PAYMENT REIMBURSEMENT POLICY

Title: PRP-12 Sub-Acute Rehabilitation (SAR)/Skilled Nursing Facility (SNF) Facility Charges

Benefit Coverage Policy: BCP-61 Sub-Acute Rehabilitation (SAR)/Skilled Nursing Facility (SNF) Facility Charges

Category: PHP_PAYMENT REIMBURSEMENT (PR)

Effective Date: 11/15/2023

Physicians Health Plan
PHP Insurance Company
PHP Service Company

1.0 Guidelines:

This policy applies to all network and non-network providers, including but not limited to percent of charge contract providers. This policy does not guarantee benefits or solely determine reimbursement. Benefits are determined and/or limited by an individual member's benefit coverage document (COC, SPD, etc.). The Health Plan reserves the right to apply clinical edits to all medical claims through coding software and accuracy of claim submission according to industry billing standards. Clinical edits are derived from nationally recognized billing guidelines such as the Centers for Medicare and Medicaid Services (CMS), the National Correct Coding Initiative (NCCI), the American Medical Association (AMA), and specialty societies. The Health Plan may leverage the clinical rationale of CMS or other nationally sourced edits and apply this rationale to services that are not paid through CMS but are covered by the Health Plan to support covered benefits available through one of the Health Plan's products. Prior approval does not exempt adherence to the following billing requirements. The provider contract terms take precedence if there is a conflict between this policy and the provider contract.

2.0 Description:

Sub-acute rehabilitation (SAR) is less intensive than acute rehabilitation and is provided in a skilled nursing facility (SNF) or a hospital setting with beds licensed as a SNF. A combination of physical, occupational, and speech therapy may be provided with the number of hours each patient receives, generally between one and two hours a day. The average length of stay at a skilled nursing facility is generally longer than at an acute rehabilitation facility.

3.0 Policy:

This policy applies to facility claims. The Health Plan reimburses SAR services provided by a licensed SNF within the member's applicable benefit limit.

In addition, reimbursement is calculated based on specific contracted payment rates (e.g., Per Diem Rate). For those contracts that allow separate reimbursement for authorized prescription drugs, there is a ceiling maximum reimbursement for prescription drugs of 130% of the Average Wholesale Price (AWP), less applicable member's cost share.

4.0 Coding and Billing:

A. Bill SNF Professional services as defined by provider contract via CMS-1500.

COVERED CODES	
CODE	DESCRIPTION
99304	Initial nursing facility care, per day, for E&M of a patient, which requires these 3 key components: A detailed or comprehensive history; A detailed or comprehensive examination; and Medical decision making this is straightforward or of low complexity
99305	Initial nursing facility care, per day, for E&M of a patient, which requires these 3 key components: A detailed or comprehensive history; A detailed

COVERED CODES	
CODE	DESCRIPTION
	or comprehensive examination; and Medical decision-making of moderate complexity
99306	Initial nursing facility care, per day, for E&M of a patient, which requires these 3 key components: A detailed or comprehensive history; A detailed or comprehensive examination; and Medical decision-making of high complexity
99307	Subsequent nursing facility care, per day, for E&M of a patient, which requires at least 2 of these 3 key components: A problem-focused interval history; A problem-focused examination; Straightforward medical decision making
99308	Subsequent nursing facility care, per day, for E&M of a patient which requires at least 2 of these 3 key components: An expanded problem-focused interval history; An expanded problem-focused examination; Medical decision-making of low complexity
99309	Subsequent nursing facility care, per day, for E&M of a patient, which requires at least 2 these 3 key components: A detailed interval history; A detailed examination; Medical decision-making of moderate complexity
99310	Subsequent nursing facility care, per day, for E&M of a patient, which requires at least 2 of these 3 key components: A comprehensive interval history; A comprehensive exam; Medical decision-making of high complexity
99315	Nursing facility discharge day management; 30 minutes or less
99316	Nursing facility discharge day management; more than 30 minutes

B. Bill SNF services as defined by the provider contract via UB-04.

1. SNF services should be billed with the claim facility type of bill code 02X-X.

2. Inpatient services must be billed with appropriate revenue codes as defined by the contract.

3. Outpatient services must be billed with appropriate revenue codes as defined by the contract and HCPCS or CPT code.

4. If the stay includes a change in the level of care, add additional lines to the claim for each revenue code(level) and indicate the number of days in the unit field

C. Levels of Skilled Health Services.

1. The level of Skilled Health Services for purposes of reimbursement shall be determined by the Health Plan in conjunction with the provider via the authorization/approval process. Please refer to the provider contract or medical policy, BCP-61, for detailed criteria for each level.

2. For network non-hospital-based facilities, the following revenue codes should be applied:

Facility	Revenue Code
Level I - Basic Skilled Nursing	0191
Level II - Basic Skilled Nursing and Rehabilitation	0192
Level III - Subacute Skilled Nursing and Rehabilitation	0193
Level IV - Full Ventilator and Intensive Subacute Skilled Nursing	0194

3. Out of network and CMS based contracted providers must bill in accordance with CMS regulations.

D. Leave of Absence (LOA) or Furlough Days.

1. Leave of absence or furlough days are "time away" dates during which a patient is discharged from but remains a patient of an inpatient hospital, residential treatment program, or SNF. If the member or patient has progressed to the point of being able to be away from the facility or is expected for follow-up care or surgery and the patient does not require a hospital level of care during the interim period, an LOA or furlough may be granted.

2. There is no reimbursement for LOA or furlough days as services are not being provided to the patient.

3. The Leave of Absence accommodation revenue codes 018X are billed to indicate the days that the patient was not in the facility. These codes indicate routine service charges, including zero charges for holding a room while the patient is temporarily away from the provider. Use of this revenue code also requires that occurrence span code 74- non-covered level of care/LOA, and date(s) of the absence.

4. Leave of Absence 018X revenue codes:

- 0180 – Leave of Absence—General
- 0182 – Leave of Absence—Patient Convenience
- 0183 – Leave of Absence—Therapeutic Leave
- 0185 – Leave of Absence—Nursing Home (for Hospitalization)
- 0189 – Leave of Absence—Other LOA

E. Interim Billing.

1. Initial claim, XXX-2 type of bill.

2. Continuing claims, XXX-3 type of bill.

3. Final/Discharge Claim, XXX-4 type of bill.

4. Bill using the "from date" to the "through date."

5. Admission date required for interim billing and admission date must be consistently applied.

6. A XXX-2(initial) claim must be on file and billed before any additional claims will be processed.

F. Discharges/Transfers (Field 17).

1. Discharge status codes are required for hospital inpatient claims, including SARs. A patient discharge status code is defined as "a two-digit code that identifies where the patient is being discharged to at the end of their facility stay, or where they will be transferred to such as acute/post-acute facility.

2. The discharging facility should ensure that documentation supports the billed discharge status code.

3. Failure to submit the appropriate code can result in denial of claims, delayed payments, or even return of reimbursement."

G. Condition Codes (Fields 18-28).

1. Required if applicable.

2. Situational two-digit codes that are entered in numerical order to describe any of the pertinent conditions or events that apply to the billing period of the claim.

H. Occurrence Codes (Fields 31-34).

1. Required if applicable. Codes and dates define specific event(s) related to the billing period of the claim.

2. Event codes are two digits, and dates are six numeric digits (MMDDYY).

I. Occurrence Span Code and Dates (Field 35-36).

1. Required for inpatient claims. The provider must enter codes and associated beginning and ending dates defining a specific event relating to the billing period of the claim.

2. Event codes are two digits, and dates are six numeric digits (MMDDYY).

J. Value Codes and Amounts (Fields 39-41).

1. Required if applicable. Codes and related dollar amount(s) identifying data of a monetary nature that are necessary for the processing of claims. The codes are two digits, and each value allows up to nine numeric digits (0000000.00). Negative amounts are not allowed except in Field 41. Whole numbers or non-dollar amounts are right justified to the left of the dollars and cents delimiter. Some values are reported as cents, so the provider must refer to specific codes for instructions.

2. If more than one value code is shown for a billing period, codes are shown in ascending numeric sequence. There are four lines of data, line "a" through line "d." The provider uses FLs 39A through 41A before 39B through 41B (i.e., it uses the first line before the second).

5.0 Documentation Requirements:

The following should be supported in the medical record:

1. Patient requires skilled services (i.e., services that must be performed by, or under the supervision of, licensed personnel for safety and to achieve the medically desired result.

2. Physical, occupational, and speech therapy time per day for at least five days per week.

3. Services can only be safely provided in an inpatient SNF and cannot be safely provided in a less restrictive clinical setting (e.g., at home with skilled home health services or in an outpatient setting).

4. Service Specific Level of Care (LCOC) Criteria are met.

5. Legible physician and/or clinician signatures.

6. Dated physician or non-physician practitioner (NPP) order(s).

7. All related care plan notes, history, progress reports, treatment encounters, lab results, therapy minute logs, and discharge summary.

6.0 Verification of Compliance:

Claims are subject to audit, prepayment, and post-payment to validate compliance with the terms and conditions of this policy.

7.0 Terms & Definitions:

Average Wholesale Price (AWP) - The average wholesale price for a pharmaceutical product as provided to Payor by the Payors designee or such other national drug database as Payor may designate.

Leave of Absence (LOA) or Furlough Days - Leave of absence (LOA) or furlough days are "time away" dates during which a patient is discharged from but remains a patient of an inpatient hospital, residential treatment program, or SNF.

Per Diem Payment - The payment made to the provider for each day of an Admission of a Member as authorized by Payor. Such payment shall be considered payment in full for all Health Services rendered to the member during each day of the Admission, including, but not limited to, nursing care, diagnostic and therapeutic services, routine radiology, routine laboratory, routine supplies, over the counter medications, and room and board charges rendered, unless otherwise provided for in the Provider Agreement. Other exclusions may apply. Please refer to Provider Agreement for additional details.

Skilled Nursing Facility – A nursing facility or portion of a hospital that is state-licensed and operated as required by law that provides skilled nursing care and skilled rehabilitation services, with the availability of nursing care 24 hours a day.

8.0 References, Citations & Resources:

BCP-61 Sub-Acute Rehabilitation (SAR)/Skilled Nursing Facility (SNF) Services.

Centers for Medicare and Medicaid Services, CMS Manual, and other CMS publications.

American Medical Association (AMA), Current Procedural Terminology (CPT), Healthcare Common Procedure Coding System (HCPCS) and associated publications.

Michigan Scope of Practice Policy.

Michigan Legislature Public Health Code Act 368 of 1978 Section 333.16215 & Section 333.17047.

Uniformed Billing Editor.

9.0 Revision History:

Original Effective Date: 01/01/2020

Next Review Date: 10/01/2022

Revision Date	Reason for Revision
11/20	Annual review, no changes, approved by CCSC 11/3/20
6/21	Annual review; procedure code table added; approved at CCSC 8/3/21 updated verbiage to the Guidelines section to make it uniform
7/23	Annual review