

Skilled Nursing Facility Payment Policy

Applicability

This Policy applies to the following Fallon Health products:

- ☑ Fallon Medicare Plus
- ☑ MassHealth ACO
- ☑ NaviCare HMO SNP
- ☑ Summit Eldercare PACE
- ☑ Fallon Health Weinberg PACE
- ☑ Community Care

Policy

This payment policy applies to medically necessary, post-acute skilled nursing and skilled rehabilitation services furnished during an authorized skilled nursing facility (SNF) stay. It does not apply to short-term custodial care or long-term custodial nursing facility services, which are addressed in the *Short-Term Custodial and Long-Term Care Payment Policy*.

Definitions

SNF services are nursing and rehabilitation services that, because of the member's clinical condition and the complexity of the service required, must be provided by or under the supervision of qualified professional or technical personnel to be safely and effectively furnished and to achieve the medically desired outcome. Qualified personnel include registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech-language pathologists, and audiologists. The service must require the specialized skills, judgment, assessment, or management of qualified personnel and must not be safely or effectively performable by non-skilled personnel.

Reimbursement

Per Diem Rate

For an authorized covered skilled stay, the SNF is reimbursed at the contracted per diem rate. The contracted per diem constitutes payment for services included under the provider contract and applicable consolidated billing requirements. The SNF is responsible for furnishing or arranging included services and may not separately bill Fallon Health or the member for services included in the per diem. Prior authorization is required before admission to a covered SNF stay, except where prohibited by applicable law or otherwise specified in the member's benefit plan or Fallon Health authorization procedures.

The following are general examples and are not all-inclusive. Specific contract terms, benefit requirements, and applicable law govern if they differ from this list:

- 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, wheelchairs). 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

Services Excluded from the Contracted Per Diem or Medicare SNF Consolidated Billing

Certain services may be excluded from the contracted per diem, excluded from Medicare SNF consolidated billing, or separately reimbursable under the applicable provider contract. CMS-designated consolidated billing exclusions and Fallon Health contractual per diem exclusions are not necessarily the same. Except for emergency services, the SNF must obtain any required prior authorization and use Fallon Health-contracted vendors when required. Payment is subject to the member's benefit, the provider contract, applicable consolidated billing requirements, and the related Fallon Health payment policy. The following examples are not all-inclusive:

- 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 wheelchairs
- 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

Certain high-cost drugs may be eligible for separate reimbursement when authorized by Fallon Health prior to administration. Separate reimbursement is subject to authorization, coding, documentation, and billing requirements.

Medicare Part B Therapy During a Non-Covered SNF Stay or Outpatient Therapy Episode

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 before admission to a covered skilled nursing facility stay, except where prohibited by applicable law or where the member's benefit plan or Fallon Health authorization procedures provide otherwise. Authorization must support the requested level of care, service period, and continued need for skilled nursing or skilled rehabilitation services. Prior authorization is not a guarantee of payment. Payment remains subject to eligibility, covered benefits, medical necessity, authorization terms, accurate billing, timely filing, coordination of benefits, and the provider contract.

Each PACE plan member is assigned to an Interdisciplinary Team. PACE provides participants with all the care and services covered by Medicare and Medicaid, as approved by the interdisciplinary team, as well as additional medically necessary care and services not covered by Medicare and Medicaid. With the exception of emergency care and out-of-area urgently needed care, all care and services provided to PACE plan members must be approved by the interdisciplinary team.

NaviCare Specific Requirement: Preadmission Screening and Resident Review (PASRR)

Nursing facilities must comply with applicable federal and MassHealth PASRR requirements. New admissions to Medicaid-certified nursing facilities are subject to PASRR screening unless an applicable regulatory exception applies. An exempted hospital discharge may apply when an individual is admitted directly from a hospital after receiving acute inpatient care, requires nursing facility services for the condition treated in the hospital, and the attending physician certifies before admission that the individual is likely to require fewer than 30 days of nursing facility services. If the stay extends beyond the applicable period, the facility must complete the required follow-up review

within the timeframe established by federal and state requirements.

The PASRR process begins with a Level I screen to identify whether an individual has or may have a serious mental illness or intellectual or developmental disability. When indicated by the Level I screen, the individual must be referred for the applicable Level II evaluation. The facility is responsible for maintaining documentation demonstrating compliance with the PASRR pathway applicable to the admission, including any exemption and required follow-up review.

Fallon Health reserves the right to audit the facility for compliance with applicable PASRR requirements.

If required PASRR documentation is not available, Fallon Health may deny or recover payment to the extent permitted by applicable law, the member's benefit, and the provider contract. The member may not be balance-billed for amounts denied or recovered because of the facility's failure to comply with applicable PASRR or billing requirements.

Billing/coding guidelines

Claims should be submitted using industry standard codes.

SNF HIPPS and Encounter Reporting Requirements for Medicare Advantage, NaviCare, and PACE Products

HIPPS codes must be submitted on applicable skilled nursing facility claims or encounters for Fallon Medicare Plus, Fallon Medicare Plus Central, NaviCare, and PACE products when required by Fallon Health. Claims submitted without the required HIPPS code may require correction before payment or encounter acceptance.

HIPPS data must be derived and reported in accordance with current CMS guidance and Fallon Health billing instructions. On the UB-04, report the HIPPS code in Form Locator 44 when required.

On the 837I, report the HIPPS code in Loop 2400, SV202-2, with the HP qualifier in SV202-1, when required by the applicable implementation guide and Fallon Health billing instructions.

For applicable Medicare Advantage, NaviCare, and PACE encounter reporting, the SNF must submit to Fallon Health the HIPPS code generated from the admission assessment completed during the plan-covered skilled stay. If no admission assessment was completed during the covered portion of the stay, use the assessment hierarchy below. Fallon Health uses submitted claim and encounter information for applicable CMS encounter-data reporting requirements.

Stays longer than 14 days

If the admission assessment was completed before the plan-covered portion of the stay, submit the HIPPS code generated from another assessment completed during the plan-covered portion of the stay. If no qualifying assessment was completed during the plan-covered portion, submit the HIPPS code from the most recent qualifying assessment completed before the covered portion.

1. Submit the HIPPS code from another assessment completed during the Medicare Advantage, NaviCare, or PACE-covered portion of the stay. If the OBRA-required Admission Assessment was completed for the current stay prior to the covered portion of the stay, and another assessment (e.g., Quarterly Assessment or other qualifying assessment) was completed during the covered portion of the stay, the SNF should submit the HIPPS code generated from that assessment.
2. Submit the HIPPS code from the most recent assessment completed prior to the covered portion of the stay if no qualifying assessment was completed during the covered portion of the stay.

Stays of 14 days or fewer

If the member was discharged before completion of an admission assessment, submit the HIPPS code generated from another assessment completed during the stay. If the stay was fewer than 14 days, the member was discharged before completion of the initial admission assessment, and no

other assessment producing a HIPPS code was completed, AAA00 may be submitted only when permitted by current CMS encounter-data guidance. AAA00 must not be used to avoid obtaining or reporting an available HIPPS code.

1. Submit the HIPPS code from another assessment completed during the stay. If no OBRA-required Admission Assessment was completed for a stay of fewer than 14 days, the SNF should submit the HIPPS code from any other qualifying assessment completed during the stay that generates a HIPPS code.
2. Submit a default HIPPS code of AAA00 only when permitted by current CMS encounter-data guidance, including when:
 - a. The stay was fewer than 14 days;
 - b. The member was discharged before completion of the initial OBRA-required Admission Assessment; and
 - c. No other assessment generating a HIPPS code was completed during the stay.

The Medicare Advantage, NaviCare, and PACE HIPPS encounter provisions in this section do not establish billing requirements for MassHealth ACO, Community Care, or other non-Medicare product lines. Claims for those products must comply with applicable state regulations, billing instructions, provider contracts, and Fallon Health guidance.

Therapy Modifiers

To align with CMS requirements, effective for dates of service on or after March 1, 2021, Fallon Health requires therapy modifiers on claims for physical therapy, occupational therapy, and speech-language pathology services furnished to Medicare plan members (Fallon Medicare Plus, Fallon Medicare Plus Central, NaviCare, and PACE) with Medicare Part B coverage when either: (1) the member resides in the SNF but the SNF stay is non-covered, such as when benefits are exhausted or there is no qualifying hospital stay; or (2) the SNF is contracted to furnish outpatient therapy services. Therapy furnished during a covered skilled stay is included in the covered SNF per diem.

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, Fallon Medicare Plus Central, 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 furnished by an appropriately supervised physical therapist assistant or occupational therapy assistant when permitted by applicable CMS requirements. Any product-specific Fallon Health reimbursement limitation for assistant-furnished services applies only when supported by the member's benefit, the provider contract, and Fallon Health billing guidance.

Effective March 1, 2021, institutional claims for physical or occupational therapy provided in whole or in part to Medicare plan members (Fallon Medicare Plus, Fallon Medicare Plus Central, 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. July 2023 – Added a Custodial/Long-Term Care reimbursement section. October 2026 – Revised the policy scope to skilled post-acute nursing facility services; clarified the separation from short-term custodial and long-term care; revised PASRR requirements to recognize applicable regulatory exceptions; distinguished Medicare Advantage and PACE HIPPS encounter requirements from MassHealth billing; and clarified Medicare Part A consolidated billing and Medicare Part B therapy requirements.

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 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.