STATE OF IOWA DEPARTMENT OF
Health AND Human
SERVICES

Skilled Level of Care
LOC-006

Iowa Medicaid Program:	Level of Care	**Effective Date:**	1/20/2012
Revision Number:	5	**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:**	5/23/2018

Descriptive Narrative

For purposes of Iowa Medicaid criteria, skilled nursing facility (SNF) level of care (LOC) is synonymous with skilled LOC. The criteria apply to all uses of this level of care across long term care settings, including nursing facilities, home and community-based services waivers, and programs for all-inclusive care of the elderly.

Criteria

To approve SNF LOC, **ALL** the following must be met:

1. The member's medical condition requires SNF services or skilled rehabilitation services as provided in 42 CFR 409.31(a), 409.32, and 409.34.

   §409.31 Level of care requirement.
   (a) *Definition.* As used in this section, *skilled nursing and skilled rehabilitation services* means services that:
   (1) Are ordered by a physician;
   (2) Require the skills of technical or professional personnel such as registered nurses, licensed practical (vocational) nurses, physical therapists, occupational therapists, and speech pathologists or audiologists; and
   (3) Are furnished directly by, or under the supervision of, such personnel.
   (b) *Specific conditions for meeting level of care requirements.*
   (1) The beneficiary must require skilled nursing or skilled rehabilitation services, or both, on a daily basis.
   (2) Those services must be furnished for a condition -
   (i) For which the beneficiary received inpatient hospital or inpatient critical access hospital (CAH) services; or
   (ii) Which arose while the beneficiary was receiving care in a SNF or swing-bed hospital for a condition for which he or she received inpatient hospital or inpatient CAH services; or
   (iii) For which, for a Medicare + Choice organization enrollee described in §409.20(c)(4), a physician has determined that a direct admission to a SNF without an inpatient hospital or inpatient CAH stay would be medically appropriate.

(3) The daily skilled services must be ones that, as a practical matter, can only be provided in a SNF or an inpatient basis.

§409.32 Criteria for skilled services and the need for skilled services.

(a) To be considered a skilled service, the service must be so inherently complex that it can be safely and effectively performed only by, or under the supervision of, professional or technical personnel.

(b) A condition that does not ordinarily require skilled services may require them because of special medical complications. Under those circumstances, a service that is usually nonskilled [such as those listed in §409.33(d)] may be considered skilled because it must be performed or supervised by skilled nursing or rehabilitation personnel. For example, a plaster cast on a leg does not usually require skilled care. However, if the patient has a preexisting acute skin condition or needs traction, skilled personnel may be needed to adjust traction or watch for complications. In situations of this type, the complications, and the skilled services they require, must be documented by physicians' orders and nursing or therapy notes.

(c) The restoration potential of a patient is not the deciding factor in determining whether skilled services are needed. Even if full recovery or medical improvement is not possible, a patient may need skilled services to prevent further deterioration or preserve current capabilities. For example, a terminal cancer patient may need some of the skilled services described in §409.33.

§409.34 Criteria for "daily basis".

(a) To meet the daily basis requirement specified in §409.31(b)(1), the following frequency is required:
(1) Skilled nursing services or skilled rehabilitation services must be needed and provided 7 days a week; or
(2) As an exception, if skilled rehabilitation services are not available 7 days a week those services must be needed and provided at least 5 days a week.

(b) A break of one or two days in the furnishing of rehabilitation services will not preclude coverage if discharge would not be practical for the one or two days during which, for instance, the physician has suspended the therapy sessions because the patient exhibited extreme fatigue.

"Supervision" means to coordinate, direct, and inspect on an ongoing basis the accomplishments of another, or to oversee, with the power to direct, the implementation of one's own or another's intentions. Performance of supervised services should be held to the same standard of care applied to the supervising practitioner.

Supervision includes but is not limited to: (1) Personal hands-on instruction regarding all services provided; (2) Initial evaluation of the abilities of persons under the supervision of skilled personnel to complete goals of treatment; (3) The continuous availability of direct communication either in person or by electronic communications between the service provider and the supervising skilled personnel; (4) The personal review of the service provider's practice and performance. (5) The delineation of a plan for emergencies; (6) Documentation of direct evaluation by the supervising practitioner, at

a minimum, quarterly regarding the member's progression to meeting specified goals and outcomes of the skilled service; **AND**

2. Services are provided in accordance with general provisions for all Medicaid providers and services as described within §441-79.9; **AND**
3. Services require another individual, either skilled technical or professional personnel or others acting under the supervision of such personnel, to deliver the services. The services are not administered by the member to his or her own person, unless the presence of skilled technical or professional personnel or others acting under the supervision of such personnel is required on a daily basis as defined above; **AND**
4. Documentation submitted for review must indicate that the member has:
    a. A physician order for all skilled services; **AND**
    b. Services that require the skills of medical personnel including registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech pathologists, or audiologists; **AND**
    c. An individualized care plan that addresses identified deficit areas; **AND**
    d. Confirmation that skilled services are provided to the member; **AND**
    e. Skilled services provided by, or under the supervision of medical personnel as described above; **AND**
    f. Skilled nursing services needed and provided 7 days a week or skilled rehabilitation services needed and provided at least 5 days a week.

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 CFR §409.31(a), 409.32, and 409.34.

42 CFR §484.2 Definitions.

42 CFR §484.115 Personnel qualifications.

Iowa Administrative Code §441 – 79.9 (249A).

American Medical Directors Association; Supervision and Collaboration: A Review of Definitions. https://www.amda.com/advocacy/ReviewDefinitions.pdf. Accessed February 24, 2015.

CMS State Operations Manual, Appendix B. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_b_hha.pdf. Accessed February 24, 2015.

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

Change Date	Changed By	Description of Change	Version

Signature

Change Date	Changed By	Description of Change	Version

Signature

Change Date	Changed By	Description of Change	Version
4/19/2024	CAC	Annual review.	5

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4/21/2023	CAC	Annual review.	4

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4/15/2022	CAC	Annual review.	3

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Criteria Change History (continued)

Change Date	Changed By	Description of Change	Version
4/16/2021	CAC	Annual review. Minor formatting changes.	2
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Change Date	Changed By	Description of Change	Version
4/17/2015	Medical Director	Insertion of relevant code, definition of "supervision," added criterion #3 and inserted references. Addition of introductory paragraph.	1
Signature C. David Smith, MD