Priority Health	BILLING POLICY No. 068
SKILLED NURSING FACILITY	
Date of origin: Dec. 30, 2024	**Review dates: 2/2025**

APPLIES TO

- Commercial
- Medicare follows CMS unless otherwise stated
- Medicaid follows MDHHS unless otherwise stated

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

- Non-acute inpatient services (#91332)

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

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

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