Tufts Medicare Preferred HMO Skilled Nursing Facility Payment Policy

The following payment policy applies to Tufts Medicare Preferred HMO contracting skilled nursing facilities (SNF) as well as noncontracting providers rendering services outside the member’s service area. Under certain circumstances, a member may be authorized by the applicable care manager (CM) for services outside the network. 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 Services and Facilities Payment Policy.

**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, in accordance with the member’s benefits.

**GENERAL BENEFIT INFORMATION**

Services and subsequent payment are based on the member’s benefit plan document. 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. The 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 are covered for Tufts Medicare Preferred HMO members in custodial care under the member’s Medicare Part B benefit.

**AUTHORIZATION REQUIREMENTS**

**Inpatient Notification for Skilled Admissions**

Prior authorization for admission to a SNF must be obtained in advance from the member’s PCP or the Tufts Medicare Preferred HMO care manager (CM) or externally managed CM. The CM 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 CM performs ongoing review of the member’s clinical information in order to determine the member’s continued status and LOP. The CM is responsible for reporting the LOP changes to the Precertification Operations 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 CM 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 CM will coordinate all of the member’s skilled needs for authorization. Services excluded from the per diem must be authorized by the CM 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, providers 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 CM 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.

**Note:** A referral is not required for members for behavioral health services rendered in place of service 31 (SNF inpatient) or 32 (SNF outpatient). This applies to both skilled and custodial admissions.

**BILLING INSTRUCTIONS**
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.

**Note:** All other HCPCS, CPT and HIPPS codes will be denied if billed for services not outlined in the provider agreement.

<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>0190</td>
</tr>
<tr>
<td>Level 1B</td>
<td>Skilled nursing and/or skilled rehabilitation</td>
<td>0191</td>
</tr>
<tr>
<td>Level 2</td>
<td>Subacute nursing and/or subacute rehabilitation</td>
<td>0192</td>
</tr>
<tr>
<td>Level 3</td>
<td>Subacute nursing and/or subacute rehabilitation - ventilation program</td>
<td>0193</td>
</tr>
</tbody>
</table>

Disagreements with a member’s authorized LOP should be discussed directly with the CM. To expedite the processing of claims, separate billing must 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 SNF may obtain authorized supplies or equipment directly from a Tufts Medicare Preferred HMO contracting DME provider. The contracting DME provider will then bill Tufts Health Plan directly.

**Tufts Medicare Preferred HMO Members with Medicare Part B**
Skilled therapy services are covered for members in custodial care under the member’s Medicare Part B benefit. Physical (PT), occupational (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 CM. All supplies and other services must be obtained from Tufts Medicare Preferred HMO contracting providers who will then 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, clattering)</td>
</tr>
<tr>
<td>Procedure Code</td>
<td>Description</td>
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<tr>
<td>---------------</td>
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</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 CPT/HCPCS codes will be denied if billed for PT, OT or ST services.

**COMPENSATION/REIMBURSEMENT INFORMATION**

Providers are compensated in accordance with the financial exhibits of their provider agreements. The SNF will be compensated the contracted per diem rate, starting on the day of admission and ending on the evening before the day of discharge.

With the exception of an emergency, the facility must obtain prior authorization and must utilize a Tufts Health Plan participating provider for any services excluded from the per diem. The cost of any nonemergency service not approved will be the responsibility of the ordering facility. Coverage requests for services for members that are not approved are subject to the organization determination process described at 42 CFR422.566 et seq.

**ADDITIONAL RESOURCES**

- Inpatient Facility Payment Policy
- Inpatient Rehabilitation and Long-Term Acute Care Facility Payment Policy

**DOCUMENT HISTORY**

- March 2018: Template updates
- September 2017: Policy reviewed by committee; removed NOMNC content; added applicability of out-of-network providers when authorized
- 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.