

**Pediatric Skilled Nursing Facility Level of Care
 LOC-005**

Iowa Medicaid Program:	Level of Care	Effective Date:	7/1/1998
Revision Number:	7	Last Rev Date:	4/19/2024
Reviewed By:	Medicaid Medical Director	Next Rev Date:	4/18/2025
Approved By:	Medicaid Clinical Advisory Committee	Approved Date:	11/18/2020

Criteria

These criteria apply to skilled nursing facility (SNF) members or Medicaid members who are residing in their homes with skilled care needs who are 17 years of age and younger. In order for the SNF level of care to be approved, **ALL** the following conditions must be met:

1. The member must require SNF services **or** skilled rehabilitation services; **AND**
2. The member must require and receive these skilled services on a daily basis:
 - a. Nursing services (registered nurses or licensed practical nurses) must be provided 7 days a week; **AND/OR**
 - b. Therapy services (physical therapist, occupational therapists, speech pathologists, audiologists) must be provided, at a minimum, 5 days a week; **AND**
 - c. The daily skilled services cannot be provided at a lower level of care, such as an intermediate care facility; **AND**
3. Skilled services must be provided as a result of licensed practitioner’s orders and must be reasonable and necessary for the treatment of the member’s illness or injury; **AND**
4. An individualized care plan that identifies support needs; **AND**
5. Confirmation that skilled services are provided to the member; **AND**
6. The member will have at least one deficit in at least one of the nine systems/categories identified below; **AND**
7. The member must require another individual to complete the service. Cares performed by the member independently are not skilled cares; skilled cares may be performed by non-skilled persons with direct training from skilled persons only when documentation of direct supervision, refresher training, and/or review of the skilled service every 6 months by licensed skilled professionals.

Skilled services must include at least **ONE** of the following (1 through 9):

1. Musculoskeletal
 - a. Physical therapy (PT) with developmental and/or restorative goals (crawling, rolling, strengthening, gait training, transfer techniques) provided daily by or under the direction and/or supervision of a licensed physical therapist. Progress notes must be present for all encounters.
 - b. Member is ambulating assisted or supervised (with or without assistive devices) an appropriate distance, progressing according to his/her plan of care. This must be used in conjunction with ‘a.’ to qualify for skilled.

- c. PT with developmental and/or restorative goals for gross motor skills, range of motion, postural tone, and weight bearing ability is provided daily as prescribed under the direction/supervision of a licensed physical therapist. Daily progress notes must be present.
- d. Occupational therapy (OT) with developmental and/or restorative goals for coordination, fine motor skills, and self-help skills are provided daily under the direction and/or supervision of a licensed occupational therapist. Daily progress notes must be present.
- e. Hydrotherapy is provided as prescribed for the member with rheumatoid and dermatomyositis diagnosis.
- f. Member requires continuous traction (Bryant's, pelvic, sternal traction). Skin care is given at frequent intervals, pressure is relieved with sheepskin pad(s), flotation mattress, etc.
- g. Home care: OT/PT plan is in place with caregiver and/or parent providing daily services under the direction and/or supervision of an occupational and/or physical therapist. Appropriate therapist visits as established by written care plan. If this is the only criterion met, refer to physician reviewer.

2. Skin

- a. Decubitus(i) ulcer/pressure ulcer/extensive skin lesion (Stage 3 or greater) is/are present on admission requiring treatment prescribed by the attending physician. Prescription medications/dressings are applied using sterile or aseptic technique at least daily. Member is repositioned at least every 2 hours and measures to relieve pressure are utilized (sheepskin pad[s], flotation mattress, etc.). Weekly documentation should note location and size, nature and amount of drainage, inflammation, or necrosis.
- b. Postoperative wound care that requires sterile packs, sterile dressings, and/or sterile irrigations is/are provided on a daily basis. Weekly documentation should note healing process and skin status. See documentation guidelines listed for criterion "a."
- c. Member requires strict isolation due to contagious/infectious or immune deficiency disease or susceptibility. Professional monitoring and evaluation for prevention of cross contamination is necessary.
- d. Decubitus(i) ulcer/pressure ulcer/extensive skin lesion (Stage 3 or greater) developed after admission to this setting requiring treatment prescribed by the attending physician. Prescription medications and/or sterile dressings are applied using sterile technique at least daily. Member is repositioned at least every 2 hours and measures to relieve pressure are utilized (sheepskin pad[s], flotation mattress, etc.). Weekly documentation should note location and size, nature and amount of drainage, inflammation, or necrosis.
- e. Member has severe physical limitations/deformities requiring position changes and nursing assessment every 1 to 2 hours. Member is repositioned at least every 2 hours and measures to relieve pressure are utilized (sheepskin pad[s], flotation mattress, etc.). If this is the only criterion met, refer to physician reviewer.
- f. Dressings are applied to infected wounds by professional staff involving prescription medications and/or aseptic or sterile technique.
- g. Home care: Caregiver and/or parent is providing services as ordered by the attending physician.

3. Respiratory Status

- a. Nasopharyngeal and/or tracheostomy suctioning by licensed professional staff is provided at least daily validated by nurse's notes.
- b. Ventilator support is required on an intermittent or continuous basis for maintenance of the member's respiratory status.
- c. Respiratory therapy is provided daily under the direction/supervision of a licensed professional with evaluation and consultation by a respiratory therapist at least monthly. If this is the only criterion met, refer to a physician reviewer.
- d. Member receives oxygen that requires physician monitoring and frequent blood gases at least weekly, as well as ongoing nursing monitoring of the member's response.
- e. Member exhibits apnea/bradycardia episodes that require the use of an apnea monitor and stimulation for maintenance of respiratory and/or cardiac status.
- f. Home care: Respiratory care plan is in place with caregiver and/or parent providing daily services under the direction and/or supervision of a registered nurse/respiratory therapist. Licensed professional visits as established by written care plan.

4. Elimination

- a. Member requires daily intermittent catheterization due to chronic deficit.
- b. Indwelling urethral catheter is present. Licensed professional staff provides daily perineal and catheter cares. Daily replacement and/or irrigation is ordered specifically by physician. Drainage bag is used. Evaluation of inability to bladder train or contraindication of bladder training must be present in long-term use of the indwelling catheter.
- c. Physician, nurse practitioner, or physician's assistant has ordered a program of intermittent catheterization or bowel/bladder training following a cerebrovascular accident, neurological accident, or deficit of sudden onset. Such a program must be carried out and evaluated by professional nursing staff. Review after 7 days if this is the only skilled criterion met.
- d. Daily care (irrigations and evaluation of elimination status) for member with an ostomy is provided under the direction/supervision of a licensed professional nurse.
- e. Member has chronic severe constipation requiring daily monitoring by a professional nurse. If this is the only criterion met, refer to physician reviewer.
- f. A qualified licensed nurse performs chronic ambulatory peritoneal dialysis as ordered by the physician. Not reimbursable by Medicare/Medicaid if this is the only criterion met.
- g. Suprapubic catheter is present. Daily care and evaluation are required and performed by licensed professional staff.
- h. Home care: Caregiver and/or parent is providing services as ordered by the attending physician.
- i. Colostomy/ileostomy/ileal conduit is present in early post-operative period requiring professional monitoring and evaluation in addition to daily care until stable. Physician documentation justifies need for SNF care.

5. Activities of Daily Living

- a. OT plan has been written for retraining or establishing skill patterns, services are provided daily by or under the direction/supervision of an occupational therapist. Daily progress notes must be present.
- b. OT is provided for bed activity skills (rolling, sitting, dangling, use of trapeze, reaching for bedside articles), as appropriate for age. This must be used in conjunction with 'a' to qualify for skilled.
- c. OT is provided for dressing/undressing skills, as appropriate for age. This must be used in conjunction with 'a' to qualify for skilled.
- d. OT is provided for personal hygiene skills, as appropriate for age. This must be used in conjunction with 'a' to qualify for skilled.
- e. OT is provided for hand activity skills (use of telephone, writing, use of bed signal lights, adaptive equipment, domestic skills, etc.), as appropriate for age. This must be used in conjunction with 'a' to qualify for skilled.
- f. Member is totally dependent on nursing staff to provide all feedings. Member is confused/unresponsive, totally involuntary of bowel function, and incontinent of urine or has indwelling catheter in place. Member's condition is not stable and needs daily assessment and evaluation by professional nursing staff.
- g. Home care: OT plan is in place with caregiver/parent providing daily service under the direction of an occupational therapist. Appropriate therapist visits as established by the written care plan.

6. Nutritional Status/Fluid Balance

- a. OT plan has been written to retrain or establish skill patterns in eating. Services are provided daily or under the direction/supervision of an occupational therapist. Daily progress notes must be present. Review for progress within 30 days. If this is the only criterion met after 30 days, refer to physician reviewer.
- b. Member is difficult to feed by mouth due to aspiration, emesis, or other substantial feeding problem requiring feeding and continuous monitoring by professional staff.
- c. Member has a fluctuating fluid and/or electrolyte status that require continuous observation and evaluation by professional staff.
- d. Member requires tube feedings including insertion and maintenance by qualified licensed nurses. Oral intake is inadequate to meet the member's nutritional needs. Intake should be documented daily. Appropriate placement of tube must be assured prior to administration of feeding. Head should be elevated.
- e. Documented plan is present to remove the nasogastric tube and reintroduce oral foods. Review for progress within 30 days. If this is the only criterion met after 30 days, refer to physician reviewer.
- f. Member receives hyperalimentation administered by qualified licensed nurse.
- g. Home care: Nutritional plan is in place with caregiver and/or parent providing nutritional needs as directed by the attending physician.
- h. Nutritional status is maintained through intravenous (IV) infusions administered by qualified licensed nurses.

7. Drug Therapy

- a. Medications are given via IV route by qualified licensed nurses; not for nutritional purposes.

- b. Medications are given via tube by qualified licensed nurses. If this is the only criterion met, refer to physician reviewer.
 - c. Intramuscular or subcutaneous excluding insulin medications are administered at least daily.
 - d. Insulin is administered that requires frequent at least daily adjustment in dosage determined by blood glucose levels as ordered by the physician. If this is the only criterion met, refer to physician reviewer.
 - e. Medications are administered that require physician monitoring and frequent lab values if appropriate, as well as ongoing professional nursing monitoring of the member's response.
 - f. Anticonvulsant blood levels and medication adjustments are required routinely and as needed (PRN), as well as ongoing nursing monitoring of the member's response. If this is the only criterion met, refer to physician reviewer.
 - g. Cardiotonic/cardiogenic/diuretic blood levels and medication adjustments are required routinely and PRN, as well as ongoing nursing monitoring of the member's response. If this is the only criterion met, refer to physician reviewer.
 - h. Home care: Caregiver and/or parent administers medications as ordered by the attending physician. If this is the only criterion met, refer to physician reviewer.
 - i. Central venous lines/ports are utilized for infusion of IV medications, chemotherapy, or blood products administered by qualified licensed nurses.
 - j. Oral medications are administered that require daily professional nursing evaluations of member's response. If this is the only criterion met, refer to physician reviewer.
 - k. Central access line/port is in place and is irrigated less than daily to maintain patency. If this is the only criterion met, refer to physician reviewer.
 - l. Continuous intrathecal narcotic infusion is provided for the terminal member with intractable pain. Member is monitored for respiratory and central nervous system depression. Care of the infusion device and catheter, as well as injection of the narcotic is performed by qualified licensed nurses.
8. Sensory – Motor
- a. Speech therapy plan has been written for retraining or establishing skills in communication. Services are provided daily by a speech therapist. Therapy must be appropriate to condition. Therapy must either be diagnostic and evaluative or therapeutic.
 - b. Home care: OT and PT plan is in place with caregiver and/or parent providing daily services under the direction/supervision of a speech therapist. Appropriate therapist visits as established by the written plan.
9. Teaching/Care Plan Management and Evaluation
- a. Individualized teaching and training programs have been initiated by licensed professionals to teach member/caregiver how to properly perform and manage his/her treatment regimen, including preventative and infection control measures.
NOTE: Reviewer should indicate the appropriate area of teaching by using 'b' – 'j' below. Review for response in 14 days. If this is the only criterion met, refer to physician reviewer.
 - b. Teaching and training activities are provided to learn general mobility/extremity function skills (transfer techniques, gait training, use and care of assistive devices, etc.).

- c. Teaching and training activities are provided to learn dressing change techniques, irrigation, or preventative skin care.
- d. Teaching and training activities are provided to learn use and care of respiratory equipment and/or self-administration of treatment (oxygen, tracheostomy care, respirator, etc.).
- e. Teaching and training activities are provided to learn care of bowel and bladder appliances and equipment or self-administration of treatment (catheterization, irrigation, stoma care, etc.).
- f. Teaching and training activities are provided to retrain or establish new skill patterns in activities of daily living.
- g. Teaching and training activities are provided to comply with prescribed diet or self-administration of tube feedings/hyperalimentation.
- h. Teaching and training activities are provided regarding medications including self-administration techniques, precautions, mechanism of action, indications, dosage, and side effects.
- i. Teaching and training activities are provided to retrain and establish new skill patterns in communication speech therapy, voice simulator, communication board, etc. Inconsistent implementation of teaching plan is evident. Advise and review in 3 days.
- j. Development, management, and evaluation of a member care plan is required and provided daily by a licensed professional to meet the member's needs, promote recovery and/or medical stability, and ensure medical safety. If this is the only criterion met, refer to physician reviewer.

Coding

NA

Compliance

1. Should conflict exist between this policy and applicable statute, the applicable statute shall supersede.
2. Federal and State law, as well as contract language, including definitions and specific contract provisions or exclusions, take precedence over medical policy and must be considered first in determining eligibility for coverage.
3. Medical technology is constantly evolving, and Iowa Medicaid reserves the right to review and update medical policy on an annual and as-needed basis.

Medical necessity guidelines have been developed for determining coverage for member benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. Criteria are revised and updated annually, or more frequently if new evidence becomes available that suggests needed revisions.

References

42 Code of Federal Regulations (CFR) 409.31(a)(1).






42 CFR 409.32.

42 CFR 409.34.

Iowa Administrative Code 441-83.

Development of utilization management criteria may also involve research into other state Medicaid programs, other payer policies, consultation with experts and review by the Medicaid Clinical Advisory Committee (CAC). These sources may not be referenced individually unless they are specifically published and are otherwise applicable to the criteria at issue.

Criteria Change History

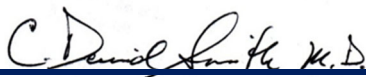
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4/19/2024	CAC	Annual review.	7
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Change Date	Changed By	Description of Change	Version
4/21/2023	CAC	Annual review.	6
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1/20/2023	CAC	Annual review.	5
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Change Date	Changed By	Description of Change	Version
1/21/2022	CAC	Annual review.	4
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Change Date	Changed By	Description of Change	Version
10/16/2020	CAC	Added criterion 4 and 5. Formatting changes.	3
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William (Bill) Jagiello, DO 			

Criteria Change History (continued)

Change Date	Changed By	Description of Change	Version
10/16/2015	Medical Director	Added criterion #4. Under #3b changed respirator to ventilator support. Removed #3e. Removed referral to physician review on #4d and #4f. Added referral to physician review to #7d and #7h. Removed #9h. Added reference addendum.	2

Signature

C. David Smith, MD



Change Date	Changed By	Description of Change	Version
10/17/2014	Medical Director	Under SNF level of care #3 changed “physician orders” to “licensed practitioner” and added #4. Before criteria listing, added “skilled services must include at least one of the following.” Grammatical and formatting changes.	1

Signature