Clinical Policy: Post-Acute Care

Reference Number: CP.MP.213 Coding Implications
Last Review Date: 12/20 Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Post–acute care refers to a wide range of services, which include skilled nursing facilities, inpatient rehabilitation facilities, home health aides, outpatient physical and occupational therapy, and long-term care facilities.1 Medicare spends more than $59 billion on post–acute care, which has more than doubled since 2001. Discharges to post– acute care facilities have increased nearly 50% during the past 15 years. 2 Post–acute care is a major contributor to the costs of a hospitalization episode, because 42% of Medicare beneficiaries are discharged from hospitals to post–acute care settings.[3]

Policy/Criteria

I. It is the policy of health plans affiliated with Centene Corporation® that skilled nursing facility (SNF) care is **medically necessary** for initial admission or continued stay when criteria are met for initial admission or continued stay **and** the appropriate level criteria are met:

Initial Admission, all of the following:

A. Skilled nursing services or skilled rehabilitation services are required, (i.e., services that must be performed by or under the supervision of professional or technical personnel); services are ordered by a physician;
B. Skilled services are required on a daily basis;
C. As a practical matter, considering economy and efficiency, the daily skilled services can be provided only on an inpatient basis in a SNF;
D. The services delivered are reasonable and necessary for the treatment of illness or injury, i.e., are consistent with the nature and severity of the illness or injury, the particular medical needs, and accepted standards of medical practice. The services must also be reasonable in terms of duration and quantity;
E. Initial admission and subsequent stay in a SNF for skilled nursing services or rehabilitation services must include development, management and evaluation of a plan of care that meets all of the following:
    1. Involvement of skilled nursing personnel is required to meet the member's/enrollee's medical needs, promote recovery and ensure medical safety (in terms of the member's/enrollee's physical or mental condition);
    2. A significant probability must exist that complications would arise without skilled supervision of the treatment plan by a physician, licensed nurse, or licensed therapist;
    3. Care plans must include realistic nursing goals and objectives for the member/enrollee, discharge plans and the planned interventions by the medical staff to meet those goals and objectives;
    4. Updated care plans must document the outcome of the planned interventions;
    5. Daily documentation of the individual's progress or complications must exist;
F. Following review for medical necessity, each approval must have a level of care documented – Continue to SNF level of care review.

Continued Stay, all of the following:

A. Skilled nursing or skilled rehabilitation services are required that must be performed by, or under the supervision of, professional or technical personnel;
B. Skilled nursing is required at least daily or skilled therapy 1-2 hours per day at least 5 days per week;
C. Medical practitioner, Nurse Practitioner (NP) or Physician Assistant (PA) assessment or oversight required > 1 time per week;
D. Interdisciplinary and goal oriented treatment by professional nursing, social worker, or case manager and/or rehabilitation therapists with specialized training, education, and/or certification;
E. Daily documentation of treatment and response to interventions with progress toward meeting goals documented at least weekly or more frequently;
F. Medical specialty consultative services, pharmacy and diagnostic services available;
G. Practically, daily skilled services can only be provided on an inpatient basis in a SNF setting;
H. SNF services must be furnished pursuant to a physician's orders and be reasonable and necessary for the treatment of a member's/enrollee's illness or injury (e.g., consistent with the nature and severity of the illness/injury, particular medical needs, and accepted standards of medical practice);
I. Initial admission and subsequent stay in a SNF for skilled nursing services or rehabilitation services must include development, management and evaluation of a plan of care as follows:
    1. Involvement of skilled nursing personnel is required to meet the member's/enrollee's medical needs, promote recovery and ensure medical safety (in terms of the member's/enrollee's physical or mental condition);
    2. A significant probability must exist that complications would arise without skilled supervision of the treatment plan by a physician, licensed nurse, or licensed therapist;
    3. Care plans must include realistic nursing goals and objectives for the member/enrollee, discharge plans and the planned interventions by the medical staff to meet those goals and objectives;
    4. Updated care plans must document the outcome of the planned interventions;
    5. Daily documentation of the individual's progress or complications must exist;
J. Following review for medical necessity, each additional approval must have a level of care documented – Continue to SNF level of care review.

NOTE: The need for respiratory therapy, either by a nurse or by a respiratory therapist, does not alone qualify an individual for SNF care.

Skilled Nursing Facility (SNF) Levels of Care

A. *SNF Setting (Short-Term) – Level of Care 1, both of the following:*
    1. Patient status meets all of the following:
        a. Medically stable with medical or surgical comorbidities manageable and not requiring acute medical attention;
        b. Requires care that is directly related and reasonable for the presenting condition and/or illness;
        c. There is expected improvement from medical and/or rehab intervention (or end-stage disease) within a reasonable and predictable period of time;
        d. Those who require rehabilitative services must exhibit a decline in physical function (compared to prior level of function) in order for rehab services to be considered medically appropriate. Prior level of function can include: independent, modified

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independent in the community, supervised or minimum assistance in the community with caregiver support, or long-term resident;

2. Program meets all of the following:
   a. Skilled nursing at least daily (1 to 4 hours) or skilled therapy up to 1 hour per day at least 5 days per week;
   b. Assessment and oversight by a medical practitioner such as a NP or PA required > 1 time per week;
   c. Interdisciplinary and goal oriented treatment by professional nursing, social worker, or case manager, and/or rehab therapists with specialized training, education and/or certification;
   d. Treatment plan developed within 2 days of admission;
   e. Daily documentation of treatment and response to interventions with progress toward meeting goals documented at least weekly or more frequently;
   f. Medical specialty consultative service, pharmacy and diagnostic services available.

B. *Skilled Sub-Acute Setting (Short-Term) – Level of Care 2, both of the following:*
   1. Patient status meets all of the following:
      a. Medically stable with medical or surgical comorbidities manageable and not requiring acute medical attention;
      b. Requires care that is directly related and reasonable for the presenting condition and/or illness;
      c. Expected improvement from medical and/or rehabilitation intervention (or end-stage disease) within a reasonable and predictable period of time;
      d. Patients who require rehabilitative services must exhibit a decline in physical function (compared to prior level of function) in order for the rehab services to be considered medically appropriate. Prior level of function can include: independent, modified independent in the community, supervised or minimum assistance in the community with caregiver support, or long-term resident;
   2. Program meets all of the following:
      a. Skilled nursing at least 4-6 hours per day, or skilled therapy up to 2 hours per day at least 5 days per week;
      b. Assessment and oversight by a medical practitioner such as an NP or PA required > 2 times per week;
      c. Interdisciplinary and goal oriented treatment by professional nursing, social worker, or case manager, and/or rehab therapists with specialized training, education and/or certification;
      d. Treatment plan developed within 2 days of admission;
      e. Daily documentation of treatment and response to interventions with progress toward meeting goals documented at least weekly or more frequently;
      f. Medical specialty consultative services, pharmacy and diagnostic services available.

C. *Sub-Acute Setting (Short-Term) – Level 3 of Care Complex, both of the following:*
   1. Patient status meets all of the following:
      a. Medically stable with medical or surgical comorbidities manageable and not requiring acute medical attention;
      b. Requires care that is directly related and reasonable for the presenting condition and/or illness;

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c. Expected improvement from medical and rehab intervention within a reasonable and predictable period of time;
d. Patients who require rehabilitative services must exhibit a decline in physical function (compared to prior level of function) in order for the rehab services to be considered medically appropriate. Prior level of function can include: independent, modified independent in the community, supervised or minimum assistance in the community with caregiver support, or long-term resident;

2. Program meets all of the following:
   a. Skilled nursing at least up to 6 hours per day and skilled therapy up to 3 hours per day at least 5 days per week;
   b. Assessment and oversight by a medical practitioner such as an NP or PA required > 2 times per week;
   c. Interdisciplinary and goal oriented treatment by professional nursing, social worker, or case manager, and rehab therapists with specialized training, education and/or certification;
   d. Treatment plan developed within 2 days of admission;
   e. Daily documentation of treatment and response to interventions with progress toward meeting goals documented at lease weekly or more frequently;
   f. Medical specialty consultative services, pharmacy and diagnostic services available.

D. *Level of Care 4 – Complex, all of the following:*
1. The patient requires medical and rehab services in a subacute setting for short-term care for conditions such as, but not limited to, bedside dialysis, severe CVA, severe head injury, stabilized spinal cord injuries, etc.;
2. Patient status meets all of the following:
   a. Medically stable with medical or surgical comorbidities manageable and not requiring acute medical attention;
   b. Requires care that is directly related and reasonable for the presenting condition and/or illness;
   c. Expected improvement from medical and rehab intervention within a reasonable and predictable period of time;
   d. Patients who require rehabilitative services must exhibit a decline in physical function (compared to prior level of function) in order for the rehab services to be considered medically appropriate. Prior level of function can include: independent, modified independent in the community, supervised or minimum assistance in the community with caregiver support, or long-term resident;
3. Program meets all of the following:
   a. Skilled nursing at least 4-5 hours per day and skilled therapy up to 3 hours per day at least 5 days per week;
   b. Assessment and oversight by a medical practitioner such as an NP or PA required > 2 times per week;
   c. Interdisciplinary and goal oriented treatment by professional nursing, social worker, or case manager, and rehab therapists with specialized training, education and/or certification;
   d. Treatment plan developed within 2 days of admission;
   e. Daily documentation of treatment and response to interventions with progress toward meeting goals documented at lease weekly or more frequently;

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f. Medical specialty consultative services, pharmacy and diagnostic services available.

E. *Sub-Acute Setting (Short-Term) – Level of Care 5 Complex, all of the following:*
   1. The patient requires medical and rehab services in a subacute setting for short-term care, for more medically complex conditions, including but not limited to, high cost drugs, bariatric patient care requiring equipment rentals (such as beds, tables, etc.), Guillian Barre syndrome, ventilator dependent patients, catastrophic multiple trauma, severe head injury, etc.;
   2. Patient status meets all of the following:
      a. Medically stable with medical or surgical comorbidities manageable and not requiring acute medical attention;
      b. Requires care that is directly related and reasonable for the presenting condition and/or illness;
      c. Expected improvement from medical and rehab intervention within a reasonable and predictable period of time;
      d. Patients who require rehabilitative services must exhibit a decline in physical function (compared to prior level of function) in order for the rehab services to be considered medically appropriate. Prior level of function can include: independent, modified independent in the community, supervised or minimum assistance in the community with caregiver support, or long-term resident;
   3. Program requirements meet all of the following:
      a. Skilled nursing at least 4-5 hours per day and/or skilled therapy up to 4 hours per day at least 5 days per week;
      b. Assessment and oversight by a medical practitioner such as an NP or PA required > 2 times per week;
      c. Interdisciplinary and goal oriented treatment by professional nursing, social worker, or case manager, and rehab therapists with specialized training, education and/or certification;
      d. Treatment plan developed within 2 days of admission;
      e. Daily documentation of treatment and response to interventions with progress toward meeting goals documented at lease weekly or more frequently;
      f. Medical specialty consultative services, pharmacy and diagnostic services available.

^High Cost Drug List

Adempas	Cuprimine	Gamunex-C
Advate	Daklinza	Gattex
Afinitor	Daraprim	Glassia
Aldurazyme	Dificid	Gleevec
Apokyn	Disperz	Harvoni
Aralast NP	Elaprase	Herceptin
Avastin	Eloctate	Hetlioz
Benefix	Erivedge	HP Acthar
Bexarotene	Esbriet	Humira Pen (Crohn's Disease)
Bosulif	Exjade	Ibrance
Advate	Farydak	Iclusig
Cimzia Starter Kit	Ferriprox	Ilaris
Cinryze	Firazyr	Imbruvica
Cubicin	Gammagard Liquid	Increlex

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Inlyta	Opsumit	Targretin
Jadenu	Pomalyst	Tasinga
Jakafi	Privigen	Tetrabenazine
Juxtapid	Procysbi	Thalomid
Kalydeco	Prolastin-C	Thiola
Kuvan	Promacta	Tobi Podhaler
Lazanda	Ravicti	Tyvaso Refill
Lenvima (24 mg Daily Dose)	Revlimid	Valchlor
Letairis	Rituxan	Velcade
Linezolid	Sabril	Viekira Pak
Leukine	Samsca	Votrient
Lynparza	Serostim	Vpriv
Mekinist	Simponi	Xalkori
Myalept	Soliris	Xenazine
Naglazyme	Sovaldi	Xtandi
Neulasta	Sprycel	Xyrem
Neupogen	Stelara	Zelboraf
Nexavar	Stivarga	Zemaira
Ofez	Subsys	Zolinza
Olysio	Supprelin LA	Zydelig
Opdivo	Sutent	Zykadia
Orenitram	Syprine	Zytiga
Orkambi	Tafinlar	Zyvox

II. It is the policy of health plans affiliated with Centene Corporation that the need for and length of stay (LOS) in a SNF is dependent upon a member/enrollee's medical condition, type, amount, and frequency of skilled nursing services provided. Members/enrollees may receive medically necessary services in a less intensive care setting (outpatient or home therapy services) and admission to a skilled nursing facility is **not medically necessary** when any of the following apply:[6]

B. Ambulatory/mobile for household distances (50-70 feet or more) with less than minimal assistance, and is capable of performing activities of daily living with less than minimal assistance (the need for some minimal or contact guard assistance is not, in itself, a reason for admission or continued stay in a skilled nursing facility);

C. In need of only custodial care. Custodial care is comprised of services and supplies, including room and board and other facility services, which are provided to the patient, whether disabled or not, primarily to assist him or her in the activities of daily living rather than to provide therapeutic treatment. Custodial care includes but is not limited to help in walking, bathing, dressing, feeding, preparation of special diets, supervision over self-administration of medications and other activities that can be safely and adequately provided by persons without the technical skills of a covered health care provider (nurse). Such services and supplies are custodial without regard to the provider prescribing or providing the services.

D. In need of maintenance programs 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,

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family, or caregivers have been taught the nursing services and have demonstrated the skills and ability to carry out the plan of care.

III. It is the policy of health plans affiliated with Centene Corporation that medical director review is required for requests for SNF admissions for the following groups of high readmission risk members/enrollees:[6]
- A. History of sepsis admission and less than minimal assistance is required, such as contact guard or supervision;
- B. Unilateral knee replacement surgery (major joint replacement) and no active co-morbidities;
- C. Members/enrollees only receiving intravenous or total parenteral nutrition (TPN) or hyperalimentation (TPN);
- D. Multiple SNF admissions in past 90 days;
- E. Any description of maximal assistance (MaxA), dependent transfers or ADLs; or total assistance, minimal assistance (MinA) and a member/enrollee's current functional status at their baseline/prior level of function, or contact guard assistance (CGA), stand-by assist (SBA), modified independent (Mod I), or supervison (SPV);
- F. Amputation status surgery with previous level of function (PLOF) determined to be a custodial nature due to lower functional status or who could benefit equally from home health, physical therapy (PT), or occupational therapy (OT).

IV. It is the policy of health plans affiliated with Centene Corporation that **medical director review** for requests for skilled nursing facility continued stays are required for the following groups of high readmission risk members/enrollees:[6]
- A. Services do not meet the medically necessary criteria;
- B. A member's/enrollee's condition has changed such that skilled medical or rehabilitative care is no longer needed;
- C. Member/enrollee refuses to participate in the recommended treatment plan;
- D. Member's/enrollee's care is or has become custodial;
- E. Services are provided by a family member/enrollee or another non-medical person. When a service can be safely and effectively self-administered or performed by the average non-medical person without the direct supervision of a nurse, the service cannot be regarded as a skilled service.

V. It is the policy of health plans affiliated with Centene Corporation that skilled nursing facility continued stay is only is **medically necessary** when skilled nursing services are needed on a dialy basis. Examples of non-covered services for (SNF) include any of the following:[6]
- A. Nonskilled care – member/enrollee takes oral medications, needs assistance with daily activities and general supportive services that do not require the skills of a licensed provider to perform the service or to manage a member's/enrollee's care.
- B. Observation and management of care plan - no significant change.
- C. Observation and management of care plan - condition improved.
- D. Therapy services for overall fitness and well-being. (Skilled therapy is physical therapy, occupational therapy, and/or speech-language pathology.)
- E. Therapy to maintain function after a maintenance program has been established.
- F. Skilled rehabilitation services not received daily - no skilled nursing.

VI. It is the policy of health plans affiliated with Centene Corporation that in order for inpatient rehabilitation facility (IRF) care to be considered reasonable and necessary, the documentation in the patient's IRF medical record (which must include the preadmission screening) must demonstrate a reasonable expectation that the following criteria were met at the time of admission to the IRF. IRF admission is considered **medically necessary** when all of the following are met:[7]

A. The member/enrollee must require the active and ongoing therapeutic intervention of more than one therapy discipline (physical therapy, occupational therapy, speech-language pathology, and/or prosthetics/orthotics), with one of which being physical or occupational therapy;

B. The member/enrollee must generally require an intensive rehabilitation therapy program. Under current industry standards, this intensive rehabilitation therapy program generally consists of at least 3 hours of therapy per day at least 5 days per week. In certain well-documented cases, this intensive rehabilitation therapy program might instead consist of at least 15 hours of intensive rehabilitation therapy within a 7 consecutive day period, beginning with the date of admission to the IRF;**

** 110.2.2 - Intensive Level of Rehabilitation Services. A primary distinction between the IRF environment and other rehabilitation settings is the intensity of rehabilitation therapy services provided in an IRF. For this reason, the information in the patient's IRF medical record (especially the required documentation described in section 110.1) must document a reasonable expectation that at the time of admission to the IRF the patient generally required the intensive rehabilitation therapy services that are uniquely provided in IRFs.

C. The member/enrollee must reasonably be expected to actively participate in, and benefit significantly from, the intensive rehabilitation therapy program at the time of admission to the IRF. The member/enrollee can only be expected to benefit significantly from the intensive rehabilitation therapy program if the patient's condition and functional status are such that the patient can reasonably be expected to make measurable improvement (that will be of practical value to improve the member's/enrollee's functional capacity or adaptation to impairments) as a result of the rehabilitation treatment, and if such improvement can be expected to be made within a prescribed period of time. The member/enrollee need not be expected to achieve complete independence in the domain of self-care nor be expected to return to his or her prior level of functioning in order to meet this standard;^^

^^ 110.3 - Definition of Measurable Improvement. A patient can only be expected to benefit significantly from an intensive rehabilitation therapy program provided in an IRF, as required in section 110.2.3, if the patient's IRF medical record indicates a reasonable expectation that a measurable, practical improvement in the patient's functional condition can be accomplished within a predetermined and reasonable period of time. In general, the goal of IRF treatment is to enable the patient's safe return to the home or community-based environment upon discharge from the IRF. The patient's IRF medical record is expected to indicate both the nature and degree of expected improvement and the expected length of time to achieve the improvement.

D. The member/enrollee must require physician supervision by a rehabilitation physician, defined as a licensed physician with specialized training and experience in inpatient rehabilitation. The requirement for medical supervision means that the rehabilitation physician must conduct face-to-face visits with the patient at least 3 days per week throughout the patient's stay in the IRF to assess the patient both medically and functionally, as well as to modify the course of treatment as needed to maximize the patient's capacity to benefit from the rehabilitation process;

E. The member/enrollee must require an intensive and coordinated interdisciplinary approach to providing rehabilitation.##
110.2.5 - Interdisciplinary team approach to the delivery of care. An IRF stay will only be considered reasonable and necessary if at the time of admission to the IRF the documentation in the patient's IRF medical record indicates a reasonable expectation that the complexity of the patient's nursing, medical management, and rehabilitation needs requires an inpatient stay and an interdisciplinary team approach to the delivery of rehabilitation care.
Interdisciplinary services are those provided by a treatment team in which all of its members/enrollees participate in a coordinated effort to benefit the patient and the patient's significant others and caregivers. Interdisciplinary services, by definition, cannot be provided by only one discipline. Though individual members/enrollees of the interdisciplinary team work within their own scopes of practice, each professional is also expected to coordinate his or her efforts with team members/enrollees of other specialties, as well as with the patient and the patient's significant others and caregivers. The purpose of the interdisciplinary team is to foster frequent, structured, and documented communication among disciplines to establish, prioritize, and achieve treatment goals.
At a minimum, the interdisciplinary team must document participation by professionals from each of the following disciplines:
    - A rehabilitation physician with specialized training and experience in rehabilitation services;
    - A registered nurse with specialized training or experience in rehabilitation;
    - A social worker or a case manager (or both); and
    - A licensed or certified therapist from each therapy discipline involved in treating the patient.

The required therapy treatments must begin within 36 hours from midnight of the day of admission to the IRF. Therapy evaluations constitute the beginning of the required therapy services.

VII. It is the policy of health plans affiliated with Centene Corporation that inpatient rehab facility care is **not medically necessary** for the following indications:[7]

A. As an alternative to completion of the full course of treatment in the referring hospital. Any member/enrollee who has not yet completed the full course of treatment in the referring hospital must remain in the referring hospital, with appropriate rehabilitative treatment provided, until they have completed the full course of treatment.
B. "Trial" IRF admissions, during which a member/enrollee is admitted to an IRF for 3 to 10 days to assess whether or not the member/enrollee would benefit significantly from treatment in the IRF setting, is not considered reasonable and necessary.
C. Any member/enrollee requiring only one discipline of therapy.

VIII. It is the policy of health plans affiliated with Centene Corporation that admission to a long term acute care facility is **medically necessary** when one of the following criteria are met:

A. Medically Complex. There are few indications that may be medically necessary for LTAC, such as short-bowel syndrome or where continuous suction is not available in SNF or INR, severe pancreatitis, malignancy complications in patients who are not receiving palliative or hospice services, dialysis that cannot be provided in a SNF. Other indications such as CHF, inflammatory bowel disease (IBD), End-Stage Renal Disease (ESRD), recent CNS injury

(stroke, SCI or TBI) or hematological disorders can most likely be treated in an alternative level of care (ALOC);

B. Acute respiratory failure (respiratory complex). The top diagnoses include pulmonary edema, acute CHF, COPD and other respiratory conditions. Appropriate conditions include chest tube management, failure of ALOC: such as Requiring trial and initiation of NIPPV , Failed home NIPPV management and adjustment required, Nocturnal ventilation prior to admission requiring increased reliance on mechanical ventilation or NIPPV support, OXYGEN > 50%;
C. Ventilator Weaning. In order to consider as medically necessary for LTAC for ventilator weaning, 3 failed attempts at weaning are required as an inpatient for at least 2 weeks for ventilator patients who are expected to require prolonged mechanical ventilation (PMV). The definition of PMV is 21 days of mechanical ventilation for at least 6 hours per day (CMS definition). Patients who are being considered for ventilation weaning must have a formal evaluation of their clinical appropriateness prior to a trial of weaning. For example, patients with a fixed obstruction of their airway due to a malignancy may not be expected to wean and would not be appropriate for LTAC; long-term ventilator patients who have been admitted to the hospital for an acute illness would also not be considered as medically necessary for LTAC. Weaning period begins after intubation & mechanical ventilation as well as tracheostomy insertion & ventilation;
D. Wound Care. This includes (but is not limited to) complex wound care. The following wound scenarios would be appropriate for medically necessary LTAC admissions:
    i. Necrotic wounds requiring multiple and aggressive surgical excisions or debridements (e.g., post-fasciotomies);
    ii. Large wound or skin conditions such as affecting > 15 % BSA.

IX. It is the policy of health plans affiliated with Centene Corporation that the following conditions can typically be treated in a SNF and are **not considered medically necessary** for LTAC admissions:

A. COPD with great than 2 readmissions in the last 6 months;
B. A respiratory condition requiring nebulizer treatments every 4 hours;
C. Simple hypoxia on room air (o2 saturations 85%-91%);
D. Most wound care can be treated at a SNF including:
    i. Wounds with extensive undermining or tunneling;
    ii. Chronic non-healing or open surgical wounds;
    iii. Wound vacuum assisted devices (wound VAC) for stage IV wounds;
    iv. Pre-op optimization;
    v. Wounds on the perineal, ischial or coccyx with incontinence;
    vi. Lower extremity wounds including;
    vii. Post skin flap or graft;
    viii. Recalcitrant wounds;
    ix. Post skin flap or graft.

Background

One in five Medicare beneficiaries is readmitted to the hospital within 30 days of discharge. The 90-day readmission rate for skilled nursing facilities (SNF) and Acute Inpatient Rehabilitation Facilities (IRF) are largely equivalent. Skilled nursing facilities (SNFs) represent the most common setting for post-acute care in the United States. Rates of readmission from SNFs are high. One in four patients discharged to a SNF is readmitted within 30 days[4] and two-thirds of

these readmissions may be preventable.[5] Hence, preventing readmissions is a goal that aligns with CMS expectations that readmissions are an event that can be preventable.

Skilled Nursing Facility (SNF)[6]
A skilled nursing facility (SNF) is an institution (or part of an institution) licensed under state laws and whose primary focus is to provide skilled nursing care and related services for residents requiring medical or nursing care. A SNF may also be a place of rehabilitation services for injured, disabled, or sick members/enrollees. The following information is a synopsis from the Medicare Benefit Policy Manual. For complete guidance please click here.

Skilled nursing and/or skilled rehabilitation services are services, furnished in accordance physician orders, that:

A. 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,
B. 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.

In order for a nursing service to be considered a "skilled service" it must be a service that it can only be safely and effectively performed by, or under the supervision of, a registered nurse or, when provided by regulation, a licensed practical nurse. If all other requirements for coverage under the SNF benefit are met, skilled nursing services are covered when an individualized assessment of the patient's clinical condition demonstrates that the specialized judgment, knowledge, and skills of a registered nurse or, when provided by regulation, a licensed practical nurse are necessary. Skilled nursing services are covered where such skilled nursing services are necessary to maintain the patient's current condition or prevent or slow further deterioration so long as the beneficiary requires skilled care for the services to be safely and effectively provided, and all other requirements for coverage under the SNF benefit are met. Coverage does not depend on the presence or absence of an individual's potential for improvement from nursing care, but rather on the beneficiary's need for skilled care.

A condition that would not ordinarily require skilled nursing services may still require skilled nursing under certain circumstances. In such instances, skilled nursing care is necessary only when:

A. the particular patient'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,
B. 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.

A service is not considered a skilled nursing service merely because it is performed by or under the direct supervision of a nurse.

The Medicare law provides for up to 100 days of coverage per benefit period. The benefit period tracks how many days of SNF benefits have been used, and how many are still available. A

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benefit period begins on the day a member/enrollee starts using hospital or SNF benefits under Part A of Medicare. A member/enrollee can get up to 100 days of SNF coverage in a benefit period. Once those 100 days are used, the member's/enrollee's current benefit period must end before they can renew SNF benefits. A benefit period ends:

- When a member/enrollee has not been in a SNF or a hospital for at least 60 days in a row; or,
- If a member/enrollee remains in a SNF when they have not received skilled care there for at least 60 days in a row.

Continued authorization for skilled nursing services will require updated clinical documentation and evidence of ongoing medical necessity or minimal improvement or plateauing of needs as determined by functional status and ability to perform activities of daily living (ADLs).

Inpatient Rehabilitation Facility (IRF)[7]
The following information is a synopsis from the Medicare Benefit Policy Manual.

Inpatient rehabilitation facility services include intense, multidisciplinary programs and rehabilitation therapies in an inpatient rehab hospital setting for patients who are medically complex and have multiple rehab needs. Although an IRF can provide medical management, a patient must complete their full inpatient hospital course of treatment before being appropriate for IRF care. Because of the intensity of the rehabilitation program patients must be able to fully participate and be expected to benefit from services before being transferred. An IRF stay will only be considered reasonable and necessary if, at the time of admission to the IRF, the documentation in the patient's IRF medical record indicates a reasonable expectation that the complexity of the patient's nursing, medical management and rehabilitation needs require an inpatient stay and an interdisciplinary team approach for their rehabilitation care. The general goal of IRF treatment is to enable the patient's safe return to the home or community-based environment upon discharge from the IRF. This goal does not require the patient to achieve complete independence in self-care or to return to his or her prior level of functioning in order to be considered successful.

Within 48 hours of being admitted to an IRF a patient must have a full pre-admission screening and medical evaluation. The preadmission screening must document the patient's prior level of function, expected level of improvement, and the expected length of time necessary to achieve that level of improvement. It must also include an evaluation of the patient's risk for clinical complications, the conditions that caused the need for rehabilitation, the treatments needed, expected frequency and duration of treatment in the IRF, anticipated discharge destination, any anticipated post-discharge treatments and other information relevant to the care needs of the patient.

Once the patient has arrived at the IRF they must have a full post-admission physician evaluation by a rehabilitation physician. The post-admission evaluation must be completed within 24 hours of the patient arriving and must document the patient's status upon admission to the IRF. The purpose of the post-admission evaluation is to compare the patient's pre-admission status with their post-admission status and note any significant changes. The post-admission evaluation will

also allow the physician to begin development of their care plan and expected course of treatment. A primary difference between IRF and other rehab settings is the interdisciplinary approach to rehabilitation. Therefore, a patient requiring only one discipline would not be appropriate for this type of care. Because of this approach, care planning is completed with input from all of the interdisciplinary team members/enrollees who will be involved in the patient's care.

The care plan must include the patient's medical prognosis and the anticipated interventions, functional outcomes, and patient's discharge plan and destination once they have completed their stay at the IRF. Interventions must include the number of hours per day, number of days per week, and total days in the IRF in which the patient is expected to participate in physical, occupational, speech-language pathology, and/or prosthetic/orthotic therapies. The interventions must also take into account the patient's impairments, functional status, comorbidities, and any other contributing factors. The patient's care plan must be completed within the first 4 days of their IRF admission and must support the decision that IRF admission is reasonable and necessary.

Another major difference between rehabilitation services performed in an IRF and any other setting is the intensity, or time spent, on rehab and therapy services. In general, the patient is expected to participate in intensive therapies for at least 3 hours per day at least 5 days per week. However, the patient could also meet the required therapy participation time by doing at least 15 hours of therapy per week over the course of a 7 consecutive day period as long as the reasons for the patient's need for this program of intensive rehabilitation are well-documented and the overall amount of therapy can reasonably be expected to benefit the patient. Many patients will benefit from more than the minimum required therapy hours. The intensity of therapy must be reasonable and must never exceed the patient's level of need or tolerance, or compromise their safety. Therapy treatments must begin within 36 hours from midnight of the day of the patient's admission to the IRF. Therapy evaluations constitute the beginning of the required therapy services.

Inpatient rehabilitation facilities provide a high level of physician involvement. While admitted to an IRF a patient will have a face to visit with their rehabilitation physician at least 3 times per week. These frequent face-to-face visits allow for the patient to have their progress as well as their medical and functional status assessed as well as to modify the course of treatment as needed to maximize the patient's capacity to benefit from the rehabilitation process.

An IRF operates with an interdisciplinary approach and at minimum a team must consist of a rehabilitation physician, a registered nurse with training in rehabilitation, a social worker or case manager and a licensed or certified therapist from each discipline involved in treating the patient. Each member/enrollee of the team works within their own scopes of practice and is expected to coordinate his or her efforts with team members/enrollees of other specialties, as well as with the patient and the patient's significant others and caregivers. The purpose of the interdisciplinary team is to foster frequent, structured, and documented communication among disciplines to establish, prioritize, and achieve treatment goals.

Each patient's interdisciplinary care team must hold a minimum of one care planning meeting per week. The meetings will focus on assessing progress toward rehab goals, considering resolutions to problems encountered in reaching the goals, reassessing previously established goals and monitoring and revising the treatment plan as necessary. The interdisciplinary team is led by the rehabilitation physician who ultimately is responsible for making the final decisions in the patient's plan of care.

Since discharge planning is an integral part of any rehabilitation program, planning must begin upon the patient's admission to the IRF. An extended period of time in the IRF is not considered reasonable or necessary once the patient has met established goals and it has been determined that any further progress is unlikely. To justify a continued need for an IRF stay, the documentation in the IRF medical record must show the patient's ongoing need for an intense level of rehab services and an interdisciplinary approach to care. Further, the IRF medical record must also demonstrate the patient is making functional improvements that are ongoing and sustainable, as well as of practical value. During most IRF stays the emphasis of therapies generally shifts from traditional, patient-centered therapeutic services to patient/caregiver education, durable medical equipment training, and other functional therapies that prepare the patient for a safe discharge to the home or community-based environment.

Long Term Acute Care (LTAC)
Long Term Acute Care (LTAC) facilities specialize in the care and rehabilitation of medically complex patients with a prolonged anticipated length of stay. Common medical problems of patients requiring LTAC care are those on ventilators and those with severe pulmonary disease and patients with skin problems or wounds complicated by secondary diagnoses. LTAC care can also be appropriate for certain patients with severe traumatic brain injuries and some cases of pre and post organ transplant patients.[8]

Coding Implications
This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2020, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CMS DATA: SNF PER DIEM PPS
The Balanced Budget Act of 1997 mandates the implementation of a **per diem** prospective payment system (PPS) for skilled nursing facilities (SNFs) covering **all** costs (routine, ancillary and capital) related to the services furnished to beneficiaries under Part A of the Medicare program.

SNF Consolidated Billing requirements
Congress then enacted the Balanced Budget Act of 1997 (BBA), Public Law 105-33, Section 4432(b), and it contains a Consolidated Billing (CB) requirement for SNFs. Under the CB

requirement, **an SNF itself must submit all Medicare claims for the services that its residents receive** (except for specifically excluded services below).

Excluded Services
There are a number of services that are excluded from SNF CB. These services are outside the PPS bundle, and they remain separately billable to Part B when furnished to an SNF resident by an outside supplier. However, bills for these excluded services, when furnished to SNF residents, must contain the SNF's Medicare provider number. Services that are categorically excluded from SNF CB are the following:

- Physicians' services furnished to SNF residents. These services are not subject to CB and, thus, are still billed separately to the Part B carrier.
    - Many physician services include both a professional and a technical component, and the technical component is subject to CB. **The technical component of physician services must be billed to and reimbursed by the SNF**.
    - Section 1888(e)(2)(A)(ii) of the Social Security Act specifies that **physical, occupational, and speech-language therapy services are subject to CB**, regardless of whether they are furnished by (or under the supervision of) a physician or other health care professional.
- Physician assistants working under a physician's supervision;
- Nurse practitioners and clinical nurse specialists working in collaboration with a physician;
- Certified nurse-midwives;
- Qualified psychologists;
- Certified registered nurse anesthetists;
- Services described in Section 1861(s)(2)(F) of the Social Security Act (i.e., Part B coverage of home dialysis supplies and equipment, self-care home dialysis support services, and institutional dialysis services and supplies);
- Services described in Section 1861(s)(2)(O) of the Social Security Act, i.e., Part B coverage of Epoetin Alfa (EPO, trade name Epogen) for certain dialysis patients. Note: Darbepoetin Alfa (DPA, trade name Aranesp) is now excluded on the same basis as EPO;
- Hospice care related to a resident's terminal condition;
- An ambulance trip that conveys a beneficiary to the SNF for the initial admission, or from the SNF following a final discharge.

CPT®* Codes	Description
99304	Initial nursing facility care, per day, for the evaluation and management of a patient, which requires these 3 key components: A detailed or comprehensive history; A detailed or comprehensive examination; and Medical decision making that is straightforward or of low complexity.
99305	Initial nursing facility care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity.

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CPT®* Codes	Description
99306	Initial nursing facility care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity.
99307	Subsequent nursing facility care, per day for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A problem focused interval history; A problem focused examination; Straightforward medical decision making.
99308	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of low complexity.
99309	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of moderate complexity.
99310	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A comprehensive interval history; A comprehensive examination; Medical decision making of high complexity.
99315	Nursing facility discharge day management; 30 minutes or less
99316	Nursing facility discharge day management; more than 30 minutes
99318	Evaluation and management of patient involving an annual nursing facility assessment, which requires these 3 key components: A detailed interval history; A comprehensive examination; and medical decision making that is of low to moderate complexity.
92507	Individual Treatment of speech, language, voice, communication, and/or auditory processing disorder
92508	Group, 2 or more - Treatment of speech, language, voice, communication, and/or auditory processing disorder
92521	Evaluation of speech fluency (eg, stuttering, cluttering)
92522	Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria);
92523	Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria); with evaluation of language comprehension and expression (eg, receptive and expressive language)
92524	Behavioral and qualitative analysis of voice and resonance
92526	Treatment of swallowing dysfunction and/or oral function for feeding
92597	Evaluation for use and or fitting of voice prosthetic device to supplement oral speech
92609	Therapeutic services for the use of speech-generating device including programming and modification
97161	Physical therapy evaluation: low complexity
97162	Physical therapy evaluation: moderate complexity
97163	Physical therapy evaluation: high complexity
97164	Re-evaluation of physical therapy established plan of care

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CPT®* Codes	Description
91765	Occupational therapy evaluation, low complexity
97166	Occupational therapy evaluation, moderate complexity
97167	Occupational therapy evaluation, high complexity
97168	Re-evaluation of occupational therapy established plan of care
97532	Development of cognitive skills to improve attention, memory, problem solving (includes compensatory training), direct (one-on-one) patient contact, each 15 minutes
97533	Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one to one) patient contact by the provider, each 15 minutes
97535	Self-care/home management training (eg, activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact by provider, each 15 minutes
97537	Community/work integration training (eg, shopping, transportation, money management, avocational activities and/or work environment/modification analysis, work task analysis, use of assistive technology device/adaptive equipment), direct one-on-one contact by provider, each 15 minutes
97542	Wheelchair management (eg, assessment, fitting, training), each 15 minutes
97760	Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(s), lower extremity(s) and/or trunk, each 15 minutes
97761	Prosthetic training, upper and/or lower extremity(s), each 15 minutes
97762	Checkout for orthotic/prosthetic use, established patient, each 15 minutes

Reviews, Revisions, and Approvals	Date	Approval Date
Original approval date	11/15	11/15
Approved by MPC. Added Covered Services Summary and section on High Cost Drugs	01/16	01/16
Approved by MPC. Clarified coverage language	04/16	04/16
Approved by MPC. Inclusion of note in Coding section re: non-coverage of codes for Nebraska.	01/17	01/17
Approved by MPC. Clarified NE verbiage and coding	09/17	09/17
Approved by MPC. Removed “Rehabilitation” from title; updated CMS language, leveling included for every SNF review.	11/17	11/17
Approved by MPC. Included information on RUG scoring.	12/17	12/17
Approved by MPC. Kentucky Medicare included in the policy as it was previously omitted.	02/18	02/18
Approved by MPC. No changes.	02/19	02/19
Approved by MPC. Removed ADL scoring; leveling medical necessity criteria; and codes (HIPPS, RUG-IV, Nebraska).	09/19	09/19
Approved by CPC. No changes.	08/20	08/20

Reviews, Revisions, and Approvals	Date	Approval Date
Transitioned to Centene policy template from HS-311. Minor rewording without clinical significance. Included plan of care criteria already included in continued stay section in section E. of "intial admission." Updated SNF exclusion to read, "Ambulatory/mobile for household distances (50-70 feet or more)", previously ready "70 feet". Replaced all instances of "member" with "member/enrollee."	12/20	12/20

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Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

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This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

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Note: For Medicaid members/enrollees, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members/enrollees, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.

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