Provider Compliance Tips for SNF Services

What’s Changed?
Updated information to include 2020 data.

You’ll find substantive content updates in dark red font.

Introduction
This publication educates providers on proper documentation and billing for skilled nursing facility (SNF) services.

Provider Types Affected
Physicians, non-physician practitioners (NPPs), and providers who bill for services related to patients in Skilled Nursing Facilities (SNFs).
Background

The Medicare Fee-for-Service (FFS) improper payment rate for SNF claims for the 2020 reporting period was 5.4%, accounting for $1.8 billion or 6.8% of the overall Medicare FFS improper payment rate.

The Medicare SNF benefit pays for certain skilled services provided in various skilled nursing settings, including swing-bed hospitals, nursing homes, and other freestanding facilities. Covered SNF services require the skills of qualified technical or professional health personnel. The SNF benefit doesn't cover custodial services alone, such as help with bathing, dressing, and using the bathroom.

Reasons for Denial

Most improper payments for SNF services are the result of insufficient documentation because the certification or recertification statement was missing or didn’t include all required information. Medicare coverage of SNF services requires certification and recertification (42 Code of Federal Regulation [CFR] 424.20).

To Prevent Denials

Claims for skilled care coverage must include enough documentation to determine whether:

- The services require the skills of qualified technical or professional health personnel who will do them safely and effectively
- The services are reasonable and necessary to treat the illness or injury and are consistent with the severity of the illness or injury, the patient’s medical needs, and accepted medical practice standards. The documentation must also show the services are proper in terms of duration and quantity and promote therapeutic goals.

You must assess treatment goals often so the resulting documentation provides enough basis for determining coverage. The patient’s medical record must have:

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

Make sure the patient’s information in the medical record is correct and avoid vague or subjective descriptions that don’t sufficiently show the need for skilled care.
Medical records must also support the medical necessity of SNF services provided. For example, required documents include:

- Certification that the patient needed daily skilled care only provided in a SNF setting
- An authenticated plan of care
- The time (in minutes) for the therapy service provided

**Resources**

- [42 CFR 424.20](#)
- [Department of Health and Human Services Agency Financial Report Fiscal Year 2019](#)
- [Medicare Benefit Policy Manual - Chapter 8 Section 30.2.2.1- Coverage of Extended Care (SNF) Services Under Hospital Insurance, Documentation to Support Skilled Care Determinations](#)
- [Medicare Fee-for-Service 2020 Improper Payments Report](#)

The Center for Program Integrity/Provider Compliance Group Policy Disclaimer Contact your MAC for any updates or changes to the Policy Article (PA) and the Local Coverage Determination (LCD) regarding policy and general documentation requirements.

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