
Skilled Nursing Facility Payment Policy

Policy Statement

Skilled nursing facility/nursing facility (SNF) 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)*
- Commercial**
- Dual CONNECT (Coordination only D-SNP)**
- INTEGRITY for Duals (Fully Integrated D-SNP)**

Prerequisites

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 [Levels of Care Clinical Medical Policy](#).

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

Coverage Includes

Medicaid

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:

- The member is referred by their PCP for skilled nursing services
- The member's condition needs skilled nursing services, skilled rehabilitation services or skilled nursing observation;
- The services are required on a daily basis and can only be provided in a skilled nursing facility.

INTEGRITY for Duals and Dual CONNECT

- All admissions, as ordered by a network physician, must meet medical necessity criteria and require prior authorization. Refer to [Levels of Care Clinical Medical Policy](#) for specific criteria.
- Custodial care is covered for INTEGRITY for Duals. Members must have an approved Long Term Supports & Services (LTSS) Nursing Facility Level of Care waiver from EOHHS to receive custodial care at a nursing facility for more than 30 consecutive days. Eligibility is determined by EOHHS, not Neighborhood.

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.
- 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

- 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 for Duals

- If a member is going to need custodial care in a skilled nursing facility for longer than 30 days, the facility should submit an LTSS waiver application. Neighborhood reserves the right to deny claims after 30 days if no LTSS waiver application has been approved or if the application has been denied by EOHHS. Refer to the LTSS payment policy for more information.
 - If the member is admitted to the hospital during the 30 days for a minimum of 3 day qualifying inpatient stay, Neighborhood would allow 30 days from hospital discharge to obtain an LTSS waiver.
- Professional therapy services billed separately during a skilled nursing facility inpatient stay will be denied.

Dual CONNECT

- 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.
- Dual CONNECT: Medicare-covered skilled nursing facility care is limited to 100 days per benefit period. To become eligible for a new 100-day Medicare covered benefit period of SNF care, the member must be out of a hospital or SNF for 60 days in a row.

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.

Services must be billed in chronological order in order to receive proper reimbursement.

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.

Skilled Nursing Facility (INTEGRITY for Duals and Dual CONNECT)

Neighborhood follows CMS Skilled Nursing Facility (SNF) Prospective Payment System (PPS) requirements as outlined in the Medicare Claims Processing Manual Chapter 6 for SNF Inpatient Part A Billing and SNF Consolidated Billing. Examples include:

- 837 Institutional file format (UB-04)
- the appropriate Health Insurance Prospective Payment System (HIPPS) code
- the appropriate type of bill (21x part A stay, 22x part B services in a non-covered stay)



Custodial Care (INTEGRITY for Duals)

Neighborhood reimburses custodial nursing facility services in accordance with patient-driven payment model (PDPM) state fee-for-service rates. Claims must be submitted with the following:

- 837 Institutional file format (UB-04)
- type of bill 26x
- revenue code 0100 with the corresponding HIPPS code for the member

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.

For Neighborhood CONNECT (Coordination only D-SNP plan), providers must submit claims to Neighborhood and any remaining copays/coinsurance amounts and Medicaid covered benefits to EOHHS for reimbursement.

INTEGRITY for Duals members may have a monthly patient share provision, as determined by the Rhode Island Executive Office of Health and Human Services (RI EOHHS).

Patient share will be applied and is deducted from the benefit allowed amount at the time of payment adjudication. Providers should submit the claim with total billed charges, including patient share.

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.

Neighborhood processes Dual CONNECT and INTEGRITY for Duals in accordance with CMS Medicare guidelines. Refer to [CMS Medicare guidance](#) for complete rules and claims processing policies.



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

Medicaid and Commercial

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

Custodial Care	Revenue Code
Custodial Care Room and Board	0100

Professional Services Coding

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.

CPT Code	Description
	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 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

CPT Code	Description
	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.
99315	Nursing facility discharge day management; 30 minutes or less
99316	Nursing facility discharge day management; more than 30 minutes
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
01/01/2026	Updated policy to include INTEGRITY for Duals and Dual CONNECT Coverage Includes, Coverage Limitations and Exclusions and Claim Submission sections.
11/07/2025	Policy Review Date. No content changes.
06/09/2025	Updated INTEGRITY Coverage Limitations and Exclusions to include LTSS waiver requirements.
12/11/2024	Added custodial care coding grid and added to Claim Submission section
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