Review and Approval of Part A vs. Part B Skilled Therapy Services

Guideline Information

Scope	Medicare Advantage Plan-ISNP, DSNP & IESNP	Effective Date	10/23/2025
Department	Clinical-Utilization Management	Revision Date	N/A
Owner	Koby Mitchell, MSN, RN	Version	1.0
Executive Sponsor	Clare Hays, MD, CMD	Status	Active
Exceptions to Scope	N/A		

Guideline Statement

This guideline outlines how Simpra reviews requests for skilled therapy services under Medicare Part A (SNF benefit) and Medicare Part B (outpatient therapy benefit). The intent is to ensure that services are reviewed in alignment with CMS guidelines, that determinations are made based on medical necessity, and that members receive the appropriate level of care to support their functional goals. Simpra currently allows contracted skilled nursing facilities to provide initial Part B therapy services without prior authorization if the Member will not require more than ten visits for any discipline, and/or over no more than 28 days. Contracted facilities must request authorization for Part A services within two business days of starting medically necessary care. Part A services are authorized if documentation supports medical necessity.

CMS Coverage Principles

Part A SNF Therapy: Covered when the member requires daily skilled services, which may be met by therapy alone (PT, OT, SLP) or in combination with skilled nursing services. Therapy under Part A must be delivered at least 5 days per week and be of such complexity that it requires the skills of a licensed therapist.

Part B Therapy: Covered when therapy remains reasonable and necessary but does not require daily skilled services. Part B services typically occur 2–3 times per week (or as clinically appropriate) and requires a physician-certified plan of care.

Rules

- Medicare Benefit Policy Manual, Ch. 8: Coverage of Extended Care (SNF) Services
- Medicare Benefit Policy Manual, Ch. 15: Covered Medical and Other Health Services
- *Jimmo v. Sebelius* Settlement Agreement (Skilled Maintenance Therapy)

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Guidelines

Health Plan Review Process

Criteria for Approving Part A Therapy

Simpra will authorize Part A skilled therapy when all the following are met:

- Member requires **daily skilled therapy (≥5 days/week)** due to medical complexity, functional deficits, or safety risks.
- Documentation demonstrates frequent therapist assessment, modification of treatment, and skilled decision-making.
- Without daily therapy, the member would be at risk for functional decline, medical complications, rehospitalization, or unsafe discharge.

Examples of Part A Approval Scenarios:

- Post-hip fracture requiring intensive daily PT/OT for mobility and ADLs.
- Acute stroke with new deficits requiring daily rehab to regain swallowing, mobility, or speech.

Criteria for Approving Part B Therapy

Simpra will authorize Part B skilled therapy when all the following are met:

- Member does not require inpatient daily skilled services to ensure safety or recovery.
- Therapy remains reasonable and necessary to improve or maintain current function.
- Documentation shows measurable progress or skilled therapist is needed to develop and train functional maintenance plan.
- Frequency may range from intermittent to daily, depending on medical necessity. Daily therapy under Part B is permitted when appropriate but does not in itself justify Part A coverage.

Examples of Part B Approval Scenarios:

- Member transitioned from Part A but continues to require strengthening 2–3x/week for safe ambulation.
- Chronic condition management (e.g., Parkinson's, MS) where skilled therapist oversight is needed while developing the functional maintenance plan.
- Stable Member receiving therapy 5x/week for conditioning and endurance training, where therapy is skilled but not tied to a skilled nursing need.

Clarifying Daily Therapy Under Part A vs Part B

Part A: Daily therapy is required because the member's condition is **unstable, complex, or at high risk** if sessions are not delivered every day in an inpatient SNF setting. Missing daily therapy would likely result in decline or unsafe discharge.

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Part B: Therapy may also be delivered daily, but the member's condition is **stable enough** that inpatient-level oversight is not medically necessary. The therapy is skilled and necessary but can safely be delivered at an outpatient level.

Important: Simpra will deny Part A coverage for daily therapy if documentation does not support an inpatient daily skilled need – even if therapy is being provided every day. Documentation must clearly show medical necessity for Part A, including evidence that the member is unstable, clinically complex, or at high risk without inpatient-level daily intervention.

When Neither Part A nor Part B is Supported

Simpra may deny therapy if:

- Documentation shows **slow progress with minimal changes** without evidence of goal modification.
- Notes only reference "ongoing therapy to prevent decline" without supporting evidence that skilled therapy is required.
- Services described could be safely delivered by non-skilled staff or caregivers.

Documentation Requirements

All therapy requests must include:

- Physician – certified **plan of care**
- **Prior level of function (PLOF):** Baseline status before current illness/episode.
- **Current level of function (CLOF):** Objective findings at present (mobility, ADLs, swallowing, communication, etc.).
- **Goals of therapy:** Short-term and long-term, specific and measurable.
- **Progress toward goals:** What gains have been made since therapy started?
- **Teaching/caregiver training:** What has been done to prepare member, family, or staff to safely manage care?

Requests for Additional Days (FMP)

Simpra expects that functional management program planning, caregiver education, and discharge preparation are integrated into therapy **throughout the episode of care**. Requests for additional days **solely to create or complete an FMP will not be approved** unless documentation demonstrates that this could not reasonably be addressed earlier due to clinical or caregiver circumstances.

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Interruptions in Care

Interruptions in therapy services can occur when a member transitions between levels of care, such as:

- **Part A → Acute hospital admission**
- **Part B → Acute hospital admission**
- **Part B → Transition to Part A SNF stay for skilled nursing needs**

Simpra Process for Interruptions:

- When a member discharges from a facility or transitions to a higher level of care, Simpra will:
  - **Flag the authorization as an interruption in care.**
  - **Adjust the authorization** to reflect the dates of service and/or number of visits provided prior to the interruption.
  - **Re-issue the notification of approval with updated dates/visits**, with notification sent to both the provider and the member.

Resumption of Care:

- Therapy services will not automatically resume under the previous authorization once the member has had an interruption.
- When the member returns to the facility or transitions back to Part B therapy, a **new authorization is required if the member will require more than 10 visits per discipline and/or over more than 28 days**.
- The new request must include updated clinical documentation supporting medical necessity (PLOF, CLOF, goals, progress, caregiver training status).

Decision-Making and Peer Review

- All **medical necessity denials** are rendered by a licensed physician.
- A **peer-to-peer (P2P) discussion** can be requested by the treating physician, NP or lead therapist on behalf of the facility prior to final determination:
  - **Standard & Concurrent Reviews:** P2P offered in writing.
  - **Expedited or Urgent Concurrent Reviews:** P2P offered both verbally and in writing.
  - P2P opportunity is provided at least **24 hours prior to a final determination**.

Notification of Determinations

- **Approvals:** Written notification provided to both provider and member.

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- **Denials:** Written notification provided to both the provider and the member, including:
  - Clinical rationale for the denial.
  - Reference to CMS coverage criteria.
  - Explanation of the right to a P2P and appeal.
- **Expedited/Urgent requests** receive both written and verbal notification of the determination.

Document Approval

Date	Approver	Role	Approved
9/22/2025	Dr. Clare Hays, MD, CMO	Chief Medical Officer	Yes
10/23/2025	UM Committee	UM activity oversight	Yes
12/15/2025	UM Committee	UM activity oversight	Yes

Review & Revision History

Date	Revision Summary	Author	Approval Required?
09/12/2025	Initial draft	Koby Mitchell	Yes