Skilled Nursing Facility Payment Policy

Policy Statement

Skilled nursing facility/nursing facility care services are rendered to a member who is an inpatient of a skilled nursing facility or nursing facility and may include: skilled nursing and/or rehabilitation care, room and board, therapies (physical, occupational, speech), medical social services, pharmaceuticals, durable medical equipment, additional nursing and personal care and other necessary routine services.

Scope

This policy applies to:

☒**Medicaid** *excluding Extended Family Planning (EFP)*
☒**INTEGRITY**
☒**Commercial**

Prerequisites

All services must be medically necessary to qualify for reimbursement. Neighborhood may use the following criteria to determine medical necessity:

- National Coverage Determination (NCD)
- Local Coverage Determination (LCD)
- Industry accepted criteria such as Interqual
- Rhode Island Executive Office of Health and Human Services (EOHHS) recommendations
- Clinical Medical Policies (CMP)

It is the provider's responsibility to verify eligibility, coverage and authorization criteria prior to rendering services.

It is the responsibility of the facility to notify Neighborhood's Utilization Management (UM) Department of any changes to the member's status (admission, discharge, level of care change, expiration, etc.) regardless of the length of time of the status change.

For more information please refer to:

- Neighborhood's plan specific Prior Authorization Reference page.
- Neighborhood's Clinical Medical Policies.

Please contact Provider Services at 1-800-963-1001 for questions related to this policy.

Coverage Includes

Medicaid

- Skilled Nursing Facility Physician Visits
    - Skilled nursing facility/nursing facility care services are covered for members while inpatient at a skilled nursing facility. Custodial level and Skilled level of care (levels 1-4) are covered.
    - Admission to an in-network skilled nursing facility/nursing facility is required unless the network does not have the appropriate skilled nursing facility/nursing facility setting for an individual member.

Commercial

Care in a Skilled Nursing Facility is covered if:

- Your network PCP refers you to skilled nursing services
- Your condition needs skilled nursing services, skilled rehabilitation services or skilled nursing observation;
- The services are required on a daily basis

INTEGRITY

- Skilled nursing facility/nursing facility care services are covered for members while inpatient at a skilled nursing facility during an approved admission. Skilled level of care (levels 1-4) are covered.
- Admission to an in-network skilled nursing facility/nursing facility is required unless the network does not have the appropriate skilled nursing facility/nursing facility setting for an individual member.
- Skilled therapy services will be reimbursed separately for INTEGRITY members in custodial care.

Coverage Limitations and Exclusions

Medicaid

- RHP, RHE members may stay inpatient for up to 30 consecutive days in a skilled nursing facility or nursing facility at a skilled or custodial level of care. RHP, RHE members who have stays longer than 30 days are disenrolled from RHP, RHE by the Executive Office of Health and Human Services (EOHHS) and enrolled in Medical Assistance.
- RIte Care coverage includes all skilled levels of care when ordered by a health plan physician.
- Skilled nursing facility services are non-covered for Extended Family Planning (EFP) members.
- Neighborhood will cover the first thirty (30) days of hospice care for RHP and RHE members when delivered in a nursing home setting. Starting on the thirty first day, Medical Assistance fee for service will reimburse the hospice care and the room and board.

- Skilled therapy services are not covered for members in custodial care.

Commercial

- All SNF admissions, as ordered by a network physician, must meet medical necessity criteria.
- Custodial care, rest care, day care, or non-skilled care in any facility is not covered. This includes care in convalescent homes, nursing homes, homes for the aged, halfway houses, or other residential facilities.

INTEGRITY

All admissions, as ordered by a network physician, must meet medical necessity criteria and require prior authorization.

- Coverage includes all skilled and custodial levels of care when ordered by a health plan physician up to 365 days a year, and is not subject to stop loss provisions.

Claim Submission

Billable services are subject to contractual agreements, when applicable. Providers are required to submit complete claims for payment within contractually determined timely filing guidelines.

Coding must meet standards defined by the American Medical Association's Current Procedural Terminology Editorial Panel's (CPT®) codebook, the International Statistical Classification of Diseases and Related Health Problems, 10th revision, Clinical Modification (ICD-10-CM), and the Healthcare Common Procedure Coding System (HCPCS) Level II.

Documentation Requirements

Neighborhood reserves the right to request medical records for any service billed. Documentation in the medical record must support the service(s) billed as well as the medical necessity of the service(s). Neighborhood follows CMS standards for proper documentation requirements.

Member Responsibility

Commercial plans include cost sharing provisions for coinsurance, copays, and deductibles. Members may have out of pocket expenses based on individual plan selection and utilization. Please review cost sharing obligations or contact Member Services prior to finalizing member charges.

Disclaimer

This payment policy is informational only and is not intended to address every situation related to reimbursement for healthcare services; therefore, it is not a guarantee of reimbursement.

Claim payments are subject to the following, which include but are not limited to: Neighborhood Health Plan of Rhode Island benefit coverage, member eligibility, claims payment edit rules, coding

and documentation guidelines, authorization policies, provider contract agreements, and state and federal regulations. References to CPT or other sources are for definitional purposes only.

This policy may not be implemented exactly the same way on the different electronic claims processing systems used by Neighborhood due to programming or other constraints; however, Neighborhood strives to minimize these variations.

The information in this policy is accurate and current as of the date of publication; however, medical practices, technology, and knowledge are constantly changing. Neighborhood reserves the right to update this payment policy at any time. All services billed to Neighborhood for reimbursement are subject to audit.

Coding

Levels of Skilled Nursing Facility Care	Revenue Code
Level I	0191
Level II	0192
Level III	0193
Level IV	0194

CPT Code	Description
99304	Initial nursing facility care, per day, for the evaluation and management of a patient, which requires these 3 key components: A detailed or comprehensive history; A detailed or comprehensive examination; and Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of low severity. Typically, 25 minutes are spent at the bedside and on the patient's facility floor or unit.
99305	Initial nursing facility care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of moderate severity. Typically, 35 minutes are spent at the bedside and on the patient's facility floor or unit.
99306	Initial nursing facility care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A

CPT Code	Description
	comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of high severity. Typically, 45 minutes are spent at the bedside and on the patient's facility floor or unit.
99307	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A problem focused interval history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering, or improving. Typically, 10 minutes are spent at the bedside and on the patient's facility floor or unit.
99308	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is responding inadequately to therapy or has developed a minor complication. Typically, 15 minutes are spent at the bedside and on the patient's facility floor or unit.
99309	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient has developed a significant complication or a significant new problem. Typically, 25 minutes are spent at the bedside and on the patient's facility floor or unit.
99310	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A comprehensive interval history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. The patient may be unstable or may have developed a significant new problem requiring immediate physician attention. Typically, 35 minutes are spent at the bedside and on the patient's facility floor or unit.

CPT Code	Description
99315	Nursing facility discharge day management; 30 minutes or less
99316	Nursing facility discharge day management; more than 30 minutes
99318	Evaluation and management of a patient involving an annual nursing facility assessment, which requires these 3 key components: A detailed interval history; A comprehensive examination; and Medical decision making that is of low to moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering, or improving. Typically, 30 minutes are spent at the bedside and on the patient's facility floor or unit.
G0490	Face-to-face home health nursing visit by a rural health clinic (RHC) or federally qualified health center (FQHC) in an area with a shortage of home health agencies; (services limited to RN or LPN only)
G9685	Physician service or other qualified health care professional for the evaluation and management of a beneficiary's acute change in condition in a nursing facility. This service is for a demonstration project

Document History

Date	Action
03/11/2024	Added authorization language to prerequisite section
09/05/2023	Policy Review Date. Added Skilled therapy services language for INTEGRITY. Added Medicaid exclusion.
10/01/2022	Policy Review Date. Format changes. No Content Changes
07/01/2017	Review Date
07/01/2016	Effective Date