What You Need to Know About Skilled Nursing Facilities
Introduction
The purpose of this document is to give you an overview of procedures, requirements and guidelines for skilled nursing facilities (SNFs).

As a reminder, please verify benefits and eligibility. Please visit My Insurance Manager℠ on our websites, www.SouthCarolinaBlues.com or www.BlueChoiceSC.com to determine the appropriate patient liability as well as benefit maximums.

If you have more questions or need additional information about SNFs after reviewing this guide, contact provider.education@bcbssc.com or call 803-264-4730.
Definition of a SNF
A SNF is an inpatient health care facility with the staff and equipment to provide skilled nursing care (such as intravenous injections), rehabilitation and other related health services to patients who need nursing care but do not require hospitalization.

A SNF differs from a hospital in the type of care and the length of stay for patients. A hospital provides a patient with short-term medical care, especially for serious acute disease or trauma. A SNF provides a patient with long-term medical care lasting usually more than 90 days, especially for persons with chronic physical impairment.

Network Participation
Providers can use the Doctor and Hospital Finder to verify network access for BlueCross and BlueShield Plans nationwide. This feature can help you determine whether your SNF is in network for a particular member’s plan no matter which Blue Plan you participate with or which Blue Plan holds the member’s health plan. To access the Doctor and Hospital Finder, visit www.bcbs.com. On the home page, choose “Find a Doctor or Hospital.”

Plan Notification Requirement
Most BlueCross members have managed care requirements in their contracts. These requirements make sure inpatient stays are medically necessary, appropriate and in accordance with the member’s group contract. The preferred method for submitting precertification requests for Preferred Blue® members is through My Insurance Manager on our website, www.SouthCarolinaBlues.com. We resolve a high percentage of Web requests immediately and provide precertification numbers instantly. If you do not have access to the Web, refer to the member’s ID card to get the telephone number for reporting admissions.

We may consider skilled nursing coverage medically necessary when all of these criteria are met:

- Services require a SNF level of care (LOC) and cannot be provided in a less intensive setting.
- Services require the skills of qualified technical or professional health personnel, such as registered nurses, licensed practical (vocational) nurses, physical therapists, occupational therapists, speech language pathologists or audiologists.
- These skilled nursing or skilled rehabilitation personnel directly provide or generally supervise services to assure the safety of the patient and to achieve the medically desired result.
- You provide services under a plan of care a physician establishes and periodically reviews.
- Services are appropriate for the treatment of the illness or injury with the expectation that the condition of the patient will improve in a reasonable and generally predictable period of time. Or, the services must be necessary for the establishment of a safe and effective maintenance program.
Authorization Requirements for SNF Stays
SNF stays require authorization prior to admission. The member must meet medical necessity criteria for approval.

All SNF admissions are subject to concurrent review. They must meet medical necessity criteria and continued stay criteria. We may request this information and/or documentation as part of the continued stay/concurrent review:

- Documentation of progress toward long- and short-term goals.
- Expected length of treatment.
- Examples of documentation we may request:
  - Nursing assessments and progress notes
  - Rehabilitation therapy assessments and progress notes
  - Physician orders and progress notes
How Should You File SNF Claims?
You should bill all services, including those typically rolled up in the per diem-eligible charge, on the UB-04 form.

SNF providers must be able to distinguish between revenue codes and CPT codes when billing for outpatient services. Revenue codes identify a specific accommodation, ancillary service or billing calculation, and come from the National Uniform Billing Committee (NUBC) Official UB-04 Data Specifications Manual. CPT codes the American Medical Association issues are part of a coding structure for medical procedures.

We require complete patient information in the applicable UB-04 fields:
- Billing Provider Name, Address, Telephone
- Billing Provider Designated Pay To Address
- Patient Name
- Patient Address
- Patient Date of Birth
- Patient Sex
- Admission Date

You must also complete the Type of Admission and Point of Origin for Admission fields. Type of admission can be these types: emergency, urgent, elective, newborn, trauma center and information not available. Eligible Points of Origin for Admission are physician referral, clinic referral, transfer from hospital, transfer from SNF and information not available.

When completing the UB-04 field for Type of Bill (TOB), use 21X for a SNF inpatient, 22X for a SNF outpatient-certified bed or 23X for a SNF outpatient non-certified bed [see Example 1]. You should enter remarks – such as Medicare secondary payer claim, LOC, adjustments, etc. – when applicable [see Example 2].

Example 1: UB-04 Type of Bill Field

Example 2: UB-04 Remarks Field
The SNF may bill for ancillary services. The SNF can bill for services other providers provide if the SNF and the outside provider made a contractual agreement.

When a provider provides physical, speech or occupational therapy in an outpatient setting, enter the appropriate two-character CPT modifier code for these services with the HCPCS code for each date of service. Modifiers for therapy services are: GN – speech language pathology (SLP), GO – occupational therapy (OT), and GP – physical therapy (PT). The SNF consolidates and bills therapy services regardless of where the services were provided. Therapy services must be bundled back to the SNF.

Note: When a Medicare patient exhausts his or her Part A benefits or did not meet the Medicare coverage criteria, submit claims to Medicare for Part B services. Claims for Part B services Medicare processes should automatically cross over for secondary payment.

**How are SNF Claims Reimbursed?**

We reimburse SNFs a per diem that we base upon the authorized LOC. Our BlueCross, BlueChoice HealthPlan, State, Federal and Health Care Exchange Products are contracted per the LOC description.

When submitting BlueCard claims, the SNF must indicate on the UB04 claim form the LOC it feels best matches services the member’s Home Plan authorizes. Therefore, patient status will determine the appropriate reimbursement rate.

Skilled nursing providers do not have contracted fee schedules for reimbursement. We base reimbursement upon the LOC the patient received either by the per-diem or per-hour method (for outpatient therapy).
Levels of Care
Generally, we cover care in a SNF if the member meets all of these four factors. The varying layers of skilled nursing care and available amenities that the beneficiary can access is dependent on the LOC required.

1. The patient requires skilled nursing services or skilled rehabilitation services, i.e., services that professional or technical personnel must perform or supervise; a physician orders and renders for a condition for which the patient received inpatient hospital services or for a condition that arose while receiving care in a SNF for a condition for which he or she received inpatient hospital services.

2. The patient requires these skilled services on a daily basis.

3. As a practical matter, considering economy and efficiency, you can only provide the daily skilled services on an inpatient basis in a SNF.

4. The services you deliver are reasonable and necessary for the treatment of a patient’s illness or injury, i.e., are consistent with the nature and severity of the individual’s illness or injury, the individual’s particular medical needs and accepted standards of medical practice. The services must also be reasonable in terms of duration and quantity.

Level I (Standard Services)
- Semi-private rooms
- 24-hour nursing service/supplies
- Pharmacy: routine medications/supplies/supplemental nourishment
- Dietary/nutritional services
- Routine oxygen
- Laboratory tests and services, including interpretation
- Radiology tests and services, including interpretation
- Standard durable medical equipment (DME)
- Family /caregiver/patient education
- Social services and comprehensive discharge planning
- Preadmission assessments
- Comprehensive, interdisciplinary care planning
- Written treatment and therapy evaluations you provide to the care manager or medical director within 72 hours of admission, as indicated
- Measurable clinical goals, including realistic time frames
- On-site care plan meetings with care management teams, as indicated
- Progress evaluations, as the care manager requests
- Quality assessment and improvement program
- Transportation

Level II
- All standard services underevel I
- Therapy evaluations (physical, occupation, speech) as indicated upon admission
- Therapy treatments: up to two hours per day, five days per week
- Education: by nursing and/or rehabilitation staff
- Wound care: up to two treatments per day, single site, surgical, amputation, burns, decubitus - Stage 3 or greater
- Pain management
• Diabetic management
• Colostomy, ileostomy, suprapubic catheter care - peritoneal dialysis
• Hospice care - respite, PO pain management
• Tracheostomy - stable
• Direct admits from operating room with CAD or SQ pump

Level III
• All standard services under Level II
• Comprehensive therapy treatments: up to three hours per day, five days per week
• Education: by nursing and/or rehabilitation staff
• IV infusion, peripheral line maintenance/supplies
• Enteral nutrition and related supplies
• Wound Care: two or more treatments daily or multiple sites requiring debridement, packing, sterile technique, whirlpool or management of drainage tubes
• Tracheostomy - suctioning two times per shift, unstable
• Post-traumatic injury, neurologically stable
• Oxygen: high concentration, nebulizer mist
• Respiratory therapy: one-two treatments daily, seven days per week
• Hospice care: respite, IV pain management, palliative treatment
• Pain management

Level IV
• All standard services under Level III
• 24-hour licensed respiratory therapy care
• Total ventilator and respiratory care, supplies and equipment
• Weekly visits by managing pulmonogist
• Comprehensive therapy treatments: up to four hours per day, seven days per week
• IV infusion, peripheral line, and pump maintenance and supplies
• Enteral nutrition and related supplies
• Isolation for infection control, private room
• Severe burns
• Complex wound care, multiple sites

LOC Reimbursement Exclusions
• Specialized or customized DME, including Clinitron or similar beds, CPM machines, custom wheelchairs, splints, casts and occupational therapy adaptive equipment supplied by an outside vendor*.
• Renal dialysis: treatment and related supplies
• High-cost medications: i.e., third generation antibiotics, epogen, etc.
• Physicians visits, except facility medical director visits

*Note: These services may require separate authorization or approval.
SNF Outpatient Therapy Rates
We reimburse outpatient services, such as PT, speech therapy, OT per hour, including supplies. While the contracted rates are shown as “per hour,” most SNFs bill outpatient therapy on the quarter-hour basis. We calculate reimbursement by dividing the per hour rate by four.
Resources
CMS Medicare Benefit Policy Manual (Pub. 100-02), chapter 8: Coverage of Extended Care (SNF) Services Under Hospital Insurance

Skilled Nursing Facility (SNF) Basics Training Modules
http://www.palmettogba.com/palmetto/providers.nsf/DocsCat/Jurisdiction-11-Part-A~9GGPNT1668