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

Criteria:
In order to approve skilled level of care, **ALL OF** the following conditions must be met:

1. The member’s medical condition requires skilled nursing 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 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 an M C 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.

§ 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.

2. Services are provided in accordance with general provisions for all Medicaid providers and services as described within 441-79.9.

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.

4. Documentation submitted for review must indicate that the member has:
   a. A physician order for all skilled services.
   b. Services that require the skills of medical personnel including registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech pathologists, or audiologists.
   c. An individualized care plan that addresses identified deficit areas.
   d. Confirmation that skilled services are provided to the member.
   e. Skilled services provided by, or under the supervision of medical personnel as described above.
   f. Skilled nursing services needed and provided seven days a week or skilled rehabilitation services needed and provided at least five days a week.

References:
42 CFR 409.31(a), 409.32, and 409.34
42 CFR 484.2 and 484.4 Definitions and Personnel qualifications
IAC 441 – 79.9
441-79.9(249A) General provisions for Medicaid coverage applicable to all Medicaid providers and services.
79.9(1) Medicare definitions and policies shall apply to services provided unless specifically defined differently.
79.9(2) The services covered by Medicaid shall:
   a. Be consistent with the diagnosis and treatment of the patient’s condition.
   b. Be in accordance with standards of good medical practice.
   c. Be required to meet the medical need of the patient and be for reasons other than the convenience of the patient or the patient’s practitioner or caregiver.
   d. Be the least costly type of service which would reasonably meet the medical need of the patient.
   e. Be eligible for federal financial participation unless specifically covered by state law or rule.
   f. Be within the scope of the licensure of the provider.
   g. Be provided with the full knowledge and consent of the recipient or someone acting in the recipient’s behalf unless otherwise required by law or court order or in emergency situations.
   h. Be supplied by a provider who is eligible to participate in the Medicaid program. The provider must use the billing procedures and documentation requirements described in 441-Chapters 78 and 80.
79.9(3) Providers shall supply all the same services to Medicaid eligibles served by the provider as are offered to other clients of the provider.
79.9(4) Recipients must be informed before the service is provided that the recipient will be responsible for the bill if a noncovered service is provided.
79.9(5) Coverage in public institutions. Medical services provided to a person while the person is an inmate of a public jail, prison, juvenile detention center, or other public penal institution of more than four beds are not covered by Medicaid. This rule is intended to implement Iowa Code section 249A.4.
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.

Change History:

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<th>Changed By:</th>
<th>Description of Change:</th>
<th>New Version Number:</th>
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<td>4/17/15</td>
<td>Medical Director</td>
<td>Insertion of relevant code, definition of “supervision,” added criterion #3 and insert references. Addition of introductory paragraph.</td>
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