Priority Health	BILLING POLICY No. 068
SKILLED NURSING FACILITY/ NON-ACUTE INPATIENT SERVICES	
Date of origin: Dec. 30, 2024	**Review dates: 2/2025, 6/2025, 8/2025, 6/2026, 08/2026**

POLICY OVERVIEW

This policy provides guidelines for billing, coding, and documentation, ensuring claims are processed according to contractual agreements and industry standards for skilled nursing facility/non-acute inpatient services.

DEFINITION

Skilled Nursing Facilities (SNFs) are places for people to live temporarily while they receive 24-hour nursing care, rehabilitation and medical treatments after hospitalization for an illness or injury.

FOR MEDICARE

For indications that don't meet criteria of NCD, local LCD or specific medical policy, a Pre-Service Organization Determination (PSOD) will need to be completed. Get more information on PSOD in our Provider Manual.

MEDICAL POLICY

Prior authorization for certain drug, services, and procedures may or may not be required. In cases where prior authorization is required, providers will submit a request demonstrating that a drug, service, or procedure is medically necessary. For more information, please refer to the Priority Health Provider Manual.

All skilled services in a Skilled Nursing, Subacute, or Rehabilitation Facility must be authorized.

A. Skilled rehabilitative services are a covered benefit as defined below and limited by the member contract when the services are primarily restorative in nature. The member's condition, the complexity, type of services, and the availability and feasibility of using a more economical alternative facility and service, including home-based services, are considered in coverage determinations.

   Admission to and services provided in a Skilled Nursing, Subacute, or Rehabilitation Facility are not covered if the necessary care or therapies can be provided safely in the home.

   When recovery or further meaningful improvement is not possible, skilled care may be needed to prevent deterioration of the patient's condition. Skilled care in this circumstance is considered custodial care and is not covered.

   Skilled nursing and/or rehabilitative services must be:

   - Primarily restorative and rehabilitative in nature.
   - Must be needed on a daily (5-7 days/week) basis, and as a practical matter, the care can only be provided in a skilled nursing or hospital facility on an inpatient basis.
   - Furnished pursuant to a physician's order.
   - Require the skills of technical or professional personnel (where the inherent complexity of the service permits it to be provided by a technically knowledgeable person only).

- Provided directly by or under the direction of such personnel and be reasonably expected to result in a meaningful improvement in the member's ability to perform functional day-to-day activities that are significant in the member's life roles within 60 days of initiation of the therapy.

B. Members who qualify for skilled, rehabilitative care are eligible for the following services while confined to a Skilled Nursing, Subacute, and Rehabilitation Facility:
- Nursing care provided 24 hours a day by or under the supervision of a registered professional nurse.
- Room and board in connection with such nursing care (private room covered only when medically indicated).
- Physical, occupational, or speech therapy (when billed through the nursing facility).
- Medical social services.
- Drugs, biologicals, supplies, appliances, and equipment (for use in the facility and billed by the SNF).
- Medical services provided by an intern or resident in training.
- Diagnostic or therapeutic services.
- Such other services necessary for the health of the patient as are generally provided by skilled nursing facilities.

C. Therapy is covered if it can be reasonably expected to result in a meaningful improvement in the member's ability to perform functional day-to-day activities that are significant in the member's life roles within 60 days of initiation of the therapy. Therapy that does not meet these goals is not covered.

D. Examples of Covered and Non-covered Services

The following are provided as examples of covered and non-covered services. They are not intended to be comprehensive nor are they intended to provide a justification for placement in a skilled nursing or other rehabilitation facility.

1. Examples of covered skilled nursing services include:

- Application of dressings involving prescription medications and aseptic techniques.
- Insertion and sterile irrigation and replacement of catheters.
- Intravenous, intramuscular, or subcutaneous injections (self-administered injections, ex: insulin, do not require skilled services).
- Overall management and evaluation of a complex care plan.
- Observation and assessment of the member's changing condition.
- Patient education services to teach self-maintenance or self-administration of care.
- Nasopharyngeal and tracheotomy aspiration.
- New intravenous, Levine tube or gastrostomy feedings to teach member or nonmedical caregiver appropriate maintenance plan.
- Treatment of extensive decubitus ulcers or other widespread skin disorder.

2. Examples of covered skilled rehabilitative services include (where the need is documented by a referring provider):

- Services to develop and manage a patient care plan, including tests and measurements of range of motion, strength, balance, coordination, endurance, functional ability, activities of daily living, perceptual deficits, speech and language or hearing disorders.
- Therapeutic exercises or activities which, because of the type of exercise or the condition of the member's, must be performed by or under the supervision of a qualified physical therapist or occupational therapist to ensure the safety of the patient and the effectiveness of the treatment.
- Hydrocollator, paraffin baths, and whirlpool where the member's condition is complicated by circulatory deficiency, desensitization, open wounds, fractures, etc.

- Services of a speech pathologist or audiologist when necessary to restore function.

3. Examples of non-covered services include but are not limited to:
    - Administration of routine medications, eye drops, and ointments.
    - Assistance in dressing, eating, and going to the bathroom.
    - Changes of dressings for noninfected postoperative or chronic conditions.
    - Custodial care.
    - General maintenance care of colostomy and ileostomy.
    - Routine services to maintain satisfactory functioning of indwelling bladder catheters.
    - General maintenance care in connection with a plaster cast.
    - General supervision of exercises which have been taught to the patient, including the carrying out of maintenance programs through the performance of repetition exercises to improve gait, maintain strength or endurance.
    - Periodic turning and repositioning in bed.
    - Prophylactic and palliative skin care, including bathing and application of creams or treatment of minor skin problems.
    - Routine care of incontinent patients, including use of diapers and protective sheets.
    - Routine care in connection with braces and similar devices.
    - Use of heat as a palliative and comfort measure, such as whirlpool and hydrocollator.
    - Routine administration of medical gases after a regimen of therapy has been established.

POLICY SPECIFIC INFORMATION

Billing

Value codes, condition codes and occurrence codes must be billed according to Uniform Billing Editor

Skilled nursing services are billed based on level of care (LOC). Use the following revenue codes that match the LOC provided.

0191: Subacute care–Level I
Note: Priority health doesn't reimburse this level of care.
Level I (skilled care) reflect minimal nursing intervention. Comorbidities do not complicate the treatment plan. An assessment of vitals and body systems is required one to two times per day.

0192: Subacute care–Level II
Level II (comprehensive care) reflects moderate nursing intervention. Active treatment of comorbidities is required. An assessment of vitals and body systems is required two to three times per day.

0193: Subacute care–Level III
Level III (complex care) reflects moderate to extensive nursing intervention. Active medical care and treatment of comorbidities is required. There is potential for the comorbidities to affect the treatment plan. An assessment of vitals and body systems is required three to four times per day.

0194: Subacute care–Level IV
This level IV (intensive care) reflects extensive nursing and technical intervention. Active medical care and treatment of comorbidities is required. There is potential for the comorbidities to affect the treatment plan. An assessment of vitals and body systems is required four to six times per day

Documentation requirements

Documentation for SNFs must include the admission orders, certification that the patient needed daily skilled care only provided in a SNF setting, an authenticated plan of care and the time (in minutes) for therapy service provided.

Additionally, the medical records must include following:

1. A nursing comprehensive assessment of the patient's needs, strengths, goals, and life history must be performed within fourteen days of admission (unless it is a readmission). The assessment must include:

    - Identification and demographic information
    - Customary routine
    - Cognitive patterns
    - Communication
    - Vision
    - Mood and behavior patterns
    - Psychosocial well-being
    - Physical functioning and structural problems
    - Continence
    - Disease diagnoses and health conditions
    - Dental and nutritional status
    - Skin condition
    - Activity pursuit
    - Medications
    - Special treatments and procedures
    - Discharge planning
    - Documentation of summary information about the other assessment done on the care areas triggered by the completion of the Minimum Data Set (MDS)

2. Documentation of assessment participation:

    - The assessment process must include direct observation and communication with the resident and with licensed and non-licensed direct care staff members on all shifts.

3. Regular assessment of treatment goals

    - The patient's medical history and physical exams, including responses or changes in behavior
    - Skilled services provided
    - The patient's response to skilled services during a visit
    - A plan for future care based on prior results
    - A detailed rationale explaining the need for skilled service
    - The complexity of service
    - Other patient characteristics

Related denial language
pf7 – Occurrence Code 50 required on SNF claims w/ Rev Code 0022

SPECIAL NOTES
This policy does not apply to substance abuse or alcoholism rehabilitation services or treatment facilities.
This policy was previously titled "Skilled Nursing Facility"

RESOURCES

- Medicare Learning Network (MLN) educational tool (CMS)
- Skilled nursing facility (SNF) care, Medicare (Priority Health)

- Priority Health Utilization Management Program (Priority Health)
- Uniform Billing Editor

DISCLAIMER

CMS and/or MDHHS guidelines apply unless otherwise specified in this policy or provider manual. Where such guidance is absent, this policy applies. Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS) and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standard, compliant codes defined by CPT, HCPCS and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document for services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align to these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made
Feb. 14, 2025	Added "Disclaimer" section
June 19, 2025	Added "Related denial language" section
Aug. 14, 2025	Added "medical policy" section
June 2026	Reviewed, no updates
August 2026	Reviewed, added policy overview