Skilled Nursing Facility Payment Policy

Applies to the following Tufts Health Public Plans products:

☒Tufts Health Direct – Health Connector

☒Tufts Health RITogether – A RI Medicaid Plan

☒Tufts Health Together – Includes MassHealth Plan and Accountable Care Partnership Plans

☒Tufts Health Unify – OneCare Plan

The following payment policy applies to Tufts Health Plan contracting skilled nursing facilities who render services for Tufts Health Public Plans products.

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.

DEFINITION

A skilled nursing facility is an appropriately licensed inpatient facility that provides skilled nursing to members who do not require, or no longer require, the services of an acute care hospital.

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 Provider Services.

Note: There is no member responsibility for covered services for Tufts Health Unify, Tufts Health Together or Tufts Health RITogether members.

Tufts Health Unify

Tufts Health Unify follows Medicare coverage guidelines for Medicare-covered benefits and Medicaid coverage guidelines for Medicaid-only covered benefits.

AUTHORIZATION/NOTIFCATION 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 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.

The facility must notify Tufts Health Plan, following procedures outlined, in the Tufts Health Public Plans Provider Manual.

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 InterQual® or 130 CMR 456.409 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, following procedures outlined in the Tufts Health Public Plans Provider Manual.

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.

Custodial Care
Tufts Health Direct and Tufts Health Together
Tufts Health Plan does not provide coverage for custodial care. However, outpatient therapy services for members that reside in a SNF may be covered if the member meets medical necessity criteria.

The facility must notify Tufts Health Plan of all custodial admissions.

Tufts Health RITogether and Tufts Health Unify
Institutional/custodial admissions are covered for Tufts Health RITogether and Tufts Health Unify members and require prior authorization.

LEVELS OF CARE

Tufts Health Plan covers the following medically necessary levels of care based on InterQual® or 130 CMR 456.409 criteria.

- Sub-acute Level 1: Skilled nursing
- Sub-acute Level 2: Subacute care
- Sub-acute Level 3: Complex care

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. For more information refer to the Professional Services and Facilities Payment Policy.

Levels of Care
The following levels of payment (LOC) must be billed with the corresponding revenue codes for SNF services. The LOC billed must match the authorized LOC and length of stay.

Revenue Code	Level of Care/Service Description
0191	Level 1 - Subacute skilled nursing
0192	Level 2 - Subacute nursing and/or subacute rehabilitation
0193	Level 3 - Subacute nursing and/or subacute rehabilitation-ventilation program

Same-Day Transfers (Tufts Health Unify)
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.

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.

Tufts Health Unify – Custodial Care 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 Tufts Health Unify member transitions to a SNF, the PPA is reduced from the monthly capitation payment.

PPA, if applicable, should be reflected as a line item on the submitted claim and identified by value code FC (recurring monthly income) with corresponding amount in the following field. Use first Value Code field for PPA. Upon processing, the PPA will be deducted from the claim payment to the facility.

ADDITIONAL RESOURCES

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

DOCUMENT HISTORY

- November 2020: Added condition code 40 billing requirement for Tufts Health Unify members being transferred to another facility, in accordance with CMS requirements
- April 2019: Policy created

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.