MEDICARE COVERAGE REQUIREMENTS: SNF

Medicare Benefit Policy Manual, Chapter 8: Coverage of Extended Care (SNF) Services

Rev. 12283 (2023) | 58 pages | 48 requirements

KEY PRINCIPLE

Coverage of nursing care and/or therapy to perform a maintenance program does not turn on the presence or absence of an individual's potential for improvement from the nursing care and/or therapy, but rather on the beneficiary's need for skilled care. Skilled care may be necessary to improve a patient's current condition, to maintain the patient's current condition, or to prevent or slow further deterioration of the patient's condition.

pp. 19, 23

Coverage Factors (All Four Required)

ALL four factors must be met simultaneously for SNF coverage. If any one factor is not met, the services are not covered under the SNF benefit.

REQUIRED pp. 18-19

The patient requires skilled nursing services or skilled rehabilitation services, i.e., services that must be performed by or under the supervision of professional or technical personnel.

REQUIRED pp. 18-19

The patient requires those skilled services on a daily basis.

Daily basis = 7 days/week for nursing, or at least 5 days/week for rehabilitation therapy (see Section 30.6, pp. 40-41).

REQUIRED pp. 18-19

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

Not available on an outpatient basis, excessive physical hardship to transport, or insufficient assistance at home to reside there safely (see Section 30.7, pp. 41-43).

REQUIRED pp. 18-19

The services 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.

Documentation Requirements

What the clinical record must demonstrate to support coverage. Leading cause of SNF denials (Section 30.2.2.1).

REQUIRED

The services themselves are reasonable and necessary, 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.

pp. 19, 25

REQUIRED

Skilled involvement is required in order for the services in question to be furnished safely and effectively.

p. 25

REQUIRED

The services are appropriate in terms of duration and quantity, and the services promote the documented therapeutic goals.

p. 25

REQUIRED

The services are ordered by a physician and rendered for a condition for which the patient received inpatient hospital services or for a condition that arose while receiving care in a SNF.

pp. 18-19

REQUIRED

The documentation in the patient's medical record must be accurate and avoid vague or subjective descriptions of the patient's care that would not be sufficient to indicate the need for skilled care.

CMS examples of insufficient documentation: 'Patient tolerated treatment well,' 'Continue with POC,' 'Patient remains stable.'

p. 27

Skilled Services That Qualify

Services that meet the skilled level of care requirement. Coverage exists for improving, maintaining, or preventing decline (Jimmo v. Sebelius).

REQUIRED

Observation and assessment of the patient's condition when the likelihood of change requires skilled nursing or skilled rehabilitation personnel to identify and evaluate the patient's need for possible modification of treatment.

pp. 29-31

REQUIRED

The development, management, and evaluation of a patient care plan based on the physician's orders and supporting documentation.

p. 27

REQUIRED

Teaching and training activities which require skilled nursing or skilled rehabilitation personnel to teach a patient how to manage their treatment regimen.

pp. 31-32

REQUIRED

Direct skilled nursing services: IV/IM injections, enteral feeding, wound care (Stage 3 or worse), catheter insertion and care, tracheostomy aspiration, and rehabilitation nursing procedures.

pp. 32-34

REQUIRED

Physical therapy, occupational therapy, or speech-language pathology services that require the judgment, knowledge, and skills of a qualified therapist.

pp. 34-39

REQUIRED

Maintenance therapy: a maintenance program to maintain the patient's current condition or to prevent or slow further deterioration is covered so long as the beneficiary requires skilled care for the safe and effective performance of the program.

Jimmo v. Sebelius: improvement is NOT required. A maintenance program that requires skilled care for safe and effective delivery is covered.

pp. 37-38

Daily Basis Requirement

The frequency threshold that must be met (Section 30.6).

REQUIRED

Skilled nursing services or skilled rehabilitation services must be needed and provided on a daily basis, i.e., on essentially a 7-days-a-week basis.

This requirement should not be applied so strictly that it would not be met merely because there is an isolated break of a day or two during which no skilled rehabilitation services are furnished and discharge from the facility would not be practical.

pp. 40-41

REQUIRED

A patient whose inpatient stay is based solely on the need for skilled rehabilitation services would meet the daily basis requirement when they need and receive those services on at least 5 days a week.

This 5-day threshold applies only when the stay is based solely on rehabilitation. If nursing services are also needed, the 7-day standard applies to the nursing component.

p. 40

Practical Matter (Inpatient Necessity)

Why the services must be delivered in a SNF rather than on an outpatient basis or at home (Section 30.7).

CONDITIONAL

The daily skilled services are not available on an outpatient basis in the area in which the individual resides.

pp. 41-43

CONDITIONAL

Transportation to the closest facility would be an excessive physical hardship.

pp. 41-43

CONDITIONAL

The patient would have insufficient assistance at home to reside there safely.

Any one of these practical matter conditions satisfies the factor. Also met when outpatient delivery would be less economical or less efficient/effective than the inpatient setting.

p. 41

Appeal-Relevant Policy Language

CMS policy language that directly counters common denial arguments. Frequently omitted from denials.

REFERENCE — p. 24

A patient's diagnosis or prognosis should never be the sole factor in deciding that a service is not skilled.

REFERENCE — pp. 25-26

When a service appears reasonable and necessary at the time it was ordered, it would not then be appropriate to deny the service retrospectively merely because the goals of treatment have not yet been achieved.

Retrospective denial of services that were reasonable when ordered is addressed explicitly in Section 30.2.2.1.

Common Denial Traps

Criteria frequently cited in denials that do not match what CMS policy actually requires.

REFERENCE — pp. 19, 23, 32, 34

TRAP: Denial requires measurable improvement. POLICY: Coverage includes maintenance therapy to maintain current condition or prevent/slow further deterioration.

Jimmo v. Sebelius (2013). Still misapplied.

REFERENCE — pp. 19, 23, 37-38

TRAP: Denial says patient has reached a plateau. POLICY: Plateau does not end coverage if skilled care is needed to maintain the patient's condition safely and effectively.

REFERENCE — pp. 18-19 (see also CMS Ch. 1, Sec. 10)

TRAP: Denial reclassifies care as custodial. POLICY: The determination of whether care is 'custodial' versus 'skilled' depends on whether skilled personnel are required for safe and effective delivery of the services.

REFERENCE — N/A (CMS-4201-F, 2024 Final Rule)

TRAP: Denial cites InterQual, MCG, or nH Predict criteria. POLICY: These are proprietary tools not part of CMS coverage policy. MA plans may not apply criteria more restrictive than Traditional Medicare standards.

External criteria references are the strongest repeatable signal the engine detects.

Documentation Consistency Review

Cross-note review for language that undermines medical necessity or SNF-level support even when services are mentioned elsewhere in the chart.

REQUIRED — p. 27

The documentation in the patient's medical record must be accurate and avoid vague or subjective descriptions of the patient's care that would not be sufficient to indicate the need for skilled care.

Generic progress language such as 'stable,' 'continue per plan,' or 'monitoring' must still be tied to concrete skilled need.

REQUIRED

Coverage of nursing care and/or therapy to perform a maintenance program does not turn on the presence or absence of an individual's potential for improvement, but rather on the beneficiary's need for skilled care.

Plateau, maintenance, or discharge-planning language must be reconciled with the continued need for skilled services.

pp. 18-19

Physician Certification

Certification and recertification requirements for SNF coverage. A routine admission order is NOT sufficient. (Section 40, 42 CFR 424.20)

REQUIRED

A physician certifies that the patient requires skilled nursing or skilled rehabilitation services on a daily basis for a condition for which the patient received inpatient hospital services, or for a new condition that arose while in the SNF.

pp. 44-45

REQUIRED

The certification is a separate signed statement. The routine admission order established by a physician is not a certification of the necessity for post-hospital extended care services.

Must be a separate signed statement indicating the patient will require on a daily basis SNF covered care.

p. 45

REQUIRED

The certification is obtained at the time of admission, or as soon thereafter as is reasonable and practicable.

p. 45

REQUIRED

The certification is signed by the attending physician, a physician on the staff of the SNF who has knowledge of the case, or a physician extender (NP, CNS, or PA) working in collaboration with the physician and without a direct or indirect employment relationship with the facility.

p. 45

Recertification Timing

Schedule for recertifying continued SNF coverage need. (Section 40, 42 CFR 424.20)

REQUIRED

The first recertification must be made no later than the 14th day of inpatient extended care services.

42 CFR 424.20(b): the first recertification is due by day 14 of the SNF stay.

p. 44

REQUIRED

Subsequent recertifications are required at intervals not exceeding 30 days.

p. 44

REQUIRED

Delayed certification and recertification statements are acceptable only when there is a legitimate reason for delay, and the delayed statement must include an explanation of the reasons for the delay.

A late recertification should be paired with a documented explanation, not left unexplained.

42 CFR 424.11(d)(3)

Qualifying Hospital Stay

Prior hospitalization requirements for SNF coverage. 3 consecutive calendar days of medically necessary inpatient care. (Section 20)

REQUIRED

The beneficiary was an inpatient of a hospital for a medically necessary stay of at least 3 consecutive calendar days.

The day of admission counts. The day of discharge does not count.

p. 8

REQUIRED

Time spent in observation or in the emergency room prior to (or in lieu of) an inpatient admission does not count toward the 3-day qualifying inpatient hospital stay.

A person placed on observation has not been admitted to the hospital as an inpatient. Documentation must confirm inpatient status.

p. 8

CONDITIONAL

The 3 consecutive calendar day stay requirement can be met by stays totaling 3 consecutive days in one or more hospitals.

p. 8

SNF Admission Timing

Transfer window from hospital to SNF. (Section 20.2)

REQUIRED

The individual must have been transferred to a participating SNF within 30 days after discharge from the hospital.

The day of discharge is not counted. Example: discharged August 1, admitted to SNF by August 31 = within 30 days.

p. 11

REQUIRED

Extended care services are post-hospital if initiated within 30 days after discharge from a hospital stay that included at least 3 consecutive days of medically necessary inpatient hospital services.

p. 11

CONDITIONAL

An elapsed period of more than 30 days is permitted when the patient's condition makes it medically inappropriate to begin active treatment in a SNF immediately after hospital discharge, and it is medically predictable at the time of discharge that the patient will require covered care within a predeterminable time period.

Exception to 30-day window for delayed need.

p. 12

Plan of Care

Plan of care documentation and structural requirements. (Section 30.2.2.1; 42 CFR 483.21)

REQUIRED
The patient's medical record must document the skilled services provided, the patient's response, and the plan for future care based on the rationale of prior results.

pp. 25-27

REQUIRED
Plan of care structural requirements (type and frequency/duration of services, therapeutic goals, physician signature) are governed by 42 CFR 483.21.

42 CFR 483.21

REQUIRED
A detailed rationale must explain the need for the skilled service in light of the patient's overall medical condition and the complexity of the service to be performed.

pp. 25-27

MDS Assessment

Minimum Data Set assessment timing. Flag for confirmation, not full engine verification. (RAI Manual)

REQUIRED
The 5-day MDS assessment must be completed with an Assessment Reference Date (ARD) set within the required window.

Flag level: engine checks whether ARD is documented. Actual MDS validation is a coding operation handled by PDPM Coach / CORE Analytics.

N/A (RAI Manual)

REQUIRED
The MDS assessment must be submitted to CMS and accepted before the claim is submitted.

Flag level: engine checks for submission confirmation documentation.

N/A (RAI Manual)

Benefit Period Status

Tracks benefit period (spell of illness) eligibility. Maximum 100 SNF days per benefit period. New benefit period starts after 60 consecutive days without inpatient hospital or SNF care.

REQUIRED
The patient must have remaining SNF benefit days within the current Medicare benefit period (maximum 100 days per benefit period).

Days 1-20 fully covered. Days 21-100 require daily coinsurance. Day 101+ not covered.

p. 4 (see also CMS Chapter 3)

REQUIRED
A new benefit period begins when the beneficiary has not been an inpatient of a hospital or SNF for 60 consecutive days.

p. 4 (see also CMS Chapter 3, Section 10)

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This document shows the CMS coverage criteria the Authority Verification Engine uses as its authority source for SNF denial verification. It is extracted from the source policy document for reference. It does not constitute legal or medical advice and does not replace the full CMS policy.