PROVIDER REIMBURSEMENT GUIDANCE			
Skilled Nursing Facility			
Original Date Approved	Effective Date		Revision Date
07/12/2019	06/10/2022	01/1/2023**	04/03/2023

Scope: Commonwealth Care Alliance (CCA) Product Lines

☒ Medicare Premier-(PPO) MA**
☒ Medicare Preferred-(PPO) MA
☒ Medicare Value - (PPO) MA*
☒ Medicare Preferred – (PPO) RI*
☒ Medicare Value - (PPO) RI*
☒ Medicare Maximum – (HMO DNSP) RI*

PAYMENT POLICY SUMMARY:

Commonwealth Care Alliance (CCA) covers Skilled Nursing Facility (SNF) admissions when medically necessary. SNF services are paid at a per diem rate. Skilled Care is defined as the provision of services and supplies that can be provided only by or under the supervision of a skilled or licensed medical personnel. CCA will cover Skilled services when medical necessity requirements have been met. Desired results of care must be clearly documented by a written treatment plan approved by a physician. The determination of medical necessity must be based on Medicare and Medicaid regulatory guidelines. Providers may also refer to the applicable Skilled Nursing Facility (SNF) payment policy for CCA's Medicare Advantage plan.

AUTHORIZATION REQUIREMENTS:

Applicable CCA notification and authorization policies and procedures apply. For more information on prior authorizations, please refer to Section 4, Prior Authorization Requirements, in the CCA Medicare Advantage Provider Manual.

Authorization is required for all SNF Services.

REIMBURSEMENT GUIDELINES:

To be considered a skilled service, the service must be of sufficient complexity that it can be safely and effectively performed only 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.

Skilled Care: Skilled nursing, skilled teaching, and skilled rehabilitation services when all of the following are true:

- Services must be delivered or supervised by licensed technical or professional

medical personnel to obtain the specified medical outcome, and provide for the safety of the patient; and
- Ordered by a physician; and
- Not delivered for the purpose of helping with activities of daily living, including dressing, feeding, bathing, or transferring from a bed or a chair; and
- Requires clinical training to be delivered safely and effectively; and
- Not custodial care, which can safely and effectively be performed by trained non-medical personnel

For Medicare Plans: SNF services are limited to 100 days and are subject to the appropriate copayment/co-insurance.

Custodial Care (*not a covered benefit under Medicare Advantage)*:

BILLING and CODING GUIDELINES:

Refer to the current coding guidelines for a complete list of ICD, CPT/HCPCS, revenue codes, and modifiers, and their usage. Providers may bill for the procedure code(s) only in accordance with the applicable financial exhibits of their provider agreements and applicable fee schedules.

SNF's must bill in sequence based upon any of the following circumstances:

- Discharge
- Decrease in level of care to less than skilled care
- Monthly bill submission

Claims must include the appropriate "from" and "to" date range reflecting the units for the period of service. The number of units must be for consecutive days and the units must match dates billed. The "to" date must be after the "from" date.

Level of Payment	Description	Revenue Code / HCPCS Code
Level 1	Skilled Nursing and/or Rehabilitation	191
Level 2	Subacute Nursing and/or Rehabilitation	192
Level 3	Subacute Nursing and/or Subacute Rehabilitation-Ventilation Program	193

Skilled Nursing Facilities are reimbursed based upon the Skilled Nursing Facility daily per diem rate according to contract. The daily Skilled Nursing Facility per diem rate includes:

- Daily nursing care
- Discharge planning
- IV (Intravenous) 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 durable medical equipment (DME) (e.g., commodes, shower chairs, walkers, wheelchairs).
- Manual wheelchairs as a backup to a power mobility device.

Any specialized DME required for patients requires prior authorization through CCA's Utilization Management Department.

For the purpose of this policy, specialized DME is defined as equipment that is customized to the patient and cannot be re-used by other patients within the facility such as custom orthotic and prosthetic devices.

The SNF daily per diem rate *does not include*:

- Blood products used in blood transfusions
- Dialysis
- Hospice Service (please see Hospice Payment Policy)
- Modified barium swallow
- Orthotic or prosthetic equipment
- Physician extenders
- Professional charges for services rendered by physicians
- Specialized/customized DME examples of those excluded):
  - Continuous passive motion (CPM)
  - 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
  - Computerized axial tomography
  - Magnetic resonance imaging
  - Ambulatory surgery involving use of operating room
  - Emergency services
  - Radiation therapy
  - Angiography
  - Lymphatic and venous procedures
  - Ultrasound

- Authorized IV Insertion by contracted providers.
- Wound Vacuums

- Specific High-Cost Drugs

RELATED SERVICE POLICIES:

- DME
- Hospice
- Hospice (VBID) program
- Skilled Nursing Facility

AUDIT AND DISCLAIMER

As every claim is unique, the use of this policy is neither a guarantee of payment nor a final prediction 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 guidelines when applicable and adherence to plan policies and procedures and claims editing logic. CCA has the right to conduct audits on any contracted provider and/or facility to ensure compliance with the guidelines stated in this payment policy. If such an audit determines that your office/facility did not comply with this payment policy, CCA has the right to expect your office/facility to refund all payments related to non-compliance.

REFERENCES

CMS Medicare Claims Processing Manual

CCA Payment Policies:

Massachusetts

Rhode Island

CCA Provider Manuals:

Massachusetts

Rhode Island

CCA Prior Authorization Forms:

Massachusetts

Rhode Island

2019 SNF Consolidated Billing Update Part A & Part B

POLICY TIMELINE DETAILS

1. Effective: 1/1/2018
2. Annual Review/Revision: format, December 2019
3. Revision: Format, Added Medicare Advantage information November 2021
4. Revision: format edited language related to DME April 2022
5. Revision: January 2023, add Medicare Premier – (PPO) MA** product,

6. Revision: April 2023, removed custodial care as it is not a Medicare benefit