Tufts Medicare Preferred HMO Skilled Nursing Facility Payment Policy

The following payment policy applies to Tufts Medicare Preferred HMO contracted skilled nursing facilities (SNF). For information on Tufts Health Plan Senior Care Options, click here. For information on Commercial, click here.

In addition to the specific information contained here, providers must adhere to the policy information outlined in the professional payment policies for Commercial and Tufts Medicare Preferred HMO/Tufts Health Plan SCO products.

**Note:** Audit and disclaimer information is located at the end of this document.

**POLICY**

Tufts Medicare Preferred HMO covers medically necessary skilled nursing facility (SNF) services.

**GENERAL BENEFIT INFORMATION**

Refer to the Electronic Services section of our website for our self-service channel options. Member eligibility and benefit specifics should be verified prior to initiating services by logging on to our website or by contacting Provider Relations.

Tufts Medicare Preferred HMO follows Medicare coverage guidelines. Tufts Health Plan cannot cover items and services not covered under the CMS-approved Tufts Medicare Preferred HMO benefit plan. Tufts Medicare Preferred HMO's benefit plan currently covers a limited number of non-Medicare covered items as supplemental benefits.

**Note:** Supplemental benefits are subject to change each year.

**Members Covered Under Medicare Part B**

Skilled nursing services will be covered for Tufts Medicare Preferred HMO members in custodial care under the member's Medicare Part B benefit.

**AUTHORIZATION REQUIREMENTS**

Prior authorization for admission to a SNF must be obtained in advance from the member’s primary care provider (PCP) or the Tufts Medicare Preferred HMO care manager or externally managed care manager. The care manager determines the member’s appropriate level of payment (LOP) with the facility based on clinical information presented at the time of admission. Refer to the SNF Level of Payment Guidelines for clarification and descriptions of LOP services.

The facility must notify Tufts Health Plan within 24 hours of an initial admission. The care manager performs ongoing review of the member’s clinical information in order to determine the member’s continued status and LOP. The care manager is responsible for reporting the LOP changes to the Precertification Department.

**Note:** Facilities that, in good faith, admit members who meet skilled criteria on a weekend or holiday will be able to obtain authorization following admission, as long as they contact the care manager on the next business day following admission.

Each time there is a change in the member’s LOP, the Precertification Operations Department will assign a new inpatient notification number as if it were a new admission. Therefore, each LOP will have a distinct inpatient notification number.

The care manager will coordinate all of the member’s skilled needs for authorization. Services excluded from the per diem must be authorized by the care manager and must be obtained from a contracting provider. Any nonemergency service that is not authorized will be the responsibility of the ordering facility.

**Lack of Information**

Tufts Health Plan must receive clinical information in a timely manner. Tufts Health Plan will deny payment of claims when the provider fails to provide the requested clinical information to Tufts Medicare Preferred HMO and/or its delegate, as soon as possible, but generally no later than 4:30
p.m. the next business day following the request. However, in rare circumstances, you may be asked to provide the information in a shorter timeframe.

For a complete description of Tufts Medicare Preferred HMO’s authorization requirements, refer to the Prior Authorizations chapter within the Tufts Medicare Preferred HMO Provider Manual.

**Members Receiving Custodial Care**

The facility must notify the Tufts Medicare Preferred HMO care manager of all custodial admissions. Tufts Medicare Preferred HMO does not provide coverage for custodial care unless it is provided in conjunction with skilled nursing care and/or skilled rehabilitation services.

Providers can request documentation of noncoverage custodial care to facilitate billing to other potential sources of payment by utilizing the following process:

- Call Provider Relations for Tufts Medicare Preferred HMO members.
- Request documentation indicating the member’s benefit plan does not provide custodial care coverage.
- Provide Tufts Health Plan with the provider’s NPI number, the patient’s Tufts Health Plan member ID number, and the provider’s mailing address or fax number.

A response will be sent out in 7-10 business days.

**Referral Not Required for Behavioral Health Services**

A referral is not required for Tufts Medicare Preferred HMO members for behavioral health services rendered in place of service 31 or 32.

**BILLING INSTRUCTIONS**

- Submit place of service 31 for procedures performed in a SNF.
- Submit a corresponding CPT and/or HCPCS procedure code for every date of service submitted when a date range is indicated in box 6 of the UB-04.

The following levels of payment must be billed with the corresponding revenue codes for SNF services. The LOP billed must match the LOP and length of stay that was authorized.

<table>
<thead>
<tr>
<th>Level of Payment</th>
<th>Service Description</th>
<th>Revenue Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 1A</td>
<td>Skilled evaluation</td>
<td>190</td>
</tr>
<tr>
<td>Level 1B</td>
<td>Skilled nursing and/or skilled rehabilitation</td>
<td>191</td>
</tr>
<tr>
<td>Level 2</td>
<td>Subacute nursing and/or subacute rehabilitation</td>
<td>192</td>
</tr>
<tr>
<td>Level 3</td>
<td>Subacute nursing and/or subacute rehabilitation - ventilation program</td>
<td>193</td>
</tr>
</tbody>
</table>

- Disagreements with a member’s authorized LOP should be discussed directly with the care manager.
- To expedite the processing of claims, it is recommended that separate billing be submitted for each inpatient notification number or distinct LOP.

Refer to the SNF Level of Payment Guidelines for additional information.

For DME supplies/equipment that are excluded from the per diem, the skilled nursing facility (SNF) may obtain authorized supplies or equipment directly from a Tufts Medicare Preferred HMO contracted DME provider. The contracted DME provider will then bill Tufts Health Plan directly.

**Tufts Medicare Preferred HMO Members with Medicare Part B**

Skilled therapy services will be covered for Tufts Medicare Preferred HMO members in custodial care under the member’s Medicare Part B benefit. Physical therapy (PT), occupational therapy (OT) and speech therapy (ST) services can be billed by the facility only with the following service codes, as described in the provider agreement, and only when prior authorization has been given by the care manager. All supplies and other services must be obtained from Tufts Medicare Preferred HMO contracting providers who will bill Tufts Medicare Preferred HMO directly.

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>92507</td>
<td>ST treatment</td>
</tr>
<tr>
<td>92521</td>
<td>Evaluation of speech fluency (e.g., stuttering, cluttering)</td>
</tr>
<tr>
<td>Procedure Code</td>
<td>Description</td>
</tr>
<tr>
<td>----------------</td>
<td>-------------</td>
</tr>
<tr>
<td>92522</td>
<td>Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria)</td>
</tr>
<tr>
<td>92523</td>
<td>Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria) with evaluation of language comprehension and expression (e.g., receptive and expressive language)</td>
</tr>
<tr>
<td>92524</td>
<td>Behavioral and qualitative analysis of voice and resonance</td>
</tr>
<tr>
<td>92610</td>
<td>Evaluation of oral and pharyngeal swallowing function</td>
</tr>
<tr>
<td>97161</td>
<td>Physical therapy evaluation: low complexity</td>
</tr>
<tr>
<td>97162</td>
<td>Physical therapy evaluation: moderate complexity</td>
</tr>
<tr>
<td>97163</td>
<td>Physical therapy evaluation: high complexity</td>
</tr>
<tr>
<td>97164</td>
<td>Re-evaluation of physical therapy established plan of care</td>
</tr>
<tr>
<td>97165</td>
<td>Occupational therapy evaluation, low complexity</td>
</tr>
<tr>
<td>97166</td>
<td>Occupational therapy evaluation, moderate complexity</td>
</tr>
<tr>
<td>97167</td>
<td>Occupational therapy evaluation, high complexity</td>
</tr>
<tr>
<td>97168</td>
<td>Re-evaluation of occupational therapy established plan of care</td>
</tr>
<tr>
<td>G0151</td>
<td>PT Treatment, 15 minutes</td>
</tr>
<tr>
<td>G0152</td>
<td>OT Treatment, 15 minutes</td>
</tr>
</tbody>
</table>

**Note:** All other HCPCS and CPT codes will be denied if billed for PT, OT or ST services.

**COMPENSATION/REIMBURSEMENT INFORMATION**

**Delivery of Termination of Services (NOMNC)**

All medical record information is to be submitted directly to Livanta to support a termination of services during the fast track appeal process for every fast track appeal requested by a Tufts Medicare Preferred HMO member. Tufts Health Plan does not require a copy of the medical record prior to the submission to Livanta.

Submission of incomplete medical record information and/or an incomplete or invalid Notice of Medicare Noncoverage (NOMNC) may result in the denial of payment for the entire SNF admission. Medical record information submitted to Tufts Health Plan to support a termination of services during the fast track appeal process must be complete. For a medical record to be considered complete the following must be submitted to Tufts Health Plan for every fast track appeal requested by a Tufts Medicare Preferred HMO member:

- Valid NOMNC, as defined by CMS (CMS notification form OMB #00938-0953)
- At a minimum, the medical record must include all of the following:
  - All items listed on the "Livanta Fax Cover Sheet for Fast Track Appeals",
  - An attending practitioner (e.g., MD or NP) progress note written within two calendar days of delivery of NOMNC, and must include all of the following:
    - A statement that the member's current condition is stable and that he/she is ready for discharge
    - A statement that member no longer requires or will benefit from inpatient skilled services
    - An outline of the member's discharge plan, to where member will be discharged and what the transition of care plan is
    - A statement that addresses any open medical issues and how they are going to be managed
  - An attending practitioner's order to discharge member from skilled services, documented in the medical record by the date that the NOMNC is issued
  - A progress note from each applicable rehabilitation service (PT, OT, ST) which describes the member's current functional level, stability of his/her medical condition and a description of the discharge plan including any treatments to be carried out after discharge (e.g., met goals, has reached maximum potential, will be discharged home with outpatient rehab services, will remain at facility at a custodial level)

Effective for dates of service on or after February 1, 2015, submission of an incomplete medical record and/or an invalid NOMNC*, which results on an overturn of the decision to discharge the member from...
skilled services, will result in the denial of payment for the entire SNF admission. Medical record information submitted to Livanta to support a termination of services during the fast track appeal process must be complete. Per Livanta, for a medical record to be complete the following must be submitted to Livanta for every fast track appeal requested by a Tufts Medicare Preferred HMO member:

- Copy of important message (hospital's) or NOMNC
- Copy of detailed notice of discharge or detailed explanation of noncoverage
- Face Sheet I Admission Order
- History and Physical I Discharge Summary
- Provider orders and current provider progress notes
- Discharge planning notes
- Therapy evaluations with current progress and goals (if applicable)
- Emergency department notes (if applicable)
- Radiology and other tests/procedure reports (if applicable)
- Operative reports/consultations (if applicable)
- Up to the last two days of the following:
  - Nurses’ notes, social service notes, vital signs, lab work and flow sheets
  - Medication administrative records (if applicable)

*A valid NOMNC is defined by CMS (CMS notification form OMB #00938-0953)

### DOCUMENT HISTORY

- June 2017: Process clarified for DME supplies ordered by SNFs
- May 2017: Removed 97001-97004, added 97161-97168
- January 2017: Template updates
- September 2015: Template conversion
- April 2015: Template updates
- January 2015: Added Revenue Codes 0681-0684, 0689, 1000-1002 accepted when submitted electronically without a corresponding CPT and/or HCPCS procedure code; template updates
- December 2014: Added that all medical record information is to be submitted directly to Livanta and updated process for submission of an incomplete medical record and/or an invalid Notice of Medicare Non-Coverage (NOMNC), effective for dates of service on or after February 1, 2015, added Revenue Codes 0681-0684, 0689, 1000-1002 accepted when submitted electronically without a corresponding CPT and/or HCPCS procedure code
- November 2014: Policy reviewed; added CPT procedure code 92610; moved Tufts Health Plan Senior Care Options to its own document; template updates
- March 2014: Added changes to Delivery of Termination of Services (NOMNC), effective May 1, 2014
- February 2014: Codes added effective January 1, 2014
- November 2013: Added information regarding Tufts Plan Senior Care Options; template updates
- September 2013: Template updates
- March 2013: Policy reviewed for addition of SCO information; template updates
- June 2011: Reviewed document for clarity; no content changes made
- May 2010: Added weekend/holiday admission under Authorization Requirements section
- January 2010: Removed references to the Tufts Medicare Preferred PPO product
- April 2009: Policy created; moved Tufts Medicare Preferred HMO to its own document

### AUDIT AND DISCLAIMER INFORMATION

Tufts Health Plan reserves the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in this payment policy. If such an audit determines that your office/facility did not comply with this payment policy, Tufts Health Plan will expect your office/facility to refund all payments related to non-compliance. For more information about Tufts Health Plan’s audit policies, refer to our website.

This policy provides information on Tufts Medicare Preferred HMO claims adjudication processing guidelines. As every claim is unique, the use of this policy is neither a guarantee of payment nor a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management guidelines when applicable, adherence to plan policies and procedures and
claims editing logic. An authorization is not a guarantee of payment. Claims for services subject to
authorization may be reviewed for accuracy and compliance with payment policies.