stay is required.

PACE (Summit Eldercare PACE, Fallon Health Weinberg PACE)
Each PACE plan member is assigned to an Interdisciplinary Team. PACE provides participants with all the care and services covered by Medicare and Medicaid, as authorized by the interdisciplinary team, as well as additional medically necessary care and services not covered by Medicare and Medicaid. With the exception of emergency care and out-of-area urgently needed care, all care and services provided to PACE plan members must be authorized by the interdisciplinary team.

Fallon Health Clinical Coverage Criteria

Fallon Health follows the Centers for Medicare and Medicaid (CMS) guidelines for skilled nursing facility level of care. Link: Medicare Benefit Policy Manual, Chapter 8 - Coverage of Extended Care (SNF) Services.

Skilled nursing facility level of care is covered when all of the following criteria are met:

- The member 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 §§30.2 - 30.4); are ordered by a physician;
- The patient requires these skilled services on a daily basis (see §30.6); and
- 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).
- 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.

No prior hospital stay is required.

Commercial members, for which the product is only medical coverage, the social need of a willing and able caregiver or barriers to enter their home are not part of the medical decision criteria.

Medical needs

- Intravenous therapy which cannot be arranged as home infusion therapy.
- Intravenous therapy in the hospital would be skilled in the SNF only if daily fluid balance is an active problem.
- Unstable medical condition which requires provider face to face evaluation to adjust treatment plan at least three times a week.
- Respiratory therapy would qualify if the acute admission was due to an exacerbation, and they did not return to baseline. If not, the PDPM will be adjusted.

Therapy needs

- Must be due to acute neuromuscular or skeletal change such as stroke, joint replacement, fracture in an extremity. Deconditioning is a self-correcting condition, and no randomized controlled trial has shown that daily skilled therapy is required to correct it.
- Cognitively able to retain teaching and make significant progress in scoring in the 18 items that cover self-care, continence, mobility, transfers, communication, and cognition, typically 1 per day.

References

1. Medicare Benefit Policy Manual. Chapter 8 - Coverage of Extended Care (SNF) Services Under Hospital Insurance (Rev. 12283; Issued: 10-05-23).

Policy history

Origination date:	06/01/2020
Review/Approval(s):	Technology Assessment Committee: 05/27/2020 (policy origination), 07/10/2021 (added clarifying language related to Medicare Advantage, MassHealth ACO,

NaviCare and PACE under Policy section), 04/23/2024 (annual review; under Policy, clarified that the Plan follows Clinical Eligibility Criteria in 130 CMR 456.409 when determining medical necessity for nursing facility services for MassHealth ACO members).

Not all services mentioned in this policy are covered for all products or employer groups. Coverage is based upon the terms of a member's particular benefit plan which may contain its own specific provisions for coverage and exclusions regardless of medical necessity. Please consult the product's Evidence of Coverage for exclusions or other benefit limitations applicable to this service or supply. If there is any discrepancy between this policy and a member's benefit plan, the provisions of the benefit plan will govern. However, applicable state mandates take precedence with respect to fully-insured plans and self-funded non-ERISA (e.g., government, school boards, church) plans. Unless otherwise specifically excluded, federal mandates will apply to all plans.