Clinical Review Criteria
In Lieu of Hospital Admission to Skilled Nursing Facility (ILOH)

NOTICE: Kaiser Foundation Health Plan of Washington and Kaiser Foundation Health Plan of Washington Options, Inc., provide these Clinical Review Criteria for internal use by their members and health care providers. The Clinical Review Criteria only apply to Kaiser Foundation Health Plan of Washington and Kaiser Foundation Health Plan of Washington Options, Inc. Use of the Clinical Review Criteria or any Kaiser Permanente entity name, logo, trade name, trademark, or service mark for marketing or publicity purposes, including on any website, or in any press release or promotional material, is strictly prohibited.

Kaiser Permanente Clinical Review Criteria are developed to assist in administering plan benefits. These criteria neither offer medical advice nor guarantee coverage. Kaiser Permanente reserves the exclusive right to modify, revoke, suspend or change any or all of these Review Criteria, at Kaiser Permanente's sole discretion, at any time, with or without notice. Member contracts differ in their benefits. Always consult the patient's Medical Coverage Agreement or call Kaiser Permanente Customer Service to determine coverage for a specific medical service.

Criteria
Meets all the following clinical criteria for ILOH admission:
1. Meets (MCG)*, current edition Inpatient and Surgical Care Guidelines Clinical Indications for Admission to Inpatient Care for condition and treatment in an acute hospital setting.
   a. On admission to a hospital or
   b. At the end of the stay but requiring continued skilled nursing care that can be safely delivered in a skilled nursing facility
   c. During evaluation in any of the following settings: emergency department, urgent care or clinic.
2. In lieu of hospital admission transfers to skilled nursing facilities are not appropriate when the care needs are limited to physical, occupational or speech therapy because these services alone do not require inpatient hospital care, except in an inpatient hospital rehabilitation admission. Inpatient hospital rehabilitation service intensity is not available in a skilled nursing facility.
3. Stable enough for management by the skilled nursing facility staff
   a. does not require critical care services support or support available only in the hospital setting
   b. does not require a high use of lab
4. Diagnosis established
5. Physician on-site rounding daily if needed, and access to physician 24 hours a day
6. Medically stable with clear plan of care and expected course
7. Patient agrees with ILOH plan of care

*MCG Manuals are proprietary and cannot be published and/or distributed. However, on an individual member basis, Kaiser Permanente may share a copy of the specific criteria document used to make a utilization management decision. If one of your patients is being reviewed using these criteria, you may request a copy of the criteria by calling the Kaiser Permanente Clinical Review staff at 1-800-289-1363.

Background
When a skilled nursing facility has the staff and services available to deliver a higher level of care, it is possible to transfer a patient earlier in the course of care to a skilled nursing facility rather than continuing care in the hospital. The most common use of this service is at the end of a hospital stay when acute care service needs have decreased but are still expected to persist for more than 2-3 days or on admission when acute care services are limited to intravenous administration of antibiotics or dressing changes that cannot be safely managed in the home through a home health provider. While use of the service is rare, it is appropriate for some plans of care.

The following information was used in the development of this document and is provided as background only. It is not to be used as coverage criteria. Please only refer to the criteria listed above for coverage determinations.

<table>
<thead>
<tr>
<th>Date Created</th>
<th>Date Reviewed</th>
<th>Date Last Revised</th>
</tr>
</thead>
<tbody>
<tr>
<td>08/11/1998</td>
<td>09/07/2010</td>
<td>02/01/2001</td>
</tr>
<tr>
<td></td>
<td>05/01/2012</td>
<td></td>
</tr>
<tr>
<td></td>
<td>03/05/2013</td>
<td></td>
</tr>
<tr>
<td></td>
<td>09/01/2015</td>
<td></td>
</tr>
<tr>
<td></td>
<td>07/05/2016</td>
<td></td>
</tr>
<tr>
<td></td>
<td>05/02/2017</td>
<td></td>
</tr>
</tbody>
</table>

MDCRPC  Medical Director Clinical Review and Policy Committee
MPC  Medical Policy Committee
**Codes**

No specific codes