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. For information on Tufts Medicare Preferred HMO, click here; for information on Commercial products, click here.

In addition to the specific information contained in this policy, providers must adhere to the 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 Health Plan covers medically necessary skilled nursing facility (SNF) services, in accordance with the member's benefits.

GENERAL BENEFIT INFORMATION

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.

Note: There is no member responsibility for covered services for Tufts Health Plan SCO members.

AUTHORIZATION/NOTIFICATION REQUIREMENTS

As a condition of payment, Tufts Health Plan requires inpatient notification for any member who is being admitted to a SNF, regardless of whether Tufts Health Plan is the primary or secondary insurer.

Inpatient notification must be obtained via electronic submission on the secure Provider website or by faxing a completed Inpatient Notification Form, along with the supporting clinical documentation, to the Precertification Operations Department.

Note: No other forms will be accepted. Incomplete forms will be returned to the submitting provider for completion and resubmission. Processing the request will be delayed until all required information is returned to Tufts Health Plan. For more information, refer to the Senior Care Options (SCO) Skilled Nursing Facility Documentation Submission Guide.

The facility must notify Tufts Health Plan prior to an elective admission to obtain an inpatient notification number, following the submission processes outlined in the Senior Products Provider Manual. Urgent/emergency admissions must be reported by 5 p.m. on the next business day following admission.

Tufts Health Plan determines the appropriateness for admission and the level of care (LOC) with the facility based on the clinical information presented at the time of admission and appropriate criteria. Tufts Health Plan performs ongoing review of the member's clinical information in order to determine the member's continued status and LOC. Any disagreements with the member's LOC should be discussed directly with the Tufts Health Plan CM. To identify the member's CM, contact Senior Products Provider Relations.

Each time there is a change in the member's LOC, a new inpatient notification number will be assigned as if it were a new admission. Therefore, each LOC will have a distinct inpatient notification number. Refer to the SNF Level of Care Guidelines for clarification and descriptions of each LOC.

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[1] Commercial products include HMO, POS, PPO, Tufts Health Freedom Plan, and CareLink℠ when Tufts Health Plan is the primary administrator.

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.

Services Excluded From the Per Diem
Services excluded from the per diem must be authorized as medically necessary by Tufts Health Plan and be obtained from a contracting provider. Any nonemergency service that is not authorized or provided by a Tufts Health Plan provider will be the responsibility of the ordering facility. Coverage requests for services that are not approved are subject to the organization determination process described at 42 CFR 422.566 et seq.

Custodial Care and Long Term Care
Notification is required for custodial and long term care admissions.

Effective for dates of service on or after November 1, 2020, Tufts Health Plan will require providers to complete and submit a Management Minutes Questionnaire (MMQ) covering the long-term care stay within 30 days from admission. Tufts Health Plan will not reimburse providers unless the MMQ has been submitted. For more information, refer to the Senior Care Options (SCO) Skilled Nursing Facility Documentation Submission Guide.

BILLING INSTRUCTIONS

Tufts Health Plan follows AMA CPT/HCPCS coding guidelines. Refer to current industry standard coding guidelines for a complete list of procedure codes, modifiers and their usage. Refer to the Professional Services and Facilities Payment Policy for more information.

- Submit claims for per diem skilled services with bill type 21X and a revenue code only
- Submit claims for Medicare Part B services with bill type 22X, a revenue code and a HCPCS code.
- **Same-day transfers:** include condition code 40 on the claim if the member is transferred to another facility before midnight on the same day as the initial admission, in accordance with CMS requirements.
- Any services excluded from the per diem should be billed to Tufts Health Plan directly by the contracting provider
- Submit separate claims for each inpatient notification number and distinct LOC
- Submit a valid HIPPS (Health Insurance Prospective Payment System) code on all SNF claims. Claims submitted without a valid HIPPS RUG code will deny.
  Note: As HIPPS levels change at each review per MDS requirement at 5, 14, 30, 60 and 90 days, the facility must submit a new inpatient notification with each RUG/MDS review.

The following LOC/service descriptions must be billed with the corresponding revenue code(s). The LOC billed must match the LOC and length of stay that was authorized.

Level of Care	Service Description	Revenue Code
Level 1A	Skilled evaluation	0190
Level 1/1B	Skilled nursing and/or skilled rehabilitation	0191
Level 2	Subacute nursing and/or subacute rehabilitation	0192
Level 3	Subacute nursing and/or subacute rehabilitation-ventilation program	0193
	Bedhold (for hospitalization)	0185
	Therapeutic leave day	0183
	Evaluation and stabilization, escalated services in lieu of hospitalization	0194
	Medicaid institutionalized members	0100
	Respite, not in the home	H0045

Outpatient Therapy Services
Skilled therapy services will be covered for Tufts Health Plan SCO members meeting the institutional level of care (refer to the Senior Care Options (SCO) Skilled Nursing Facility Documentation Submission Guide). Physical (PT), occupational (OT) and/or speech therapy (ST) services can be billed by the facility only with the following procedure codes, as described in the provider agreement, and only when prior authorization has been given by Tufts Health Plan.

Code	Description
92507	ST treatment
92521	Evaluation of speech fluency
92522	Evaluation of speech sound production
92523	Evaluation of speech sound production with evaluation of language comprehension and expression
92524	Behavioral and qualitative analysis of voice and resonance
92610	Evaluation of oral and pharyngeal swallowing
97161	Physical therapy evaluation: low complexity
97162	Physical therapy evaluation: moderate complexity
97163	Physical therapy evaluation: high complexity
97165	Occupational therapy evaluation, low complexity
97166	Occupational therapy evaluation, moderate complexity
97167	Occupational therapy evaluation, high complexity
G0151	PT treatment, 15 minutes
G0152	OT treatment, 15 minutes

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. The SNF will only be compensated for the day of discharge if the member stays in the same facility for long term care.

Preadmission Screening and Resident Review (PASRR)

In accordance with federal regulation and the Massachusetts Executive Office of Health and Human Services (EOHHS), effective for dates of service on or after January 1, 2020, Tufts Health Plan will not compensate SNF services provided to Tufts Health Plan SCO members unless the SNF has completed the PASRR process. Skilled nursing facilities must follow the Preadmission Screening and Resident Review (PASRR) process to help ensure that individuals are not inappropriately placed in nursing homes for long term care.

Tufts Health Plan may request copies of completed PASRR forms for members; if the SNF is unable to provide a completed form, Tufts Health Plan may retract and/or deny future payment until the PASRR process is completed.

Patient Paid Amount (PPA)

The PPA is the portion of monthly income that a member in a nursing facility must contribute to the cost of care. When a SCO member transitions to a nursing facility, the PPA is reduced from the monthly capitation payment to the senior care organization. The senior care organization is responsible for reconciling the PPA with the appropriate facility.

PPA, if applicable, should be reflected in fields 39-41 on the UB-04, Value Codes. Acceptable Value Codes to report the PPA are 23, 24, 31 or FC. Upon processing, the PPA will be deducted from the claim payment to the facility. The absence of a PPA, when applicable, will result in a reduced payment to reflect the state reported PPA.

ADDITIONAL RESOURCES

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

DOCUMENT HISTORY

- November 2020: Added condition code 40 billing requirement for members being transferred to another facility, in accordance with CMS requirements
- September 2020: Adjusted effective date of required MMQ form submission to dates of service on or after November 1, 2020
- February 2020: Added content that Tufts Health Plan will no longer reimburse long-term care skilled nursing facilities without a completed MMQ, effective for dates of services on or after May 1, 2020; updated policy and billing sections; clarified PPA

- November 2019: Added PASRR process requirements for compensation of SNF services, effective for dates of service on or after January 1, 2020
- March 2019: Policy reviewed by committee; clarified authorization time frames for admissions
- June 2018: Template updates
- May 2018: Updated Tufts Health Plan SCO inpatient notification fax number effective for dates of submission on or after May 1, 2018
- 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
- July 2016: Updated inpatient notification process effective July 1, 2016
- September 2015: Template conversion
- April 2015: Template updates
- December 2014: Tufts Health Plan SCO information was moved into its own policy, added changes to the Fast Track process, effective on or after dates of service February 1, 2015

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 a provider/facility did not comply with this payment policy, Tufts Health Plan will expect the provider/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 CareLink℠ 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.