Clinical Policy: Skilled Nursing Facility Leveling

Reference Number: CP.MP.206
Date of Last Revision: 08/22

Coding Implications
Revision Log

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

Description
Criteria for skilled nursing facility (SNF) levels of care, to be used *in conjunction with general SNF placement criteria in InterQual®.*

Note: *For post-acute care leveling (used for plans without InterQual criteria), see CP.MP.213 Post-Acute Care.*

Policy/Criteria

I. It is the policy of health plans affiliated with Centene Corporation® that the following skilled nursing facility levels of care, for facilities contracted for levels 1 through 4, are **medically necessary** when the applicable criteria are met in A through C:

A. Patient status meets all of the following:
   1. Medically stable with medical or surgical comorbidities manageable and not requiring acute medical attention;
   2. Requires care that is directly related and reasonable for the presenting condition and/or illness;
   3. There is expected improvement from medical and/or rehab intervention (or end-stage disease) within a reasonable and predictable period of time;
   4. 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 independent in the community, supervised in the community or minimum/moderate/maximum/total assistance in the community with caregiver support, or long-term resident.

B. Program requirements meet all of the following:
   1. Assessment and oversight by a medical practitioner such as a doctor, nurse practitioner (NP) or physician assistant (PA) required > 1 time per week;
   2. Interdisciplinary and goal-oriented treatment by professional nursing, social worker, or case manager, and/or rehab therapists with specialized training, education and/or certification;
   3. Treatment plan developed within 2 days of admission;
   4. Daily documentation of treatment and response to interventions with progress toward meeting goals documented at least weekly or more frequently;
   5. Medical specialty consultative service, pharmacy and diagnostic services available.

C. Skilled nursing facility level of care meets one of the following:
   1. *Level of Care 1 (Rev Code 191) - Skilled Nursing Services Requirements:* Skilled nursing up to 4 hours per day, 7 days per week, or skilled therapy 1 to 2 hours per day, at least 5 days per week;

Examples of conditions and treatments appropriate to Level 1 include, but are not limited to: nebulizer treatments; stable tracheostomy maintenance and suctioning, tube feedings or percutaneous endoscopic gastrostomy (PEG) tubes; simple wound care for healing surgical wounds, cellulitis not requiring debridement, or more than two dressing changes or topical antibiotic treatments per day; intramuscular or subcutaneous injections and in and out catheterizations.

2. *Level of Care 2 (Rev Code 192)- Comprehensive Care Services Requirements:* Skilled nursing at least 4 hours per day, 7 days per week, or skilled therapy for at least 2 hours per day, at least 5 days per week.
   Examples of conditions and treatments appropriate to Level 2 include, but are not limited to: negative pressure wound therapy; open wounds and up to Stage III decubiti; new tracheotomy requiring suctioning and site care, but not ventilator dependent; IV therapy for hydration; oxygen use and treatments for multiple medical complexities.

3. *Level of Care 3 Complex (Rev Code 193) - Medical/Surgical Sub-Acute Care Services Requirements:* Skilled nursing for more than 4 hours per day, 7 days per week, and skilled therapy for at least 3 hours per day, at least 5 days per week;
   Examples of conditions and treatments appropriate to Level 3 include, but are not limited to: combination IV antibiotic therapy; initiation or adjustment of parenteral anticoagulant therapy; orthopedic cases; total parenteral nutrition (TPN) administration; spinal or pelvic fractures; completed transient ischemic attack (TIA)/cerebrovascular accident (CVA) care; congestive heart failure requiring IV medication; urosepsis, respiratory disease requiring high flow oxygen treatment, arterial blood gas oximetry, tracheostomy tube changes and postural drainage and percussion.

4. *Level of Care 4 (Rev Code 194) – Intensive Care Services Requirements, both of the following:*
   a. Skilled nursing for more than 4 hours per day, 7 days per week;
   b. Patient requires Level 4 – Intensive Care Services due to one of the following high acuity needs:
      i. Catastrophic multiple traumas;
      ii. Severe head injury or CVA;
      iii. Stabilized spinal cord injury;
      iv. Weanable and non-weanable ventilator dependent patients.

II. It is the policy of health plans affiliated with Centene Corporation that the following skilled nursing facility levels of care, for facilities contracted for levels 1 through 5, are **medically necessary** when the criteria in A through C are met:

A. Patient status meets all of the following:
   1. Medically stable with medical or surgical comorbidities manageable and not requiring acute medical attention;

2. Requires care that is directly related and reasonable for the presenting condition and/or illness;
3. There is expected improvement from medical and/or rehab intervention (or end-stage disease) within a reasonable and predictable period of time;
4. 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 independent in the community, supervised in the community, or minimum/moderate/maximum/total assistance in the community with caregiver support, or long-term resident.

B. Program requirements meet all of the following:
   1. Assessment and oversight by a medical practitioner such as a doctor, nurse practitioner (NP) or physician assistant (PA) required > 1 time per week;
   2. Interdisciplinary and goal-oriented treatment by professional nursing, social worker, or case manager, and/or rehab therapists with specialized training, education and/or certification;
   3. Treatment plan developed within 2 days of admission;
   4. Daily documentation of treatment and response to interventions with progress toward meeting goals documented at least weekly or more frequently;
   5. Medical specialty consultative service, pharmacy and diagnostic services available.

C. Skilled nursing facility level of care meets one of the following:
   1. *Level of Care 1 (Rev Code 191) – Skilled Nursing Services Requirements:* Skilled nursing up to 4 hours per day, 7 days per week, or skilled therapy 1 to 2 hours per day, at least 5 days per week.

      Examples of conditions and treatments appropriate to Level 1 include, but are not limited to: nebulizer treatments; stable tracheostomy maintenance and suctioning, tube feedings or PEG tubes; simple wound care for healing surgical wounds, or cellulitis not requiring debridement, or more than two dressing changes or topical antibiotic treatments per day; intramuscular or subcutaneous injections and in and out catheterizations.

   2. *Level of Care 2 (Rev Code 192) – Comprehensive Care Services Requirements:* Skilled nursing at least 4 hours per day, 7 days per week, or skilled therapy for at least 2 hours per day, at least 5 days per week.

      Examples of conditions and treatments appropriate to Level 2 include, but are not limited to: negative pressure wound therapy; open wounds and up to Stage III decubiti; new tracheotomy requiring suctioning and site care, but not ventilator dependent; IV therapy for hydration; oxygen use and treatments for multiple medical complexities.

3. *Level of Care 3 (Rev Code 193) – Medical/Surgical Services Requirements:* Skilled nursing for more than 4 hours per day, 7 days per week, and skilled therapy for at least 3 hours per day, at least 5 days per week;

   Examples of conditions and treatments appropriate to Level 3 include, but are not limited to: combination IV antibiotic therapy; initiation or adjustment of parenteral anticoagulant therapy; orthopedic cases; TPN administration; spinal or pelvic fractures; completed TIA/CVA care; congestive heart failure requiring IV medication; urosepsis, respiratory disease requiring high flow oxygen treatment, arterial blood gas oximetry, tracheostomy tube changes and postural drainage and percussion.

4. *Level of Care 4 (Rev Code 194) – Medically Complex Services Requirements:* Skilled nursing more than 4 hours per day, 7 days per week, and skilled therapy at least 3 hours per day, at least 5 days per week;

   Examples of conditions and treatments appropriate to Level 4 include, but are not limited to: bedside dialysis, severe cerebrovascular accident, severe head injury, stabilized spinal cord injuries, etc.

5. *Level of Care 5 (Rev Code 199) – Intensive Care Services Requirements:* Skilled nursing required for more than 4 hours per day, 7 days per week.

   Examples of conditions and treatments appropriate to Level 5 include, but are not limited to: more medically complex conditions, including but not limited to: high cost drugs, Guillain Barre syndrome, ventilator dependent patients, catastrophic multiple trauma, severe head injury, etc.

Background

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:

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 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.
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.

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.

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.
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.

CPT®* Codes	Description
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
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

CPT®* Codes	Description
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	Revision 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
Transitioned to Centene policy template from HS-311. Recategorized into 4 levels of care. Minor rewording without clinical significance. Removed list of high cost drugs. Removed CMS billing requirements and exclusions from background.	12/20	12/20
Added negative pressure wound therapy to I.B., "Examples of treatments appropriate to Level 2".	02/21	
Added note to refer to CP.MP.213 Post-Acute Care if IQ criteria not available. Specified that criteria I applies to facilities contracted for levels 1-4 and added criteria II, which applies to facilities contracted for levels 1-5. Condensed criteria that was the same between levels.	04/21	04/21

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Changed hourly requirements for nursing and therapy for each LOC. Updated background.		
Updated therapy requirement verbiage for SNF Level 1 from "skilled therapy for up to 2 hours per day" to "skilled therapy 1-2 hours per day." For SNF Levels 1 and 2, changed requirement from skilled nursing hours and therapy hours to skilled nursing hours or therapy hours. Changed "review date" in the header to "date of last revision" and "date" in the revision log header to "revision date."	06/21	06/21
Annual review. In I.B.1 and II.B.I, corrected list of appropriate oversight to include doctors. References reviewed and updated. Reviewed by specialist.	08/21	08/21
Added corresponding revenue codes to each level's "care requirements" section in I.C and II.C.	01/22	
Annual review completed. Added "in the community" and "moderate/maximum/total" to Section I.A.4. and II.A.4. Updated II.C.4. from 3 hours of skilled therapy per day to "at least" 3 hours of skilled therapy per day. Additional minor rewording with no clinical significance. References reviewed and updated. Specialist reviewed.	08/22	08/22

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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.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

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.