Tufts Medicare Preferred HMO Skilled Nursing Facility Payment Policy

Applies to the following Tufts Health Plan products:

- ☐ Tufts Health Plan Commercial (including Tufts Health Freedom Plan)¹
- ☒ Tufts Medicare Preferred HMO (a Medicare Advantage product)
- ☐ Tufts Health Plan Senior Care Options (SCO) (a dual-eligible product)

The following payment policy applies to Tufts Health Plan 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 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, as described below.

<table>
<thead>
<tr>
<th>GENERAL BENEFIT INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Services and subsequent payment are pursuant to the member’s benefit plan document. Member eligibility and benefit specifics should be verified prior to initiating services by logging on to the secure Provider website or by contacting Senior Products Provider Relations.</td>
</tr>
</tbody>
</table>

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

Inpatient notification for admission to a SNF must be obtained by faxing a completed Inpatient Notification Form to the Precertification Operations Department at 617.972.9409. Refer to the Notifications chapter of the Tufts Medicare Preferred HMO Provider Manual for more information on the inpatient notification process.

The member’s care manager (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 each LOP.

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 LOP changes to the Precertification Operations Department.

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¹ Commercial products include HMO, POS, PPO, Tufts Health Freedom Plan, and CareLinkSM when Tufts Health Plan is the primary administrator.
**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, a new inpatient notification number will be assigned 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 may request documentation of noncoverage custodial care to facilitate billing to other potential sources of payment by utilizing the following process:
- Call Senior Products Provider Relations at 800.279.9022
- 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 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 may 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, cluttering)</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 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.

**DOCUMENT HISTORY**

- October 2018: Template updates
- July 2017: Policy reviewed by committee; added Tufts Medicare Preferred HMO and Tufts Health Plan SCO product information to combine policies
- January 2017: Template updates
- September 2015: Template conversion, template updates
- July 2015: Added allergy testing/screening policies effective for dates of service on or after October 1, 2015, template updates
- June 2015: Template updates
- June 2014: Policy reviewed, formatting changes, template updates
- September 2013: Template conversion
- January 2013: Template updates
- September 2012: Removed CPT procedure codes 95004, 95024 from note on page 3, as CMS no longer considers these codes as “incident to services”
- June 2012: Added the procedure codes covered only under direct provider supervision, which were previously documented in the Noncovered Services Medical Necessity Guidelines
- April 2012: Template updates
- March 2012: Updated CareLink disclaimer language
December 2009: Reviewed without changes
April 2009: Removed the following edit: Allergy testing CPT procedure codes 95004-95024 will not be reimbursed when billed with CPT procedure code 95027. This is no longer effective.
February 2008: Revised general benefit information with self-service channels information

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 an office/facility did not comply with this payment policy, Tufts Health Plan will expect the office/facility to refund all payments related to noncompliance. For more information about Tufts Health Plan’s audit policies, refer to the Provider website.

This policy provides information on Tufts Health Plan claims adjudication processes. As every claim is unique, this policy is neither a guarantee of payment, nor a final indication 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 requirements (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.

This policy applies to the Tufts Health Plan products, as identified in the checkboxes on the first page, and to CareLinkSM for providers in Massachusetts and Rhode Island service areas. Providers in the New Hampshire service area are subject to Cigna’s provider agreements with respect to CareLink members. This policy does not apply to the Private Health Care Systems (PHCS) network (also known as Multiplan). Tufts Health Plan reserves the right to amend a payment policy at its discretion.