Skilled Nursing Facility Payment Policy

Policy

The Plan covers medically necessary skilled nursing facility (SNF) admissions.

Definitions

To be considered a skilled service, the service must be of sufficient complexity that it can only be safely and effectively performed by or under the supervision of professional or technical personnel. Skilled nursing and/or skilled rehabilitation services are those services furnished pursuant to physician orders, that:

- Require the skills of qualified technical or professional health personnel such as registered nurses, licensed practical (vocational) nurses, physical therapists, occupational therapists, and speech-language pathologists or audiologists; and
- Must be provided directly by or under the general supervision of these skilled nursing or skilled rehabilitation personnel to assure the safety of the patient and to achieve the medically desired result.

Reimbursement

SNF facilities are reimbursed at a single all-inclusive (per diem) rate as determined by the contracted rate. Prior authorization is required and notification to the Plan must be made within appropriate time frames.

The per diem rate is generally considered payment in full for all services provided to the member and includes the following (please note that these are general examples of what is covered in the per diem rate; this list is not necessarily all inclusive and may be subject to the particular contract with the facility):

- Daily nursing care
- Discharge planning
- IV therapy
- Lab
- Medical supplies and equipment (including, but not limited to, respiratory and oxygen supplies, IV sets and equipment, pumps)
- Oxygen
- Pharmaceuticals
- Private Room, when medically indicated
- Radiology, EEG, EKG - Diagnostic component only
- Recreational therapy
- Respiratory therapy
- Semi-private room and board
- Social services
- Standard DME (i.e.: commodes, shower chairs, walkers, wheel chairs). Any specialized DME required for patients should be requested via prior authorization.
    - Non-disposable single patient use DME provided as part of an individual member's skilled stay is included in the per diem rate and should be sent home with the member upon discharge from the facility. This includes (but is not limited to) bed pans, emesis basins, splints, and tens.
    - Non-disposable/multi-patient use DME provided as part of an individual member's skilled stay that is owned or rented by the facility is included in the per diem rate and should not be sent home with the member upon discharge. This includes (but is not limited to) wheelchairs, walkers, and canes.
    - If the Plan purchases any DME on behalf of an individual member receiving care within the facility (either purchased from the SNF or from an independent DME

provider), those items must be sent home with the patient upon discharge from the facility. These items include but are not limited to: Customized orthotics, prosthetics, adaptive devices, and bariatric equipment.
    - ➢ The SNF agrees to not delay obtaining authorization and ordering any custom-type device that is medically necessary to promote discharge and rehabilitation of the member. This type of DME must be authorized by the Plan and ordered through a Plan-contracted DME provider.
- Therapies: Physical therapy, Occupational therapy, and Speech therapy (including evaluation and documentation)
- Tracheostomy supplies/other tubes
- Transportation that is medically necessary (ambulance or chair van) that is part of the patient plan of care

<u>Services Not Included in the Per Diem Rate</u>

With the exception of emergencies, the SNF agrees to obtain prior authorization for these services and will utilize the Plan's contracted vendors. Covered services provided by outside vendors should be billed to the Plan by the vendor, unless noted as an inclusion. The SNF will be financially responsible for any excluded transportation service that does not have proper authorization. (This list is not necessarily all inclusive and may be subject to the particular contract with the facility):

- Blood products used in blood transfusions
- Dialysis
- Hospice Service (please see Hospice Payment Policy)
- Modified barium swallow
- MRI/CT Scan
- Orthotic or prosthetic equipment
- Physician extenders
- Professional charges for services rendered by physicians
- Radiation therapy/chemotherapy
- Specialized/customized DME (typical high-priced DME items that are excluded):
    - CPM machine
    - Respiratory assist device
    - Ventilator
    - Non-powered advanced pressure reduction overlay
    - Powered pressure reducing Air Mattress
    - Powered air flotation bed – loss air therapy
    - Special wheel chairs
- Total parenteral nutrition (TPN)
- Transportation (ambulance or chair van) excluded only for the following services:
    - Cardiac catheterizations
    - Chemotherapy services
    - Computerized axial tomography
    - Dialysis
    - Magnetic resonance imaging
    - Ambulatory surgery involving use of operating room
    - Emergency services
    - Radiation therapy
    - Angiography
    - Lymphatic and venous procedures

    Refer to *Transportation* Services payment policy for additional information.
- Ultrasound
- Ventilator
- Authorized IV Insertion by contracted providers.
- Wound Vacuums

Pharmaceutical Exclusions
Drugs may be eligible for exclusion if the cost per day for the drug is more than 10% of the SNF daily rate. Prior authorization is required.

Therapy Services Covered Under Medicare Part B
Therapy services (physical therapy, occupational therapy and speech-language therapy) are separately reimbursable for Medicare plan members (Fallon Medicare Plus, NaviCare and PACE) when the plan member has Medicare Part B coverage for therapy services and either (1) the plan member is a resident of the SNF and the SNF stay is non-covered (e.g., benefits exhausted, no qualifying hospital stay, etc.), or (2) the SNF is contracted to provide outpatient therapy services to plan members. Under these circumstances the SNF must provide and bill or obtain under arrangement and bill for the rehabilitation services.

Referral/notification/prior authorization requirements

Prior authorization is required for all Plan products including commercial, Medicare and MassHealth.

Fallon Health Weinberg, and Navicare® models of care are based on patient care coordination; therefore, we encourage referring providers to contact the member's designated navigator if there are questions or concerns prior to prescribing tests, supplying equipment, or any other additional appointments or services that may not routinely be authorized or require prior authorization.

Summit ElderCare® is based on member care coordination; therefore, the referring Summit ElderCare PACE site must be contacted for approval, prior to coordinating and/or rendering services.

NaviCare specific requirements
Preadmission Screening and Resident Review (PASRR) for Nursing Facilities:

The Preadmission Screening and Resident Review (PASRR) process requires that all Enrollees going to Medicaid certified nursing facilities be given a preliminary assessment to determine whether they might have Serious Mental Illness (SMI) or Intellectual Disability (ID).

This is called a "Level I screen." Those Enrollees who test positive at Level I, they are then evaluated in depth, called "Level II" PASRR. The results of this evaluation outline a determination of need, determination of appropriate setting, and a set of recommendations for services to inform the Enrollee's plan of care. It is a requirement and the responsibility of the facility to insure that every Fallon Health Enrollee admitted for nursing care has a PASRR performed and related documentation is on file.

The Plan reserves the right to audit the facility to insure compliance with the PASRR. In addition to the audit, if it is then determined that there is no evidence of a completed PASRR on file for any admitted NaviCare Enrollee,

The Plan reserves the right to deny or retract payment to the facility for that admission. Furthermore, the facility acknowledges that NaviCare Enrollees do not have a financial obligation in this matter and will not be subject to any balance billing from the facility; for any balance billing attempts, the facility may be in breach of its contract with The Plan.

Billing/coding guidelines

Claims should be submitted using industry standard codes.

Health Insurance Prospective Payment System (HIPPS) codes:
HIPPS codes must be submitted on claims for members enrolled in Fallon Senior Plan, NaviCare, Fallon Total Care, and Summit ElderCare. Claims submitted without a HIPPS codes for members of these plans will require submission of a corrected claim with the HIPPS code.

HIPPS data should be collected using the most recent Medicare guidelines.

HIPPS codes should be placed in box 44 on the industry standard UB-04 form.

HIPPS codes should be billed in Loop 2400 SVC202-2 with the HP qualifier (HIPPS Skilled Nursing Facility Rate Code) in Loop 2400SVC202-1 on the 837I.

SNFs are required to submit an HIPPS code for the comprehensive Admission Assessment completed during the MA-covered stay at a skilled nursing facility, as required by the Omnibus Budget Reconciliation Act (OBRA). If such an assessment was not completed during the MA-covered part of the stay, then SNFs are to follow the guidance below.

Stays of more than 14 days - If the Admission Assessment for a stay in the facility was completed prior to the MA-covered portion of the stay, then SNFs must submit an HIPPS code by following the guidance in the order listed below.

1. Submit the HIPPS code from another assessment completed during the MA-covered portion of the stay. If the OBRA-required Admission Assessment was completed for the current stay prior to the MA-covered portion of the stay, and another assessment (e.g., Quarterly Assessment or any Prospective Payment System assessment) was completed during the MA-covered portion of the stay, the SNF should submit the HIPPS code generated from that other assessment on their encounter submissions.
2. Submit the HIPPS code from the most recent assessment that was completed prior to the MA-covered portion of the stay. If no assessment was completed during the MA-covered portion of the stay from which a HIPPS code could be generated, then the SNF should submit to the Centers for Medicare & Medicaid Services (CMS) the HIPPS code from the most recent OBRA-required or other assessment that was completed prior to the MA-covered portion of the stay (which may be the Admission Assessment).

Stays of 14 days or less - If there was no Admission Assessment completed before discharge for a stay of less than 14 days, then SNFs must submit an HIPPS code by following the guidance in the order listed below.

1. Submit the HIPPS code from another assessment from the stay. If no OBRA-required Admission Assessment was completed for a SNF stay of less than 14 days, then the SNF should submit to CMS the HIPPS code from any other assessment that was completed during the stay that produces HIPPS codes.

2. Submit a default HIPPS code of ‘AAA00’. SNFs may submit a default HIPPS code for SNF encounter submissions to CMS only if (1) the SNF stay was less than 14 days within a spell of illness, (2) the beneficiary has been discharged prior to the completion of the initial OBRA-required Admission Assessment, and (3) no other assessment was completed during the stay. SNFs may not use this default code in other situations, such as to avoid collecting the proper HIPPS code, or when the SNFs systems are not prepared to submit HIPPS codes.

Therapy Modifiers

To align with the Centers for Medicare & Medicaid Services (CMS), effective for dates of service on or after March 1, 2021, the Plan will require therapy modifiers on claims for physical, occupational and speech-language therapy services provided to Medicare plan members (Fallon Medicare Plus, NaviCare and PACE) with Medicare Part B coverage for therapy services and either (1) but the plan member is a resident of the SNF and the SNF stay is non-covered (e.g., when benefits exhausted, no qualifying hospital stay, etc.), or (2) the SNF is contracted to provide outpatient therapy services to plan members. Note: If the plan member is in a covered SNF stay, the therapy services would be included in the SNF’s per diem payment for the covered SNF stay itself.

Effective March 1, 2021, institutional claims (e.g., UB-04 or 837i) submitted by SNFs for physical, occupational or speech-language pathology services provided to Medicare plan members (Fallon Medicare Plus, NaviCare and PACE) with Medicare Part B coverage for therapy services, and either (1) the plan member is a resident of the SNF and the SNF stay is non-covered (e.g., when benefits exhausted, no qualifying hospital stay, etc.), or (2) the SNF is contracted to provide

outpatient therapy services to plan members, must submit revenue codes and modifiers only in the following combinations:

- Revenue code 042X (physical therapy) lines may only contain modifier GP (Services delivered under an outpatient physical therapy plan of care);
- Revenue code 043X (occupational therapy) lines may only contain modifier GO (Services delivered under an outpatient occupational therapy plan of care);
- Revenue code 044X (speech-language pathology) lines may only contain modifier GN (Services delivered under an outpatient speech-language pathology plan of care).

Claims that do not meet these requirements will be denied.

Therapist Assistants
For Medicare plan members (Fallon Medicare Plus, NaviCare and PACE), therapy services may be provided by an appropriately supervised physical or occupational therapist assistant (PTA/OTA). Please note: Fallon Health does not reimburse therapy services provided in whole or in part by PTAs or OTAs for commercial or MassHealth ACO plan members.

Effective March 1, 2021, institutional claims for physical or occupational therapy provided in whole or in part to Medicare plan members (Fallon Medicare Plus, NaviCare and PACE) with Medicare Part B coverage for therapy services, and either (1) the plan member is a resident of the SNF and the SNF stay is non-covered (e.g., when benefits exhausted, no qualifying hospital stay, etc.), or (2) the SNF is contracted to provide outpatient therapy services to plan members, must contain one of the following modifiers on the claim to identify PTA and OTA services furnished under a physical therapy or occupational therapy plan of care along with the GP or GO modifier:

- CQ modifier – Outpatient physical therapy services furnished in whole or in part by a physical therapist assistant.
- CO modifier – Outpatient occupational therapy services furnished in whole or in part by an occupational therapy assistant.

The CQ modifier must be paired to the GP therapy modifier and the CO modifier with the GO modifier. Claims not so paired will be denied.

Policy history

Origination date:	01/1/2015
Previous revision date(s):	01/1/2015 - New policy. 05/01/2015 - Added default HIPPS code language. 01/01/2016 - Updated to new Plan template.
Connection date & details:	November 2016 – Updated reimbursement section. January 2018 – Annual review, no updates October 2018 – Clarified Hospice Services are not included in the Per Diem. October 2019 – Added NaviCare Pre-Admission Screening requirements. January 2021 – Added information about billing for therapy services covered under Medicare Part B.

The criteria listed above apply to Fallon Health plan and its subsidiaries. This payment policy has been developed to provide information regarding general billing, coding and documentation guidelines for the Plan. Even though this payment policy may indicate that a particular service or supply is considered covered, specific provider contract terms and/or member individual benefit plans may apply and this policy is not a guarantee of payment. The Plan reserves the right to apply this payment policy to all of the Plan companies and subsidiaries. The Plan routinely verifies that charges billed are in accordance with the guidelines stated in this payment policy and are appropriately documented in the medical records. Payments are subject to post-payment audits and retraction of overpayments.