Harvard Pilgrim Health Care | TUFTS Health Plan

Point32Health companies

Payment Policy:
Skilled Nursing Facility (SNF)

Applies to:

Commercial Products

☐ Harvard Pilgrim Health Care Commercial products
☐ Tufts Health Plan Commercial products

Public Plans Products

☐ Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product)
☐ Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans
☐ Tufts Health RITogether – A Rhode Island Medicaid Plan
☐ Tufts Health One Care – A dual-eligible product

Senior Products

☐ Tufts Health Plan Senior Care Options (SCO) (a dual-eligible product)
☒ Tufts Medicare Preferred HMO/PPO (Medicare Advantage products)

The following payment policy applies to Tufts Health Plan contracting skilled nursing facilities. Providers may also refer to the applicable payment policies for information on Commercial, Tufts Health Plan SCO, and Tufts Health Public Plans products.

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.

Custodial Care

Tufts Health Plan does not provide coverage for custodial care unless it is provided in conjunction with skilled nursing care and/or skilled rehabilitation services.

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 portal or by contacting Provider Services.

Referral/Prior Authorization/Notification Requirements

Certain procedures, items and/or services may require referral and/or prior authorization. While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you must confirm that prior authorization has been obtained. For more information, refer to the Referral, Prior Authorization, and Notification chapter of the Senior Products Provider Manual.

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 portal 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.

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 to determine the member's continued status and LOC. Any disagreements with the member's LOC should be discussed directly with Provider Services.

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 if they contact the utilization management clinician (UMC) on the next business day following admission.

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.

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 non-emergency 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 CFR422.566 et seq.

Custodial Care
The facility must notify Tufts Health Plan of all custodial admissions. Providers may contact Provider Services to request documentation of noncoverage of custodial care to facilitate billing to other potential sources of payment.

Billing Instructions

Unless otherwise stated, Tufts Health Plan follows industry standard coding guidelines. Refer to current industry standard coding guidelines for a complete list of ICD, CPT/HCPCS, revenue codes, modifiers, and their usage. Providers may only bill the procedure code(s) in accordance with the applicable financial exhibits of their provider agreements and applicable fee schedules. 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 or distinct LOC
- **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

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

Outpatient Therapy Services Covered Under 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 procedure codes, as described in the provider agreement, and only when prior authorization has been given by Tufts Health Plan.

Procedure 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 function
97161	Physical therapy evaluation: low complexity
97162	Physical therapy evaluation: moderate complexity
97163	Physical therapy evaluation: high complexity
97165	Occupational therapy evaluation, low complexity

Procedure Code	Description
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 according to the applicable contracted rates and applicable fee schedules.

The SNF will be compensated the contracted per diem rate for the authorized LOC(s), starting on the day of admission and ending on the evening before the day of discharge.

Related Policies and Resources

Payment Policies

- Inpatient Facility
- Inpatient Rehabilitation and Long-Term Acute Care Facility
- Physical, Occupational, and Speech Therapy

Publication History

- July 2024: Annual policy review; Added Inpatient Facility, Inpatient Rehabilitation and Long-Term Acute Care Facility, and Physical, Occupational, and Speech Therapy Payment Policies to Related Policies and Resources; administrative edits
- September 2023: Annual policy review;
- July 2022: Annual policy review; template updates
- February 2022: clarified existing process of good faith admissions on weekends and holidays
- November 2020: Added condition code 40 billing requirement for members being transferred to another facility, in accordance with CMS requirements
- March 2019: Policy reviewed by committee; clarified inpatient notification time frames and requirements for admissions
- October 2018: Template updates

Background and disclaimer information

This policy applies to the products of Harvard Pilgrim Health Care and Tufts Health Plan and their affiliates, as identified in the check boxes on the first page for services performed by contracted providers.

Payment is based on member benefits and eligibility on the date of service, medical necessity review, where applicable, and the provider's network participation agreement with the Plan. 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.

Point32Health reserves the right to amend a payment policy at its discretion. CPT and HCPCS codes are updated as applicable; please adhere to the most recent CPT and HCPCS coding guidelines.

We reserve the right to conduct audits on any provider and/or facility to ensure accuracy and 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, Harvard Pilgrim Health Care and Tufts Health Plan will expect the provider/facility to refund all payments related to noncompliance.