Clinical Policy: Post-Acute Care

Reference Number: CP.MP.213 Coding Implications
Date of Last Revision: 08/21 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, including 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]

Note: *This policy is to be used instead of MCG, when InterQual criteria are not available. See CP.MP.206 Skilled Nursing Facility Leveling when InterQual criteria are available.*

Policy/Criteria

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

Initial Admission and Continued Stay, 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);
B. As a practical matter, considering economy and efficiency, the daily skilled services can be provided only on an inpatient basis in a SNF;
C. 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;
D. 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 medical needs, promote recovery and ensure medical safety (in terms of the 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 as well as 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;
E. Following review for medical necessity, each approval must have a level of care documented – Continue to SNF level of care review.

Skilled Nursing Facility (SNF) Levels of Care, all A-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. There is expected improvement from medical and/or rehab intervention (or end-stage disease) within a reasonable and predictable period of time;
3. 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 or minimum 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 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 – Skilled Nursing Services Requirements:* Skilled nursing up to 4 hours per day, 7 days per week, or skilled therapy 1-2 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, 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 – 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 – 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 – Medically Complex Services Requirements:* Skilled nursing more than 4 hours per day, 7 days per week, and skilled therapy 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 – 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, more medically complex conditions, including but not limited to: high cost drugs (see list below), Guillian Barre syndrome, ventilator dependent patients, catastrophic multiple trauma, severe head injury, etc.

^High Cost Drug List

Adempas	HP Acthar	Promacta
Advate	Humira Pen (Crohn's Disease)	Ravicti
Afinitor	Ibrance	Revlimid
Aldurazyme	Iclusig	Rituxan
Apokyn	Ilaris	Sabril
Aralast NP	Imbruvica	Samsca
Avastin	Increlex	Serostim
Benefix	Inlyta	Simponi
Bexarotene	Jadenu	Soliris
Bosulif	Jakafi	Sovaldi
Advate	Juxtapid	Sprycel
Cimzia Starter Kit	Kalydeco	Stelara
Cinryze	Kuvan	Stivarga
Cubicin	Lazanda	Subsys
Cuprimine	Lenvima (24 mg Daily Dose)	Supprelin LA
Daklinza	Letairis	Sutent
Daraprim	Linezolid	Syprine
Dificid	Leukine	Tafinlar
Disperz	Lynparza	Targretin
Elaprase	Mekinist	Tasinga
Eloctate	Myalept	Tetrabenazine
Erivedge	Naglazyme	Thalomid
Esbriet	Neulasta	Thiola
Exjade	Neupogen	Tobi Podhaler
Farydak	Nexavar	Tyvaso Refill
Ferriprox	Ofez	Valchlor
Firazyr	Olysio	Velcade
Gammagard Liquid	Opdivo	Viekira Pak
Gamunex-C	Orenitram	Votrient
Gattex	Orkambi	Vpriv
Glassia	Opsumit	Xalkori
Geevec	Pomalyst	Xenazine
Hrvoni	Privigen	Xtandi
Herceptin	Procysbi	Xyrem
Hetlioz	Prolastin-C	Zelboraf

Zemaira	Zydelig	Zytiga
Zolinza	Zykadia	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 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]

A. 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);
B. 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.
C. In need of maintenance programs or care. Functional maintenance programs are drills, techniques and exercises that preserve the present level of function and prevent regression of that function. Maintenance begins when the therapeutic goals of a treatment plan have been achieved and/or when no further functional progress is apparent or expected to occur. Maintenance medical care occurs when the patient's condition is stable or predictable; the plan of care does not require a skilled nurse to be in continuous attendance; or the patient, family, or caregivers have been taught the nursing services and have demonstrated the skills and ability to carry out the plan of care.
B. The need for respiratory therapy, either by a nurse or by a respiratory therapist, does not alone qualify an individual for SNF 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 high readmission risk groups:[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. Those who are 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 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 high readmission risk groups:[6]

A. Services do not meet the medically necessary criteria;
B. Those whose condition has changed such that skilled medical or rehabilitative care is no longer needed;
C. Those who refuse to participate in the recommended treatment plan;
D. Care is or has become custodial;
E. Services are provided by a family member 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 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 their condition and functional status are such that they can reasonably be expected to make measurable improvement (that will be of practical value to improve the their 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 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 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 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.

VI. It is the policy of health plans affiliated with Centene Corporation that inpatient rehab facility (IRF) 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.

VII. 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. Respiratory Complex (acute respiratory failure). 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:
   1. Necrotic wounds requiring multiple and aggressive surgical excisions or debridements (e.g., post-fasciotomies);
   2. Large wound or skin conditions such as affecting > 15% BSA.

VIII. 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:
   1. Wounds with extensive undermining or tunneling;
   2. Chronic non-healing or open surgical wounds;
   3. Wound vacuum assisted devices (wound VAC) for stage IV wounds;
   4. Pre-op optimization;
   5. Wounds on the perineal, ischial or coccyx with incontinence;
   6. Lower extremity wounds including;
   7. Post skin flap or graft;
   8. Recalcitrant wounds;

9. 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 those who are injured, disabled, or sick. 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;
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 service is not considered a skilled nursing service merely because it is performed by or under the direct supervision of a nurse.

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 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.

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.

A major difference between rehabilitation services performed in an IRF and any other setting is the intensity, or time spent, on rehab and therapy services. The patient is expected to participate in intensive therapies for at least 3 hours per day at least 5 days per week or 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.

Inpatient rehabilitation facilities provide a high level of physician involvement. While admitted to an IRF a patient will have a face-to-face 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 patient's interdisciplinary care team must hold a minimum of one care planning meeting per week.

Since discharge planning is an integral part of any rehabilitation program, planning must begin upon admission to the IRF. 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.

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.

CPT®* Codes	Description
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.
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

CPT®* Codes	Description
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
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

Reviews, Revisions, and Approvals	Revision Date	Approval Date
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. 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
Added note to use this policy instead of MCG, if no IQ criteria are available. In section I, SNF LOC, condensed criteria that was the same between LOC. Changed hourly requirements for nursing and therapy for each LOC. Updated background.	04/21	04/21
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. Removed duplicative criteria points in criteria I. and combined initial admission criteria with ongoing stay criteria, with no impact to clinical significance. Moved respiratory therapy exclusion note from criteria I. to exclusion list in criteria II. Removed the non-medically necessary section as it was stated elsewhere. Condensed background section and removed CMS billing requirements. Reviewed by specialist. References reviewed and updated.	08/21	08/21

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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.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

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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.