PROVIDER REIMBURSEMENT GUIDANCE		
Nursing Facility		
Original Date Approved	Effective Date	Revision Date
07/12/2019	06/10/2022	04/03/2023
Scope: Commonwealth Care Alliance (CCA) Product Lines ☒ Senior Care Options MA ☒ One Care MA		

PAYMENT POLICY SUMMARY:

Commonwealth Care Alliance (CCA) covers Nursing Facility (NF) admissions when medically necessary. Nursing Facility 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. Custodial care is defined as the provision of non-medical services and supplies to assist with the activities of daily living. This type of care can be provided by non-licensed caregivers. CCA will cover Skilled or Custodial care 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.

- MassHealth Regulation 101 CMR 206.00, Standard Payments to Nursing Facilities, effective October 1, 2022, included new payment provisions that allow nursing facilities to receive member-specific “add-on” payment amounts when specific criteria are met for One Care and Senior Care Options members.
- Nursing facilities may begin billing CCA for applicable add-ons for dates of service on or after January 1, 2023.
- Nursing facilities are required to submit claims to CCA in accordance with 101 CMR 206.00 and the MassHealth Nursing Facility Rate Add-ons Billing Guidance.

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 Senior Care Options and One Care Provider Manual.

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 services that are 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 and or audiologists.
- 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

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

Custodial Care: Non-skilled services that may include any of the following:

- Non-health-related services, such as help with daily living activities, including but not limited to eating, dressing, bathing, transferring, and ambulating; or
- Health-related services that can safely and effectively be performed by trained non-medical personnel and are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function, as opposed to improving that function to an extent that might allow for a more independent existence.

CCA will reimburse authorized, rehabilitative therapy that may be provided to CCA enrollees at the Custodial Level of Care in accordance with the provider contract.

Leave of Absence: Consists of Medical Leave of Absence (MLOA) to a hospital and Non-Medical Leave of absence (NMLOA).

- Medical Leave of Absence (MLOA) to a hospital – 20 days maximum
- Non-Medical Leave of Absence (NMLOA) – 10 days maximum

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.

Skilled Nursing Facilities (SNF) 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
NF Custodial/Respite	Any non-medical care that can reasonable and safely be provided by non-licensed caregivers that takes place in a nursing home.	120
Bed Hold Hospital Leave Day	Medical Leave of Absence (MLOA) to a hospital	185
Bed Hold Therapeutic Leave Day	Non-Medical Leave of Absence (NMLOA)	183

SNFs are reimbursed based upon the SNF daily per diem rate according to contract. The daily SNF per diem rate includes:

- Daily nursing care
- Discharge planning
- Intravenous (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 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) 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
  - 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

Medicare Part B Therapies for Custodial Level of Care with Rev Code(s) 0420,0430 and 0440: Physical (PT), occupational (OT) and speech therapy (ST) services can be billed by the facility as authorized by CCA's Utilization Management Department. Services may include:

Procedure Code	Descriptor
92610	Evaluation of oral and pharyngeal swallowing function
97161	PT evaluation: low complexity
97162	PT evaluation: moderate complexity
97163	PT evaluation: high complexity
97164	Re-evaluation of PT: established plan of care
97165	OT evaluation, low complexity
97166	OT evaluation, moderate complexity
97167	OT evaluation, high complexity
97168	Re-evaluation of OT: established plan of care
G0151	PT Treatment, 15 minutes
G0152	OT Treatment, 15 minutes

Specific Add-Ons

HCPCS Code	Description
S0311	Homeless Add-on
S0316	Temporary Resident Add-on
S0317	Medicaid Transitional Add-on
S0340	Behavioral Indicator Add-on
S0341	SUD Add-on
S0342	Tracheostomy Add-on
S0353	Den Dialysis Service Fee Add-on

RELATED SERVICE POLICIES

- Durable Medical Equipment (DME)
- Hospice
- Hospice VBID Program
- Skilled Nursing Facility (Medicare Advantage Plans)

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

CCA Payment Policies: Massachusetts

CCA Senior Care Options and Once Care Provider Manual Prior Authorization Forms: Massachusetts

MassHealth 101 CMR 206.00-Standard Payments to Nursing Facilities

MassHealth Nursing Facility Rate Add-ons Billing Guidance

Department of Public Health 105 CMR 150.00-Standards for Long-Term Care Facilities

MassHealth 130 CMR 409.415

MassHealth 130 CMR 428.410

POLICY TIMELINE DETAILS

1. Effective: 1/1/2018
2. Annual Review/Revision: format, December 2019
3. Revision: format edited language related to DME April 2022
4. Revision: June 2022, updated formatting
5. Revision: January 2023, updated Add-ons payment provisions information; added HCPCS Add-on codes under Billing and Coding Guidelines.
6. Revision: April 2023, removed GP, GO, GN as these modifiers are not required for custodial members.