MEDICAL POLICY

Medical Policy Title	**Skilled Nursing Facility Care / Level of Care Criteria**
Policy Number	**11.01.21**
Current Effective Date	**July 16, 2026**
Next Review Date	**July 2027**

Our medical policies are guides to evaluate technologies or services for medical necessity. Criteria are established through the assessment of evidence based, peer-reviewed scientific literature, and national professional guidelines. Federal and state law(s), regulatory mandates and the member's subscriber contract language are considered first in the determination of a covered service.
(Link to Product Disclaimer)

Additional coverage for MEDICAID MANAGED CARE/HARP MEMBERS is addressed at the end of this document.

POLICY STATEMENT(S)

I. Services rendered in a skilled nursing facility (SNF) are considered **medically appropriate** when **ALL** of the following criteria are met:

A. The patient requires skilled nursing or rehabilitation services that include **BOTH** of the following:

1. must be performed by or under the supervision of professional or technical personnel;
2. are ordered by the patient's physician;

B. The patient requires skilled services on a daily basis (needed and received a minimum of five (5) days per week);

C. Considering economy and efficiency, the daily skilled services can be provided only on an inpatient basis in a SNF;

D. The services are reasonable and necessary for the treatment of a patient's presenting condition, illness or injury;

E. The services are reasonable in terms of duration and quantity.

II. The determination of **medical necessity** of a current or proposed level of SNF care is subject to the following:

A. Level I Skilled Nursing Facility (SNF) Care (Revenue Code 191) is considered **medically appropriate** when **ALL** of the following criteria are met:

1. The patient requires skilled nursing services at least daily or skilled therapy for at least one (1) hour but less than two (2) hours per day at least five (5) days per week;
2. The patient's illness, injury, or exacerbation began no more than 30 days earlier, or the patient was discharged from an inpatient facility, and one (1) or more of the following conditions are present:

a. Cardiovascular or peripheral vascular condition, with **EITHER**:

i. dyspnea;

ii. hypoxia on room air within three (3) days prior to admission;

b. Diabetes with uncontrolled blood sugar;

c. Gastrointestinal (GI) or genitourinary (GU) condition with at least one (1) of the following:

i. hepatic encephalopathy, Stage II;

ii. inadequate oral intake;

iii. persistent diarrhea;

iv. malnutrition;

d. Malignant or end-stage disease;

e. Uncontrolled pain;

f. Alteration in skin integrity due to pressure injury or wound requiring parenteral anti-infective or wound care;

g. Functional limitation requiring therapy services with at least one (1) discipline, one (1) to two (2) hours per day for five (5) days or more per week, due to one (1) or both of the following:

i. impairment (new) requiring at least minimum or extensive assistance; and/or

ii. rehabilitation potential based on prior level of function, with expectation for clinical or functional improvement;

3. Treatment is precluded at a lower level of care due to one (1) or more of the following:

a. Clinical complexity or existing debility makes care at home unsafe;

b. Patient is cognitively unable to manage care, and no caregiver is available;

c. Home environment is not conducive to care;

d. Services are unavailable to patient through home care or as an outpatient.

B. Level II Subacute Care (SAC) (Revenue Code 192) is considered **medically appropriate** when **ALL** of the following criteria are met:

1. The patient requires skilled nursing services more than two (2) hours per day or skilled therapy two (2) to three (3) hours per day, or a combination of skilled nursing and skilled therapy two (2) to three (3) hours per day at least five (5) days per week;

2. The patient's illness, injury, or exacerbation began no more than 30 days earlier, or the patient was discharged from an inpatient facility, and one (1) or more of the following conditions are present:

a. Cardiovascular or peripheral vascular, with **EITHER**:

i. dyspnea;

ii. hypoxia on room air within three days prior to admission;

b. Gastrointestinal (GI) or genitourinary (GU) condition with at least one (1) of the following:

i. hepatic encephalopathy, Stage II;

ii. inadequate oral intake;

iii. persistent diarrhea;

iv. malnutrition;

c. Uncontrolled pain;

d. Transplant recipient less than or equal to thirty days or transplant candidate in lieu of continued acute hospitalization when at least one (1) of the following criteria are met:

i. pre-transplant (heart, lung, liver, bone marrow, or small bowel);

ii. Oxygen saturation less than 89 percent;

iii. symptomatic bone marrow disorder;

iv. post-transplant (renal, heart, lung, liver, bone marrow, small bowel, or pancreas);

e. Alteration in skin integrity due to burn, pressure injury or wound requiring parenteral anti-infective or wound care;

f. Functional limitation requiring therapy services with at least one discipline, two (2) hours to three (3) hours per day for five (5) days or more per week, due to one (1) or both of the following:

i. impairment (new) requiring at least minimum or extensive;

ii. rehabilitation potential based on prior level of function, with expectation for clinical or functional improvement;

3. Treatment is precluded in a lower level of care due to one (1) or more of the following:

a. Clinical complexity or existing debility makes care at home unsafe;

b. Cognitive inability to manage care and no caregiver available;

c. Home environment not conducive to care;

d. Services unavailable through home care or outpatient.

C. Level III Medically Complex Care (MCC) (Revenue Code 193) is considered **medically appropriate** when **ALL** of the following criteria are met:

1. The patient requires skilled nursing services at least four (4) hours per day and skilled

therapy two (2) to three (3) hours per day at least five (5) days per week;

2. The patient's illness, injury, or exacerbation began no more than 30 days earlier, or the patient was discharged from an inpatient facility, and one (1) or more of the following conditions are present:
    a. Cardiovascular or peripheral vascular condition, with **EITHER**:
        i. dyspnea;
        ii. hypoxia on room air within three days prior to admission;
    b. Gastrointestinal (GI) or genitourinary (GU) condition with at least one (1) of the following:
        i. hepatic encephalopathy, Stage II;
        ii. inadequate oral intake;
        iii. persistent diarrhea;
        iv. malnutrition;
    c. Hematologic or oncologic disease;
    d. Infection requiring anti-infective;
    e. Uncontrolled pain;
    f. Transplant recipient less than or equal to thirty days or transplant candidate in lieu of continued acute hospitalization when at least one (1) of the following criteria are met:
        i. pre-transplant (heart, lung, liver, bone marrow, or small bowel);
        ii. Oxygen saturation less than 89 percent;
        iii. symptomatic bone marrow disorder;
        iv. post-transplant (renal, heart, lung, liver, bone marrow, small bowel, or pancreas);
    g. Alteration in skin integrity due to burn, pressure injury or wound requiring parenteral anti-infective or wound care;
    h. Functional limitation requiring therapy services with at least one discipline two (2) hours to three (3) hours per day for five (5) days or more per week, due to one (1) or both of the following:
        i. impairment (new) requiring at least minimum or extensive;
        ii. rehabilitation potential based on prior level of function, with expectation for clinical or functional improvement;
3. Treatment is precluded in a lower level of care due to one (1) or more of the following:

a. Clinical complexity or existing debility makes care at home unsafe;

b. Cognitive inability to manage care and no caregiver available;

c. Home environment not conducive to care;

d. Services unavailable through home care or outpatient.

D. Revenue Code 194 will be used to reflect Ventilator and/or Traumatic Brain Injury (TBI) Level of Care. Admission for ventilator or TBI Level of Care is **medically appropriate** when **ALL** of the following criteria are met:

1. Medical necessity criteria for Level of Care (Revenue Codes 191, 192 or 193) (refer to Policy Statement II.A.-II.C.);

2. Meets medically complex criteria relating to ventilator management or weaning or brain injury (Current InterQual criteria, LOC: Inpatient Rehabilitation Subacute Rehabilitation).

E. Care that is strictly custodial in nature is considered **not medically necessary**.*

*For Medicaid Managed Care/HARP members, if the member does not meet level 1 criteria, and a safe discharge plan is still under development, then the member is eligible for a custodial benefit.

RELATED POLICIES

Corporate Medical Policy

11.01.11 Comfort, Convenience, or Custodial Services

POLICY GUIDELINE(S)

I. Treatment must be reasonable and necessary based upon the patient's clinical status, as determined by the Minimum Data Set (MDS) assessment.

II. The Health Plan considers direct admission to an appropriate level of care facility (e.g., SNF) to be desirable for patients presenting to either a physician's office or emergency room, when it would be considered unsafe for the patient to return to the patient's place of residence; the patient does not meet criteria for admission to an acute care hospital inpatient setting; and the criteria for coverage of the admission to the appropriate level of care facility (e.g., SNF) are met.

DESCRIPTION

Skilled nursing facility (SNF) care is a level of care that must be ordered by a doctor and must be given or supervised by licensed health care professionals. It may be skilled nursing care, skilled rehabilitation services, or both. Skilled nursing care includes services that require the skills of a licensed nurse to perform or supervise. Skilled rehabilitation services include physical therapy, speech therapy, and occupational therapy.

SUPPORTIVE LITERATURE

Not Applicable

PROFESSIONAL GUIDELINE(S)

Not Applicable

REGULATORY STATUS

Not Applicable

CODE(S)

- Codes may not be covered under all circumstances.
- Code list may not be all inclusive (AMA and CMS code updates may occur more frequently than policy updates).
- (E/I)=Experimental/Investigational
- (NMN)=Not medically necessary/appropriate

CPT Codes

Code	Description
Not Applicable	

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HCPCS Codes

Code	Description
Not Applicable	

ICD10 Codes

Code	Description
Multiple Codes	

REFERENCES

Centers for Medicare & Medicaid Services [Internet]. Long term care facility resident assessment instrument 3.0 user's manual version 1.18.11. 2023 Oct [accessed 2026 May 29]. Available from: https://www.cms.gov/files/document/finalmds-30-rai-manual-v11811october2023.pdf

Gustavson AM, et al. Application of high-intensity functional resistance training in a skilled nursing facility: an implementation study. Physical Therapy. 2020;100:1746–1758.

Herrera-Escobar JP, et al. Reduced chronic pain: Another benefit of recovery at an inpatient rehabilitation facility over a skilled nursing facility? The American Journal of Surgery. 2021;216-221.

InterQual criteria, LOC: Inpatient Rehabilitation Subacute Rehabilitation

New York State Public Health Law 4401, CHAPTER 28, ARTICLE 49, TITLE 1 §4900 [Internet]. 2024 Jan 5 [accessed 2026 May 29]. Available from: https://www.nysenate.gov/legislation/laws/ISC/4900#:~:text=Insurance%20%28ISC%29%20CHAPTER%2028%2C%20ARTICLE%2049%2C%20TITLE%201,on%20the%20information%20provided%2C%20is%20not%20medically%20necessary

SEARCH TERMS

Direct admission to non-acute care facilities

CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)

Skilled Nursing Facility Care is not addressed in a National or Local Medicare coverage determination or policy. However, Skilled Nursing Facility Level of Care is addressed in the Medicare Benefit Policy Manual Chapter 8, Section 30-Coverage of Extended Care (SNF) Services under Hospital Insurance.

(Rev. 12283) Please refer to the following website for Medicare Members: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c08pdf.pdf Issued 2023 Oct 5 [accessed 2026 May 29]

For Medicare members, coverage of skilled services rendered in a non-acute setting without a preceding three-day acute care admission is contingent upon CMS approval of the Health Plan's annual application for approval via the CMS Bid Waiver Process.

When medically necessary skilled services are required for the medically appropriate care of a patient, and the care can be rendered in a non-acute care setting (e.g., SNF), the services will be approved for that level of care without requiring a prior three-day acute care hospital admission.

ADDITIONAL COVERAGE FOR NYS MEDICAID MANAGED CARE/HARP PRODUCT MEMBERS

PEDIATRIC SPECIALTY RATE (Revenue Code 123):

Refer to the following website: https://www.health.ny.gov/facilities/long_term_care/reimbursement/nhr/benchmark/2021-02-19_benchmark_letter-jul.htm Issued 2021 Feb 19 [accessed 2026 May 29]

Pediatric patients have medically complex conditions requiring long term stays that may extend for a succession of years and are characterized as "medically fragile." A medically fragile child is under 21 years of age and , has a chronic debilitation condition or conditions* and meets **ANY** of the following criteria:

I. is technologically dependent for life or health sustaining functions;

II. requires a complex medication regimen or medical intervention to maintain or improve health status;

III. is in need of ongoing assessment or intervention to prevent serious deterioration of their health status or medical complication that places life, health or development at risk.

*Chronic debilitating conditions include, but are not limited to, bronchopulmonary dysplasia, cerebral palsy, congenital heart disease, microcephaly, pulmonary hypertension, and muscular dystrophy. The

term “medically fragile child” shall also include traumatic brain injury, the nature of which typically requires care in a specialty center for medically fragile children, even though the child does not have a chronic debilitating condition or also meet one of the three conditions above. Notwithstanding the definitions set forth in this subsection, any patient which has received prior approval from an insurer for admission to a specialty care facility for medically fragile children shall be considered a medically fragile child at least until discharge from that facility occurs. Pediatric residential health care facilities may not retain patients over the age of 21.

The requesting facility must be credentialed in skilled nursing pediatric care.

For the New York State definition of medically fragile, or for more information, refer to:

https://www.nysenate.gov/legislation/laws/ISC/107 [accessed 2026 May 29]

NEUROBEHAVIORAL SPECIALTY RATE (Revenue Code 124):

Healthy NY Title: Section 415.39: https://regs.health.ny.gov/content/section-41539-specialized-programs-residents-requiring-behavioral-interventions Issued 1994 Mar 16 [accessed 2026 May 29]

I. Admission Criteria

A. As a minimum, for residents admitted to the program, there shall be documented evidence in the resident’s medical record that:

1. the resident’s behavior is dangerous to themselves or to others;
2. the resident’s behavior has been assessed according to severity and intensity;
3. within 30 days prior to the date of application to the program, the resident has displayed:
    a. verbal aggression which constitutes a clear threat of violence towards others or self; or
    b. physical aggression which is assaultive or combative and causes or is likely to cause harm to others or self; or
    c. persistently regressive or socially inappropriate behavior which causes actual harm;
4. various alternative interventions have been tried and found to be unsuccessful;
5. the resident cannot be managed in a less restrictive setting; and
6. the prospective resident has the ability to benefit from such a program.

II. Assessment and Care Planning Criteria

A. The interdisciplinary team shall have determined preliminary approaches and interventions to the severe behavior and recorded them in the resident care plan prior to admission to the unit.

B. Each resident's care plan shall include care and services which are therapeutically beneficial for the resident and selected by the resident when able and as appropriate. The care plan shall be prepared by the interdisciplinary team, which shall include psychiatrist, psychologist,

or social worker participation as appropriate to the needs of the resident.

C. Based on the resident's response to therapeutic interventions, the care plan including the discharge plan shall be reviewed and modified, as needed, but at least once a month.

III. Discharge Criteria

A. A proposed discharge plan shall be developed within 30 days of admission for each resident as part of the overall care plan and shall include input from all professionals caring for the resident, the resident and their family, as appropriate, and any outside agency or resource that will be involved with the resident following discharge.

B. When the interdisciplinary team determines that discharge of a resident to another facility or community-based program is appropriate, a discharge plan shall be implemented which is designed to assist and support the resident, family and caregiver in the transition to the new setting. Program staff shall be available post-discharge to act as a continuing resource for the resident, family or caregiver.

C. The resident shall be discharged to a less restrictive setting when they no longer meet the admission criteria for this program as stated above.

D. There shall be a written transfer agreement with any nursing home of origin which allows for priority readmission to such transferring facility when a resident is capable of a safe discharge.

PRODUCT DISCLAIMER

- Services are contract dependent; if a product does not cover a service, medical policy criteria do not apply.
- If a commercial product (including an Essential Plan or Child Health Plus product) covers a specific service, medical policy criteria apply to the benefit.
- If a Medicaid product covers a specific service, and there are no New York State Medicaid guidelines (eMedNY) criteria, medical policy criteria apply to the benefit.
- If a Medicare product (including Medicare HMO-Dual Special Needs Program (DSNP) product) covers a specific service, and there is no national or local Medicare coverage decision for the service, medical policy criteria apply to the benefit.
- If a Medicare HMO-Dual Special Needs Program (DSNP) product DOES NOT cover a specific service, please refer to the Medicaid Product coverage line.

POLICY HISTORY/REVISION

Committee Approval Dates

12/07/06, 12/13/07, 02/26/09, 02/25/10, 02/24/11, 02/27/12, 02/28/13, 02/27/14, 02/26/15, 02/25/16, 04/27/17, 04/26/18, 02/28/19, 02/27/20, 02/25/21, 06/24/21, 02/17/22, 08/18/22, 08/17/23, 07/18/24, 07/17/25, 07/16/26

Date	Summary of Changes
07/16/26	• Annual review, policy intent unchanged.
07/17/25	• Annual review, policy intent unchanged.
01/01/25	• Summary of changes tracking implemented.
12/07/06	• Original effective date