



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 than 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:

- Fallon Medicare Plus
- MassHealth ACO
- NaviCare HMO SNP
- PACE (Summit Eldercare PACE, Fallon Health Weinberg PACE)
- Community Care

Prior authorization is required.

Fallon Health Clinical Coverage Criteria

Fallon Health Clinical Coverage Criteria apply to Community Care members.

Fallon Health follows Medicare coverage criteria for skilled nursing facility level of care (Source: [Medicare Benefit Manual Chapter 8](#)).

Skilled nursing facility level of care criteria must be met for admission and for continued stay.

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); and the skilled services 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.

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.

In reviewing whether the level of care requirements are met, the Plan first considers whether a member needs skilled care. If a need for a skilled service does not exist, then the “daily” and “practical matter” requirements are not addressed.

Three-Day Prior Hospitalization

Fallon Health does not require a qualifying inpatient hospital stay for coverage of SNF level of care.

Determining Medical Necessity and Appropriateness of Admission/Discharge

SNF level of care is only covered when a patient's medical condition, safety, or health would be at significant and direct risk if cared for in a less intensive setting. This means the patient requires daily skilled nursing or rehabilitative therapy that can't be safely or effectively provided at home or in a less supervised setting. Without accompanying medical conditions, factors that may cause the patient inconvenience in terms of time and money needed to care for the patient at home or for travel to a physician's office, or that may cause the patient to worry, do not justify a continued hospital stay or justify your approval of a higher-than necessary level of care (Source: Medicare Quality Improvement Organization Manual, Chapter 4, Section 4110).

In the SNF setting, the term “non-covered care” refers to any level of care less intensive than the SNF level of care that is covered under the program (Source: Medicare Benefit Policy Manual, Chapter 8, section 20.1).

Skilled Services Defined

Skilled nursing and/or skilled rehabilitation services are those services, furnished pursuant to physician orders, 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 (Source: Medicare Benefit Manual, Chapter 8, Section 30.2.1).

Daily Skilled Services Defined

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.)

When rehabilitation services are the primary services, the key issue is whether the skills of a therapist are needed. The deciding factor is not the patient's potential for recovery, but whether the services needed require the skills of a therapist or whether they can be provided by nonskilled personnel.

A service that is ordinarily considered nonskilled could be considered a skilled service in cases in which, because of special medical complications, skilled nursing or skilled rehabilitation personnel are required to perform or supervise it or to observe the patient. In these cases, the complications and special services involved must be documented by physicians' orders and notes as well as nursing or therapy notes.

In determining whether services rendered in a SNF constitute covered care, it is necessary to determine whether individual services are skilled, and whether, in light of the patient's total condition, skilled management of the services provided is needed even though many or all of the specific services were unskilled (Source: Medicare Benefit Manual, Chapter 8, Section 30.6).

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 nurse (See 42 CFR §409.32).

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 (Source: Medicare Benefit Manual, Chapter 8, Section 30.3).

Direct Skilled Therapy Services to Patients

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 42 CFR §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 (Source: Medicare Benefit Manual, Chapter 8, Section 30.4).

Skilled physical therapy services must meet all of the following conditions:

- 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 physical therapist after admission to the SNF and prior to the start of physical 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 physical therapy services in the SNF;
- The services must be of a level of complexity and sophistication, or the condition of the patient must be of a nature that requires the judgment, knowledge, and skills of a qualified physical therapist;
- 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. NOTE: See Section E. Maintenance Therapy for more guidance regarding when skilled therapy services are necessary for the performance of a safe and effective maintenance program.
- The services must be considered under accepted standards of medical practice to be specific and effective treatment for the patient's condition; and,
- 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.

Documentation to Support Skilled Care Determinations (Source Medicare Benefit Manual, Chapter 8, Section 30.2.2.1)

Requests for skilled nursing facility level of care coverage must include sufficient documentation to enable a reviewer to determine whether:

- Skilled involvement is required in order for the services in question to be furnished safely and effectively; and
- The services themselves are, in fact, 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 documentation must also show that the services are appropriate in terms of duration and quantity, and that the services promote the documented therapeutic goals.

Such determinations would be made from the perspective of the patient's condition when the services were ordered and what was, at that time, reasonably expected to be appropriate treatment for the illness or injury. However, if it becomes apparent at some point that the goal set for the patient is no longer a reasonable one, then the treatment goal itself should be promptly and appropriately modified to reflect

this, and the patient should then be reassessed to determine whether the treatment goal as revised continues to require the provision of skilled services.

It is expected that the documentation in the patient's medical record will reflect the need for the skilled services provided. 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. Taken as a whole, then, 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.

Thorough and timely documentation with respect to treatment goals can help clearly demonstrate a beneficiary's need for skilled care in situations where such need might not otherwise be readily apparent, as when the treatment's purpose changes (for example, from restoration to maintenance), as well as in establishing the efficacy of care that serves to prevent or slow decline—where, by definition, there would be no "improvement" to evaluate. For example, when skilled services are necessary to maintain the patient's current condition, the documentation would need to substantiate that the services of skilled personnel are, in fact, required to achieve this goal.

Therefore, the patient's medical record must document as appropriate:

- The history and physical exam pertinent to the patient's care, (including the response or changes in behavior to previously administered skilled services);
- The skilled services provided;
- The patient's response to the skilled services provided during the current visit;
- The plan for future care based on the rationale of prior results.
- A detailed rationale that explains the need for the skilled service in light of the patient's overall medical condition and experiences;
- The complexity of the service to be performed;
- Any other pertinent characteristics of the member.

The documentation in the patient's medical record must be accurate and avoid vague or subjective descriptions of the patient's care that would not be sufficient to indicate the need for skilled care. For example, the following terminology does not sufficiently describe the reaction of the patient to his/her skilled care:

- Patient tolerated treatment well
- Continue with POC
- Patient remains stable

Medicare Variation

Medicare statutes and regulations do not have coverage criteria for skilled nursing facility level of care. Medicare does not have an NCD for skilled nursing facility level of care. National Government Services, Inc. the Part A/B Medicare Administrative Contractor with jurisdiction in the Plan's service area does not have an LCD for skilled nursing facility level of care (Medicare Coverage Database search 04/23/2026).

The Medicare Benefit Policy Manual, Chapter 8 - Coverage of Extended Care (SNF) Services Under Hospital Insurance, has 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. Coverage criteria for skilled nursing facility level of care are fully established by Medicare; therefore the Plan's coverage criteria are not applicable.

Skilled nursing facility level of care criteria must be met for admission and for continued stay.

30 - Skilled Nursing Facility Level of Care - General

Care in a SNF is covered if all of the following four criteria 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.

In reviewing requests for SNF services to determine whether the level of care requirements are met, the Plan first considers whether a member needs skilled care. If a need for a skilled service does not exist, then the "daily" and "practical matter" requirements are not addressed.

Three-Day Prior Hospitalization

To qualify for Medicare coverage, patients must meet the "3-day rule" before SNF admission. The 3-day rule requires the patient to have a medically necessary 3-consecutive-day inpatient hospital stay, which doesn't include the discharge day or pre-admission time in the emergency department or outpatient observation. Fallon Health does not require this qualifying inpatient hospital stay for SNF level of care for Medicare Advantage members.

Determining Medical Necessity and Appropriateness of Admission/Discharge

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- The patient's response to the skilled services provided during the current visit;
- The plan for future care based on the rationale of prior results.
- A detailed rationale that explains the need for the skilled service in light of the patient's overall medical condition and experiences;
- The complexity of the service to be performed;
- Any other pertinent characteristics of the member.

The documentation in the patient's medical record must be accurate and avoid vague or subjective descriptions of the patient's care that would not be sufficient to indicate the need for skilled care. For example, the following terminology does not sufficiently describe the reaction of the patient to his/her skilled care:

- Patient tolerated treatment well
- Continue with POC
- Patient remains stable

MassHealth Variation

MassHealth does not have Guidelines for Medical Necessity Determination for skilled nursing facility level of care (MassHealth website search 04/23/2026),

The Plan follows Clinical Eligibility Criteria in 130 CMR 456.409 when determining medical necessity for skilled nursing facility services for MassHealth ACO members. To be considered clinically eligible for skilled 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 ACO Contract Year.

Requests for authorization for skilled nursing facility services must include documentation of the completed clinical assessment; other nursing, medical, or psychosocial evaluations or assessments; documentation that available alternatives to skilled nursing facility care were considered and were deemed inadequate to meet the member's needs; and any other documentation that the Plan, requests in order to complete the review and determination of clinical authorization, including additional assessments of the member.

Exclusions

- The services of a private duty nurse or private duty attendant (aide) are not covered.

Coding

For Billing/coding guidelines, refer to Fallon Health's Skilled Nursing Facility Payment Policy.

Revenue Codes

Code	Description
0022	HIPPS - Skilled nursing facility
0120	Room and board – use for room and board SNF Level A
0190	Subacute care – use for room and board SNF Level B
0191	Subacute care – use for room and board SNF Level C
0192	Subacute care – use for room and board SNF Level D
0193	Subacute care – use for room and board SNF Level E
0194	Subacute care – use for room and board SNF Level F
0199	Subacute care – use for room and board SNF Level G

Summary of Evidence

N/A

Analysis of Evidence (Rational for Determination)

N/A

References

1. Medicare Benefit Policy Manual. Chapter 8 - Coverage of Extended Care (SNF) Services Under Hospital Insurance (Rev. 12283; Issued: 10-05-23). Available at: <https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/bp102c08pdf.pdf>. Accessed 04/22/2025.

2. MassHealth Nursing Facility Manual. Program Regulations 130 CMR 456.000. Available at: <https://www.mass.gov/lists/nursing-facility-manual-for-masshealth-providers#subchapter-4:-nursing-facility-providers-regulations->. Accessed 04/22/2025.

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), 04/29/2025 (annual review; added new sections for Medicare Variation and MassHealth Variation; no changes to coverage criteria), 04/28/2026 (annual review; no changes to coverage criteria).
Utilization Management Committee: 05/20/2025 (annual review; approved), 05/19/2026 (annual review; approved with no changes to coverage criteria).

Instructions for Use

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).

Fallon Health generally 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.

For plan members enrolled in NaviCare, Fallon Health first follows 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.

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.

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.

