Chapter 8 Section 2

Skilled Nursing Facility (SNF) Prospective Payment System (PPS)

Issue Date: April 1, 2002
Authority: 32 CFR 199.14(b); Sections 701 and 707 of NDAA FY 2002

1.0 APPLICABILITY

This policy is mandatory for reimbursement of services provided by either network or non-network providers. However, alternative network reimbursement methodologies are permitted when approved by the Defense Health Agency (DHA) and specifically included in the network provider agreement.

2.0 ISSUE

What is the definition of a Skilled Nursing Facility (SNF) and how are SNFs to be reimbursed under SNF Prospective Payment System (PPS)?

3.0 SNF DEFINITION

In accordance with 32 CFR 199.6(b)(4)(vi), a SNF is an institution (or a distinct part of an institution) that is engaged primarily in providing to inpatients medically necessary skilled nursing care, which is other than a nursing home or intermediate facility, and which:

3.1 Has policies that are developed with the advice of (and with provisions for review on a periodic basis by) a group of professionals, including one or more physicians and one or more registered nurses, to govern the skilled nursing care and related medical services it provides;

3.2 Has a physician, a registered nurse, or a medical staff responsible for the execution of such policies;

3.3 Has a requirement that the medical care of each patient must be under the supervision of a physician, and provides for having a physician available to furnish necessary medical care in case of an emergency;

3.4 Maintains clinical records on all patients;

3.5 Provides 24-hour skilled nursing service that is sufficient to meet nursing needs in accordance with the policies developed as provided in paragraph 3.1 and has at least one registered professional nurse employed full-time;

3.6 Provides appropriate methods and procedures for the dispensing and administering of drugs and biologicals;

3.7 Has in effect a utilization review plan that is operational and functioning;

3.8 In the case of an institution in a state in which state or applicable local law provides for the licensing of this type facility, the institution:

- Is licensed pursuant to such law, or
- Is approved by the agency of such state or locality responsible for licensing such institutions as meeting the standards established for such licensing;

3.9 Has in effect an operating plan and budget;

3.10 Meets such provisions of the most current edition of the Life Safety Code as are applicable to nursing facilities; except that if the Secretary of Health and Human Services has waived, for such periods, as deemed appropriate, specific provisions of such code which, if rigidly applied, would result in unreasonable hardship upon a nursing facility; and

3.11 Is an authorized provider under the Medicare program, and meets the requirements of Title 18 of the Social Security Act, sections 1819 (a), (b), (c), and (d) (42 United States Code (USC) 1395 i-3(a) - (d)). If a pediatric SNF is certified by Medicaid, it will be considered to meet the Medicare certification requirement in order to be an authorized provider under TRICARE. The Social Security Act defines a SNF as follows:

> SEC. 1819. [42 USC 1395i-3] (a) SKILLED NURSING FACILITY DEFINED.--In this title, the term "skilled nursing facility" means an institution (or a distinct part of an institution) which--
>
> > 1. is primarily engaged in providing to residents-- (A) skilled nursing care and related services for residents who require medical or nursing care, or (B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons, and is not primarily for the care and treatment of mental diseases;
> >
> > 2. has in effect a transfer agreement (meeting the requirements of section 1861(l)) with one or more hospitals having agreements in effect under section 1866; and
> >
> > 3. meets the requirements for a skilled nursing facility described in subsections (b), (c), and (d) of this section.

Note: If a pediatric SNF is certified by Medicaid, it will be considered to meet the Medicare certification requirement in order to be an authorized provider under TRICARE.

4.0 POLICY

In accordance with 32 CFR 199.4(b)(3)(xiv), covered services in SNFs are the same as provided

under Medicare under section 1861(h) and (i) of the Social Security Act (42 U.S.C. 1395x(h) and (i)) and 42 CFR 409, Subparts C and D, except that the Medicare limitation on the number of days of coverage under section 1812(a) and (b) of the Social Security Act (42 U.S.C. 1395d(a) and (b)) and 42 CFR 409.61(b) shall not be applicable under TRICARE. This paragraph applies to SNF admissions on or after August 1, 2003. The provisions cited in this paragraph may be accessed at http://www.gpoaccess.gov/.

Note: Medicare co-insurance amounts do not apply to TRICARE when TRICARE is the primary payer. For TRICARE beneficiary cost-shares, see Chapter 2.

4.1 Beneficiaries Subject to the Provisions of SNF PPS

SNF PPS will apply to TRICARE beneficiaries who satisfy the qualifying coverage requirements of the TRICARE SNF benefit. The beneficiary must receive care from a Medicare-certified and TRICARE-approved SNF and must be assessed using the Minimum Data Set (MDS) assessment form.

Note 1: SNF PPS will apply to Supplemental Care benefits for Active Duty Service Member (ADSM), Transitional Assistance Management Program (TAMP), and Continued Health Care Benefit Program (CHCBP). See paragraphs 5.4, 5.5, and 5.6.

Note 2: Beneficiaries under age 10 (on the date of SNF admission) and the Critical Access Hospital (CAH) swing beds will not be subject to SNF PPS. Unless required in their Memorandum of Understanding (MOU) or Provider Agreement, Veteran Affairs (VA) facilities may not be subject to SNF PPS. However, these categories are not exempt from the SNF benefit requirements in paragraph 4.3.3.

4.2 For Admissions Before August 1, 2003

See Section 1.

4.3 For Admissions on or after August 1, 2003, when TRICARE is Primary Payer

4.3.1 TRICARE is the primary payer for SNF care for Medicare-eligible beneficiaries who have no OHI and who satisfy the TRICARE SNF qualifying coverage requirements (as discussed in paragraphs 4.3.3 and 4.3.4) after exhausting their 100 day covered Medicare SNF benefit. TRICARE is also the primary payer for non-Medicare-eligible TRICARE beneficiaries who have no OHI and who meet the TRICARE SNF coverage requirements. In both situations, TRICARE's coordination of benefit rules will determine TRICARE's status as primary payer.

4.3.2 For TRICARE dual eligible beneficiaries, the Medicare SNF benefit provides for 100 days of SNF care per benefit period. The Medicare benefit period is a period of time for measuring the use of hospital insurance benefits. It is a period of consecutive dates during which covered services furnished to a patient, up to certain specified maximum amounts, can be paid. This benefit period begins with the first day (not included in a previous benefit period) on which a patient is furnished SNF care. The benefit period ends with the close of a period of 60 consecutive days during which the patient did not receive hospital care or was not in a SNF. (A new benefit period starts when a beneficiary has not received hospital or SNF care for 60 days in a row). After the 100 days of Medicare-covered care, the TRICARE benefit becomes primary if the beneficiary continues to satisfy the TRICARE coverage requirements and has no OHI.

4.3.3 For a SNF admission to be covered under TRICARE, the beneficiary must both have a qualifying hospital stay of 3 consecutive days or more, not including the hospital discharge day, and the beneficiary must enter the SNF within 30 days of discharge from the hospital. For TRICARE dual eligible beneficiaries, this requirement is already met before TRICARE becomes primary. TRICARE and Medicare do make exceptions to this "within 30 days" rule for those cases that require future therapy after 30 days (e.g., a hip fracture patient who can't do weight-bearing exercises until after 30 days). TRICARE will follow Centers for Medicare and Medicaid Services (CMS) policy as provided in the Medicare Benefit Policy Manual, Chapter 8. Any application of the Medicare Benefit Policy Manual to TRICARE shall be subject to TRICARE requirements in the law, 32 CFR Part 199, and TRICARE manuals. The Medicare Benefit Policy Manual (Publication # 100-02) is an Internet Only Manual (IOM) and can be accessed at http://www.cms.hhs.gov/manuals. When TRICARE is the primary payer, it will be the responsibility of the contractor to determine whether the beneficiary has had a qualifying three day inpatient stay and has met the 30 day discharge standard. The contractor will use the information in block 35 and 36 of CMS 1450 UB-04 to make this determination. If block 36 of CMS 1450 UB-04 is blank, the SNF claim will be denied unless the patient was involuntarily disenrolled from Medicare+Choice plan (see paragraph 4.3.4). The contractor will calculate the Length-Of-Stay (LOS) based on the SNF actual admission date provided on the CMS 1450 UB-04 claim form. Any adverse TRICARE determinations involving medical necessity issues will be appealable to TRICARE whenever TRICARE is the primary payer. However, a denial based on the factual dispute (not the medical necessity) of SNF benefit for failure to meet the three day prior hospitalization of "within 30 days" requirement is not appealable. Any factual disputes surrounding the three day prior hospitalization or "within 30 days" requirement can be submitted to the TRICARE contractor for an administrative review.

Note 1: If the qualifying hospital stay is denied as not being medically necessary and appropriate care, the SNF admission will be denied.

Note 2: If a beneficiary receives custodial, non-covered services, or care at an inappropriate level in a SNF for greater than 30 consecutive days, a new qualifying hospital stay requirement is to be met for a medically necessary SNF stay in order to be covered under TRICARE with the exception for medical appropriateness reasons as provided in the Medicare Benefit Policy Manual, Chapter 8.

4.3.4 Covered SNF services must meet the requirements in 32 CFR 199.4(b)(3)(xiv) and are to be skilled services as provided in the Medicare Benefit Policy Manual, Chapter 8. Such skilled services must be for a medical condition that was either treated during the qualifying three day hospital stay, or started while the beneficiary was already receiving covered SNF care. These coverage requirements are the same as applied under Medicare. TRICARE will follow CMS policy and waive the three day prior hospitalization requirement for those TRICARE dual eligible beneficiaries involuntarily disenrolling from Medicare+Choice plans. Code 58 in the Condition Codes block in CMS 1450 UB-04 will be the indication that patient is a terminated enrollee in a Medicare+Choice Organization plan whose three day inpatient hospital stay was waived. With regard to the requirement that the skilled services must be for a medical condition that was treated during the qualifying three day hospital stay, it will generally be presumed that this requirement is met if the qualifying three day hospital requirement is met. When the facts which come to the attention of the contractor/claims processor in their normal review process indicate that the skilled services are not related to any of the diagnoses treated during the qualifying hospital stay, the SNF claim may be denied.

4.3.5 TRICARE reimbursement will follow Medicare's SNF PPS methodology and assessment schedule. However, if the SNF admission precedes the TRICARE implementation date of SNF PPS (regardless of the discharge date), all claims for that admission will be processed using the payment methodology as provided in Section 1, paragraph 3.1.

4.3.6 Under the SNF PPS methodology and assessment schedule system, the patient will be assessed upon admission to the SNF using the MDS assessment tool. The Nursing Home Reform Act of the Omnibus Budget Reconciliation Act (OBRA 1987) mandates that all certified Long-Term Care (LTC) facilities must use the MDS as a condition of participating in Medicare or Medicaid which TRICARE is also adopting.

4.3.7 The MDS is a set of clinical and functional status measures that provides the basis for the Resource Utilization Group (RUG) classification system and the PPS. Nursing facilities must collect these data on each of their residents at prescribed intervals and upon any significant change in physical or mental condition. The MDS data are then used to classify residents into one of the SNF case-mix RUGs based on their clinical characteristics, functional status and expected resource needs. Until December 31, 2005, there were 44 RUGs (see Addendum A, Figure 8.A-1). Effective January 1, 2006, 9 additional RUGs were added for a total of 53 RUGs (see Addendum A, Figure 8.A-2). Effective October 1, 2010, 13 additional RUGs were added for a total of 66 RUGs (see Addendum A, Figure 8.A-3).

4.3.8 SNF residents will be assessed by SNFs on days 5, 14, 30, 60, and 90. Thereafter, under TRICARE, the residents will be assessed every 30 days using the same MDS assessment form. For untimely assessments, there will be penalties similar to those used by CMS. In a case of untimely assessment, the SNF will submit the claim with a default rate code and the SNF will be reimbursed at the lowest RUG pricing. If a SNF resident returns to the SNF following a temporary absence for hospitalization or therapeutic leave, it will be considered a readmission. A leave of absence will be counted as an inpatient day (i.e., not treated as a discharge and readmission) if the patient returns to the SNF by midnight of the same day.

4.3.9 SNFs are not required to assess a resident upon readmission, unless there has been a significant change in the resident's condition. If the resident experiences a significant change in condition (i.e., either an improvement or decline in the physical, mental or psychosocial level of well-being), the facility must complete a full comprehensive assessment by the end of the 14th calendar day following determination that a significant change has occurred. A "significant change" is defined as a major change in the resident's status that:

4.3.9.1 Is not self-limiting (i.e., the condition will not normally resolve itself without further clinical intervention);

4.3.9.2 Impacts on more than one area of the resident's health status; and

4.3.9.3 Requires interdisciplinary review or revision of the care plan.

Note: If a SNF has discharged a resident without the expectation that the resident would return, then the returning resident is considered a new admission (return stay) and would require an initial admission comprehensive assessment including Sections AB (Demographic Information) and AC (Customary Routine) of the assessment form within 14 days of admission.

4.3.10 SNFs are not required to automatically transmit MDS assessment data to the TRICARE contractors. However, the TRICARE contractor, at its discretion, may collect the MDS assessment data and documentation for claim adjudication or audit and tracking purposes at any time from SNFs when TRICARE is the primary payer. MDS forms and relevant background information may be found on the following web sites: http://www.cms.gov/NursingHomeQualityInits/25_NHQIMDS30.asp#TopOfPage, http://www.cms.gov/medicaid/mds20/man-form.asp, and http://www.cms.hhs.gov/MinimumDataSets20/. For TRICARE dual eligible beneficiaries, during the first 100 days of an inpatient SNF stay, TRICARE will function as a secondary payer to Medicare under SNF PPS in which case there is no need to collect the MDS assessment data. At any time TRICARE is primary payer, the MDS assessment data may be collected for audit and tracking purposes. Effective for dates of service June 1, 2010, SNF care received in the U.S. and U.S. territories must be preauthorized for /TRICARE dual eligible beneficiaries. The TRICARE Dual Eligible Intermediary Contract (TDEFIC) contractor shall preauthorize SNF care beginning on day 101, when TRICARE is primary payer (see the TRICARE Policy Manual (TPM), Chapter 1, Section 7.1 and TRICARE Operations Manual (TOM), Chapter 7, Section 2).

4.3.11 SNF staff will input the MDS assessment data into the MDS RUG-III/IV grouper, depending on the date of service. The Grouper will then generate an appropriate three digit RUG-III/IV code. A complete listing of three digit RUG-III/IV codes with corresponding definitions is included in Addendum A. To supplement the three digit RUG-III/IV codes, the SNF will add the appropriate two digit modifier to indicate the reason for the MDS assessment before submitting the claim for payment. The three digit RUG-III/IV code and the two digit modifier make up the five digit Health Insurance Prospective Payment System (HIPPS) code. The assessment indicators and the HIPPS code information related to SNF are available at http://www.cms.hhs.gov/prospmedicarefeesvcpmtgen/02_hippscodes.asp. The SNF will enter the HIPPS code on the CMS 1450 UB-04 claim form in the HCPCS code field that corresponds with the Revenue Code 022. After the 100th day, for TRICARE patients, SNFs will use an appropriate three digit RUG-III/IV code with a TRICARE-specific two digit modifier that makes up the HIPPS code. The TRICARE-specific two digit modifiers will be as follows:

120-day assessment	8A
150-day assessment	8B
180-day assessment	8C
210-day assessment	8D
240-day assessment	8E
270-day assessment	8F
300-day assessment	8G
330-day assessment	8H
360-day assessment	8I
Post 360-day assessments with 30-day interval	8X

4.3.12 Upon completion of the requisite HIPPS coding, when TRICARE is the primary payer, the SNF will submit the claim to the TRICARE claims processor for payment only after the beneficiary has been admitted, has satisfactorily met the qualifying coverage criteria and has had an appropriate MDS assessment completed. When TRICARE is the secondary payer, the claim will be submitted in accordance with standard billing procedures.

4.3.13 Consistent with Medicare's SNF PPS methodology, under the TRICARE SNF PPS:

4.3.13.1 The PPS payment rates will cover all costs of furnishing covered SNF services (routine, ancillary, and capital-related costs).

4.3.13.2 The PPS per diem payment rate is the sum of three parts: the nursing component, the therapy component, and the non-case-mix component. The nursing component includes nursing, social service and non-therapy ancillary costs (such as medications, laboratory tests, radiology procedures, respiratory therapy, medical supplies, and intravenous therapy). The therapy component includes physical, occupational and speech-language therapy costs. The non-case-mix component includes administrative, overhead and other generally fixed patient care costs (such as dietary services).

4.3.13.3 The MDS data are used to classify residents into one of the case-mix RUGs. (RUG-III was in place and effective prior to October 1, 2010. RUG-IV is effective on/after October 1, 2010.) Each of these RUG subgroups is assigned a relative weight factor (when applicable) to determine the nursing component and the therapy component of the total PPS rate. The relative weight factor reflects the costliness of providing services to residents in that group relative to the average costliness of residents across all groups. The relative weight factor is multiplied by the applicable nursing or therapy base rate (urban or rural) which results in the nursing component and the therapy component of the total rate. Patients who are expected to be more resource-intensive (based on the MDS assessment), are assigned to a RUG-III/IV category that carries a higher relative weight factor. The non-case-mix component is not adjusted. The total PPS payment rate is the sum of the nursing component, the therapy component and the non-case-mix component. The labor portion of the total PPS payment rate is then adjusted for geographic variation in wages using the wage index. Contractors are not required to do these calculations as all of these calculations are automated in using the RUG-III/IV Pricer software.

4.3.13.4 Section 4432(b) of the Balance Budget Act of 1997 (BBA 1997) sets forth a Consolidated Billing (CB) requirement applicable to all SNFs providing Medicare services. Under this requirement, SNFs must submit to Medicare all bills for Medicare-covered services furnished to their residents, regardless of who provides the services. This requirement is similar to the requirement that has been in effect for inpatient hospital services. TRICARE is adopting the Medicare's CB requirements applicable to SNFs. Services excluded from CB have been mandated by the provisions of two separate pieces of legislation. First, there are several services that are beyond the general scope of SNF comprehensive care plans (excluded under 42 CFR 411.15 (p)(3)(iii)). Second, there are several other services excluded from CB per the provisions of Section 1882(c)(2)(A)(iii) of the Social Security Act, as amended by Section 103 of the Balanced Budget Refinement Act of 1999 (BBRA 1999). A comprehensive listing of these services excluded from CB is provided in paragraph 4.3.13.5. The contractor will not issue benefit modifications for non-Medicare covered, medically necessary services for TRICARE beneficiaries receiving SNF care. There will be no benefit exceptions permitted. Services excluded from the CB provisions of the SNF PPS (e.g., cardiac catheterizations and emergency services, etc.) will be paid at the TRICARE rates.

4.3.13.5 The cost of the services listed below will be excluded from the SNF PPS rate. These services may be billed directly and paid separately using TRICARE rates. The "technical" component of a covered SNF service is included in the PPS rate but the "professional" component shall be billed separately. The identifying codes for contractor implementation of the CB provisions of the SNF PPS are provided at http://www.cms.hhs.gov/SNFConsolidatedBilling/. This web site provides the SNF

CB annual updates in Excel and PDF formats. Annual update files, as well as subsequent quarterly updates (if any), for SNF CB can be found at the above web site. This file lists services by HCPCS Code, Short Descriptors, and the Major Category under which the HCPCS falls. HCPCS added or removed by subsequent quarterly updates will be listed under the respective year's annual update section at the above web site. The respective year's annual update file will be updated to add or remove the HCPCS listed in the quarterly updates. A separate file containing the explanation of the five Major Categories for SNF CB can also be found at the above web site and it includes additional exclusions that are not driven by HCPCS codes (as some Major Categories exclude services by revenue code as well as bill types). These additional exclusions shall be included in SNF CB implementation. The effective dates for CB updates for TRICARE shall be the same as under Medicare and those will be provided with the CB updates at the above web site. With regard to the identifying codes for CB, contractors should program to call a table, so as changes occur the contractor can simply update or replace the table. No additional services will be added by the annual or quarterly updates related to CB; that is, new updates are required by changes to the coding system, not because the services subject to SNF CB are being redefined. Contractors will implement these updates within 30 days of release on the above web site (unless the implementation date provided in the update allows for greater time for implementation) at no additional cost to the government. To implement this requirement, contractors shall check the above web site for annual SNF CB updates no later than (NLT) the fifth business day in December for implementation in the following January each year. If the annual CB update is delayed by CMS (due to delay in the Medicare Physician Fee Schedule), contractors shall check the above CMS web site for annual CB updates by NLT the annual CMAC update for implementation within 30 days of the annual CMAC update. For quarterly SNF CB updates, contractors shall check the above CMS web site NLT the fifth business day in March, June, and September of each year for implementation of any updates in April, July, and October of each year respectively. Contractors will closely monitor billings and claims to prevent any duplicate billings. Following is a list of services excluded from the SNF PPS and CB:

4.3.13.5.1 Services provided to individual SNF residents by authorized practitioners, such as, physicians, certified nurse-midwives, clinical psychologists, certified clinical social workers (CSWs), nurse anesthetists;

4.3.13.5.2 Home dialysis supplies and equipment;

4.3.13.5.3 Erythropoietin (EPO) for dialysis patients as under Medicare;

4.3.13.5.4 Hospice care related to a beneficiary's terminal condition. Such hospice care will be excluded from the CB provisions of the SNF PPS and will be reimbursed in accordance with the TRICARE hospice benefit.

4.3.13.5.5 An ambulance trip that transports a beneficiary to the SNF for the initial admission or from the SNF following a final discharge. If the beneficiary is a resident of the SNF, then ambulance services are covered under CB and are included in the bundled rate. The initial admission ambulance ride and the final discharge ambulance ride are not covered under CB because the patient is not considered a SNF resident. (42 CFR 411.15 (p)(3)(I)-(iv). TRICARE will follow CMS policy for medical necessity for ambulance transportation (42 CFR 410.40(d)(I)) which is consistent with the DHA policy.

Note: If the beneficiary meets the criteria of a SNF resident, then ambulance transportation for "medically necessary" services are covered under CB and are included in the bundled SNF PPS rate. However, when a SNF resident leaves the SNF to receive any outpatient hospital services that are specifically excluded from CB (e.g., cardiac catheterization, Computerized Tomography (CT) scans, Magnetic Resonance Imagings (MRIs), emergency room services, etc.), then that beneficiary is no longer considered to be a SNF resident for CB purposes. As such, any associated ambulance trips themselves would be excluded from CB. Such ambulance trips associated with the receipt of excluded services are not included in the bundled SNF PPS rate and may be billed separately to Part B (Medicare) and TRICARE. If the beneficiary leaves the SNF to receive outpatient hospital services that are excluded from CB, then by definition that beneficiary no longer retains the status of a SNF "resident". See Medicare fact sheet regarding CB and ambulance services at Addendum C which is being adopted for TRICARE.

4.3.13.5.6 Chemotherapy items and administration services;

4.3.13.5.7 Radioisotope services;

4.3.13.5.8 Customized prosthetic devices;

4.3.13.5.9 Ambulance transportation for dialysis;

4.3.13.5.10 Certain outpatient services when provided in a hospital (including associated medically indicated ambulance transport) as these services are considered beyond the scope of the SNF care. These services include:

- Cardiac catheterization
- CT scans
- MRIs
- Ambulatory surgery performed in operating rooms
- Emergency services
- Radiation therapy
- Angiography
- Venous and lymphatic procedures.

Note: If the listed service is delivered in another setting (such as an ambulatory surgery center or imaging center) or if another (not excluded) service is provided in a hospital outpatient department (such as an x-ray), the beneficiary is still considered a SNF resident, and the service, and payment for it, is included in the SNF PPS rate.

4.3.13.5.11 Additional services as identified in SNF CB updates at http://www.cms.hhs.gov/SNFConsolidatedBilling/.

4.3.13.6 If the SNF submits a PPS claim that also includes an excluded service (see paragraph 4.3.13.6), the service that is excluded will be ignored and the claim will process and pay as it would without the excluded service. The SNF PPS claims are priced strictly on the RUG-III groups, and none of the ancillaries are themselves paid. If the SNF claim is just for the excluded service that SNFs may not bill, the claim will be rejected, and an explanation should appear on the Explanation Of Benefits (EOB). This is similar to a denial, but does not carry appeal rights.

4.3.14 SNF Pricer

4.3.14.1 DHA will provide the annual SNF PPS pricer cartridge to the claims processors with the issuance of this instruction. Any updated pricer cartridge will be provided to the claims processors upon receipt from CMS (annually and/or about each quarter) and the claims processors are required to replace the existing pricer with the updated pricer within 10 calendar days of receipt. As the annual or quarterly pricer cartridge totally replaces the previous pricer, claims processors are not required to maintain quarterly iterations. Claims processors must maintain the last version of the pricer software for each prior fiscal year and the most recent quarterly release of the current fiscal year.

4.3.14.2 Claims processors will use the 100% of the PPS rate and override any rate that is less than 100% of the PPS rate. For the call to the SNF pricer the claims processors should use the following:

- HIPPS = HIPPS code from claim
- EFFECTIVE DATE = end date of service or through date from claim
- FEDERAL BLEND = 4
- FACILITY RATE = 0

The federal blend and facility rate fields were used to provide a percentage mixture between straight PPS and facility rate payments. During Medicare's phase in period Federal blend went from 0 - 4 and this caused a percentage of the facility rate to be part of the PPS calculations. Now that the PPS is fully phased in TRICARE will use Federal Blend of 4 and no percentage of the old facility rate.

4.3.14.3 The pricer will automatically give the contractor the calculated rate for a one day stay for the claim's dates of service. Contractors will need to multiply the PPS rate given to the revenue 022 line units on the claim to come up with the complete rate for that HIPPS claim line.

4.3.14.4 Claims processors will not need to split claims when an SNF admission cross fiscal year dates. Providers are to prepare separate bills for services prior to and on or after October 1 as the SNF PPS rate is updated for each fiscal year. This split billing by providers ensures that the claim is paid using the correct rate.

Note: The provider shall bill the appropriate RUG category based on the calendar date of service. For days of service before January 1, 2006, the provider shall record the 44-group RUG on the claim. For days of services beginning on or after January 1, 2006, the provider shall record the 53-group RUG on the claim. For days of services beginning on or after October 1, 2010, the provider shall record the 66-group RUG on the claim.

4.3.14.5 For information purposes, the Policy and Statistical Analysis Services contractor will electronically transmit the current Wage Index file, the SNF PPS rates, and other related updates annually to DHA. These will be issued as routine changes to Addendums A, B, D, E, and F, as applicable. Contractors do not need to wait for issuance of these routine changes for implementation, as the SNF rate, wage index, and these updates are built into the SNF Pricer. See paragraph 4.3.14.1 regarding implementation of the SNF Pricer.

4.3.15 If the SNF does an off-schedule assessment, a late patient assessment or, in some cases, no patient assessment at all, the SNF will submit the claim using the default HIPPS rate code of AAA and the two digit default assessment indicator modifier code of 00 which will result in payment of the default rate.

4.3.16 With regard to payment for the lower 18 RUGs (i.e., IB2, IB1, IA2, IA1, BB2, BB1, BA2, BA1, PE2, PE1, PD2, PD1, PC2, PC1, PB2, PB1, PA2, PA1), for services prior to October 1, 2010, and the lower 14 RUGs (i.e., BB2, BA2, BB1, BA1, PE2, PD2, PC2, PB2, PA2, PE1, PD1, PC1, PB1, PA1) for services on/after October 1, 2010, TRICARE will follow the SNF level of care criteria as provided in the Medicare Benefit Policy Manual, Chapter 8 (Publication # 100-02), which can be accessed at http://www.hhs.gov/manuals. Beneficiaries in the lower 14 RUGs do not automatically qualify for SNF coverage. Instead, these beneficiaries will be individually reviewed to determine whether they meet criteria for skilled services and the need for skilled services as defined in 42 CFR 409.32, Subpart D, which can be accessed at http://www.gpoaccess.gov/. In determining "medical necessity", the contractor will use generally acceptable criteria such as InterQual.

Note: Prior to January 1, 2006, the upper 26 RUGs (i.e., the first 26 RUGs listed in Addendum A, Figure 8.A-1) represent the required SNF level of care during the immediate post-hospital period. With the addition of nine new RUGs, effective January 1, 2006, the upper 35 RUGs (i.e., the first 35 RUGs listed in Addendum A, Figure 8.A-2) represent the required SNF level of care during the immediate post-hospital period. With the addition of 13 new RUGs, effective October 1, 2010, the upper 52 RUGs (i.e., the first 52 RUGs listed in Addendum A, Figure 8.A-3) represent the required SNF level of care during the immediate post-hospital period. A beneficiary who is correctly assigned to one of the upper RUGs under the initial five day assessment is automatically classified as meeting the SNF level of care definition and does not require a medical review unless there is a reason to do so (e.g., data analysis suggests an unusual pattern of claims submission). When a beneficiary is correctly assigned to one of the upper RUG-III/IV groups, depending on the date of service, under the initial five day assessment, the SNF level of care requirement is met for the period from SNF admission up to and including the assessment reference date for that assessment. This presumption of coverage only applies if the beneficiary is admitted to the SNF immediately following a three day qualifying hospital stay, and lasts through the assessment reference date of the five day assessment, which must occur NLT the eighth day of the stay due to the three day grace period for SNF assessments.

Note: For TRICARE dual eligible beneficiaries: Medicare is primary payer during the presumption of coverage period; therefore, TRICARE will follow Medicare's determination. If the services are determined not to be medically necessary under Medicare, they will not be covered under TRICARE. Effective for dates of service June 1, 2010, SNF care received in the U.S. and U.S. territories will require preauthorization. The TDEFIC contractor will preauthorize care beginning on day 101, when TRICARE becomes primary payer.

4.3.17 If a pediatric SNF is certified by Medicaid, it will be considered to meet the Medicare certification requirement in order to be an authorized provider under TRICARE. The cover letter to SNFs and the Participation Agreement are provided at Addendum G which the contractor will send to SNFs. SNFs must provide evidence that they are certified by Medicare (or Medicaid). The contractor will be responsible for verification that the SNF is Medicare-certified (or Medicaid-certified), and has entered into a Participation Agreement with TRICARE. TRICARE will not permit a waiver to allow non-Medicare (or non-Medicaid) certified SNFs to be authorized SNFs under TRICARE. Non-participating SNFs will not be eligible for reimbursement under TRICARE. If a PPS

claim is received from a SNF that has not signed a TRICARE Participation Agreement, the contractor will deny the claim and send a Participation Agreement to the SNF for signature. Once the SNF has signed the Participation Agreement, the claim will be processed provided the SNF was Medicare (or Medicaid) certified and met all other TRICARE SNF criteria at the time when the services were furnished to the TRICARE beneficiary.

Note: VA facilities are required to be Medicare approved or they are required to be Joint Commission accredited in order to have deemed status under Medicare or TRICARE. The VA facilities that enter into an MOU with Department of Defense (DoD) are not required to enter into the Participation Agreement provided at Addendum G.

4.3.18 At their own discretion, the contractors may conduct any data analysis to identify aberrant PPS providers or those providers who might inappropriately place TRICARE beneficiaries in a high RUG.

4.3.19 Refer to the TRICARE Systems Manual (TSM), Chapters 2 and 4 for the SNF PPS related revenue and edit codes.

4.4 For Admissions on or after August 1, 2003, when TRICARE is Secondary Payer to Medicare

4.4.1 TRICARE is the secondary payer to Medicare for SNF care for beneficiaries under age 65 who are eligible for Medicare, with no OHI and for beneficiaries age 65 and over who are eligible for Medicare with less than a 100-day covered Medicare SNF stay with no OHI.

4.4.2 The beneficiary has no liability under Medicare for days 1 through 20; therefore, there will not be any unpaid amount for TRICARE to reimburse until day 21. For days 21 to 100, the beneficiary does have a cost-share for which TRICARE will pay the remaining liability as secondary payer.

4.4.3 The Medicare-eligible patient will be assessed by the SNF using the MDS.

4.4.4 The MDS data will be run through the MDS RUG-III/IV grouper to generate a three digit RUG-III/IV code. (RUG-III was in place and effective prior to October 1, 2010. RUG-IV is effective on/after October 1, 2010). The RUG grouper software assigns a RUG code for billing and payment purposes. Each Medicare-certified SNF must process the MDS assessment data by using the appropriate RUG grouper, depending on the date of service. A two digit modifier will be added to this to get the five digit HIPPS code which the SNF will put on the claim and send that to the Medicare claims processor for payment.

4.4.5 For TRICARE dual eligible beneficiaries, the Medicare claims processor will pay the SNF claim as the primary payer and then electronically submit the claim to the TRICARE contractor for secondary payer purposes.

4.4.6 For a beneficiary who is both Medicare and TRICARE eligible, TRICARE can pay secondary for a SNF that participates in Medicare and has entered into a Participation Agreement with TRICARE. Upon exhaustion of Medicare benefits, TRICARE may pay primary to such SNFs.

4.4.7 As secondary payer, TRICARE will use Medicare's determination of coverage rather than performing an additional review. If Medicare denies the services as not medically necessary, TRICARE will also deny the care and the beneficiary will have appeal rights through Medicare.

5.0 MISCELLANEOUS POLICY

5.1 DHA will follow CMS policy regarding use of the default payment rate whenever the SNF does an off-schedule assessment, a late patient assessment, or in some cases, no patient assessment at all (but can prove patient eligibility). The default payment will always be equal to the lowest RUG group rate (currently, this is the payment rate for PA1).

5.2 TRICARE contractors, at their discretion, may conduct concurrent or retrospective review for Standard and Extra patients when TRICARE is the primary payer. The review required for the lower 18 RUGs (services prior to October 1, 2010) and lower 14 RUGs (services effective October 1, 2010) is a requirement for all TRICARE patients when TRICARE is primary (see paragraph 4.3.16). There will be no review for Standard and Extra patients where TRICARE is the secondary payer. The existing referral and authorization procedures for Prime beneficiaries will remain unaffected.

5.3 Effective for dates of service **June 1, 2010**, SNF care received in the U.S. and U.S. territories must be preauthorized for TRICARE dual eligible beneficiaries. The TDEFIC contractor will preauthorize SNF care beginning on day 101, when TRICARE becomes primary payer. For those beneficiaries inpatient on the effective date, a preauthorization will be required August 1, 2010. In the event that TRICARE is the primary payer for these services and preauthorization was not obtained, the contractor shall obtain the necessary information and perform a retrospective review. The payment reduction may be applied in these cases. There will be no review when TRICARE is the secondary payer.

5.4 Supplemental care benefits for ADSM will be paid according to the TRICARE SNF PPS. If the ADSM is enrolled to a Military Treatment Facility (MTF), this care must be approved by the MTF. Otherwise the care will be approved by the Service Point of Contact/Military Medical Support Office (SPOC/MMSO). TRICARE will pay the claim and the ADSM will not have any out-of-pocket expense.

5.5 SNF PPS will apply to Transitional Assistance Management Program (TAMP) beneficiaries.

5.6 SNF PPS will apply to Continued Health Care Benefit Program (CHCBP) beneficiaries.

5.7 SNF PPS claims are required to be filed sequentially at least every 30 days. Current timeliness standards will continue to apply which require claims to be filed within one year after the date the services were provided or one year from the date of discharge for an inpatient admission for facility charges billed by the facility. If a claim is not filed sequentially, the contractor may return that to the submitting SNF.

5.8 TRICARE will allow those hospital-based SNFs with medical education costs to request reimbursement for those expenses. Only medical education costs that are allowed under the Medicare SNF PPS will be considered for reimbursement. These education costs will be separately invoiced by hospital-based SNFs on an annual basis as part of the reimbursement process for hospitals (see Chapter 6, Section 8). Hospitals with SNF medical education costs will include appropriate lines from the cost report and the ratio of TRICARE days/total facility days. The product

will equal the portion that TRICARE will pay. TRICARE days do not include any days determined to be not medically necessary, and days included on claims for which TRICARE made no payment because Other Health Insurance (OHI) or Medicare paid the full TRICARE allowable amount. The hospital's reimbursement requests will be sent on a voucher to the DHA Finance Office for reimbursement as a pass through cost.

5.9 Swing Bed Providers

5.9.1 TRICARE will follow CMS policy regarding swing bed providers. To be reimbursed under SNF PPS, a hospital must be certified as a swing bed provider by CMS.

5.9.2 TRICARE will exempt CAH swing beds from the SNF PPS. Section 203 of the Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP) Benefits Improvement and Protection Act of 2000 [Public Law 106-554], exempted CAH swing beds from the SNF PPS. Accordingly, it will not be necessary to complete an MDS assessment for CAH swing bed SNF resident. The CAH will directly bill the claims processor for the services received. Under the TRICARE benefit, CAHs will be reimbursed for their swing bed SNF services based on the reasonable cost method, reference as provided in Section 1, paragraph 3.1. Currently, the list of current CAHs can be accessed at http://www.flexmonitoring.org.

5.9.3 The CAH swing bed claims can be identified by the Medicare provider number (CMS 1450 UB-04). There are two provider numbers issued to each CAH with swing beds. One number is all numeric and the second number is an alpha "z" in the third digit. For example, the acute beds would use 131300 and the swing beds 13z300. Other than the "z" the numbers are identical. The first two digits identifies the State code, and the 1300-1399 series identifies the CAH category.

5.10 Children under age 10 at the time of admission to a SNF will not be assessed using the MDS. TRICARE contractors will determine whether SNF services for these pediatric residents are covered based on the criteria of skilled services defined in 42 CFR 409, Subpart D and the Medicare Benefit Policy Manual, Chapter 8. The criteria used to determine SNF coverage for a child under the age of 10 will be the same whether that child is or is not Medicare-eligible. SNF benefit requirements will apply to these pediatric patients. SNF care for children under age 10 will be paid as provided in Section 1, paragraph 3.1. The TRICARE contractor will have the ability to negotiate these reimbursement rates.

5.11 The Waiver of Liability provisions in the TRICARE Policy Manual (TPM), Chapter 1, Section 4.1 apply to SNF cases.

5.12 Enteral Feedings Alone May Not Qualify For TRICARE Coverage Of SNF Services

The need for enteral feedings may not, alone, provide a sufficient basis for obtaining TRICARE coverage of care provided in a SNF. Enteral feedings are not services that can be provided only at a SNF level of care. The SNF extended care benefit covers relatively short-term care as a continuation of treatment begun in the hospital. The initiation of enteral feedings or provision of skilled care needed to manage documented difficulties or complications with the feedings may be considered skilled services that qualify for SNF care. However, once a beneficiary is stabilized for routine enteral feedings, a lower level of care may be more appropriate, such as a home care setting or assisted living facility, with non-licensed family members or facility staff trained to provide feedings and only intermittent involvement of nursing personnel needed to provide oversight. The appropriate

level of care is subject to medical necessity review.

5.13 Billing TRICARE for Outpatient SNF Services When TRICARE Has Denied Inpatient SNF PPS Or Continued Services

When no TRICARE inpatient SNF PPS program payment is possible, otherwise covered medically necessary services and supplies may be allowed under TRICARE's outpatient benefit. However, nursing care provided in a SNF setting is not billable under the TRICARE outpatient benefit. For TRICARE dual eligible beneficiaries, Medicare is primary payer for all Medicare Part B services; therefore, the SNF will need to bill CMS for these outpatient SNF services, rather than first submitting a claim to TRICARE. (See Chapter 4, Section 4.)

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