Skilled Nursing Facility (SNF) Prospective Payment System (PPS) For Care Rendered On Or After October 1, 2019

Issue Date: December 13, 2019
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 REVISIONS FOR FISCAL YEAR (FY) 2020

Under 10 United States Code (USC) 1079(i)(2), the amount to be paid to hospitals, SNFs, and other institutional providers under TRICARE shall, by regulation, be established "to the extent practicable in accordance with the same reimbursement rules as apply to payments to providers of services of the same type under Medicare.

On August 8, 2018, the Centers for Medicare and Medicaid Services (CMS) published the Prospective Payment System (PPS) and Consolidated Billing for Skilled Nursing Facilities (SNF) Final Rule for Fiscal Year (FY) 2019. In the rule, CMS documented its plan to replace the SNF PPS RUG-IV classification system with a new case-mix classification model called the Patient-Driven Payment Model (PDPM) beginning on October 1, 2019.

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 that meets requirements established in 32 CFR 199.6(b)(4)(vi). 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, which can be accessed at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/index.html.

4.0 ISSUE

How are SNFs reimbursed?

5.0 POLICY

5.1 Statutory Background

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 USC 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 USC 1395d(a) and (b)) and 42 CFR 409.61(b) shall not be applicable under TRICARE.

5.2 Applicability And Scope

All TRICARE authorized SNFs must be authorized SNF providers under the Medicare program, and meet 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)), or subsequent regulations.

5.2.1 If a pediatric SNF is certified by Medicaid, it will be considered to meet the Medicare certification requirement to become an authorized provider under TRICARE. The contractor shall send a cover letter and Participation agreement, which is provided at Addendum A, to any SNFs that are not authorized by Medicare, but would qualify as a TRICARE-approved pediatric SNF. The contractor shall be responsible for verification that the SNF is Medicare-certified (or Medicaid-certified) and has entered into a Participation Agreement with TRICARE.

5.2.2 Department of Veterans Affairs (VA) facilities are required to be Medicare approved or they are required to be Joint Commission accredited to have deemed status under Medicare or TRICARE. Unless required in their Memorandum of Understanding (MOU) or Participation Agreement, VA facilities may not be subject to SNF PPS (see section 5.0.2).

5.3 SNF Admission Criteria

5.3.1 TRICARE follows Medicare requirements for admission to a SNF and any exception policy per Medicare Benefit Policy Manual, Chapter 8. For a SNF admission to be covered under TRICARE, the beneficiary must both have a qualifying hospital stay of three 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.

5.3.2 TRICARE is adopting Medicare's Interrupted Stay Policy.

- TRICARE will adopt the Medicare definition of an interrupted stay as one in where a patient is discharged from a SNF and subsequently readmitted to the same SNF during the interruption window. The interruption window is a three-day period that begins on the first non-covered day following a SNF stay and ends at 11:59pm on the third consecutive non-covered day. If both conditions are met, the subsequent stay is considered a continuation of the previous "interrupted" stay for the purposes of both the variable per diem schedule and the assessment schedule.

- If the patient is readmitted to the same SNF outside the interruption window, or any

instance when the patient is admitted to a different SNF (regardless of the length of time between stays), then the Interrupted Stay Policy does not apply, and the subsequent stay is considered a new stay. In such cases, the variable per diem schedule resets to Day 1 payment rates, and the assessment schedule also resets to Day 1, necessitating a new five-day assessment required.

5.3.3 When TRICARE is the primary payer, the contractor shall determine whether the beneficiary meets the criteria for coverage. The contractor shall use the information in block 35 and 36 of CMS 1450 UB-04 to make the admission determination. If block 36 of CMS 1450 UB-04 is blank, the SNF claim will be denied unless the patient was involuntarily disenrolled from a Medicare + Choice plan. The contractor shall 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 or "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.

5.4 SNF Minimum Data Set (MDS) Assessments

5.4.1 The Medicare-certified SNF must assess the beneficiary using the MDS assessment form for the SNF PPS rate to be applied.

5.4.2 Under the PDPM, SNF residents will be assessed using MDS by SNFs at day five and at discharge (see PDPM FAQ on Medicare Website at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM.html). The interim payment assessment (IPA) is optional and will be completed when providers determine that the patient has undergone a clinical change that would require a new PPS assessment. SNFs are not required to assess a resident upon readmission, unless there has been a significant change in the resident's condition. If a significant change is found, the facility will follow Medicare policy for additional reviews.

5.4.3 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.

5.4.4 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 the SNF PPS in which case there is no need for TRICARE to collect the MDS assessment data. At any time when TRICARE is primary payer, the MDS assessment data shall be collected by TRICARE for audit and tracking purposes.

5.4.5 SNF staff will follow Medicare policy and use the MDS grouper which uses MDS data to classify patients into PDPM groups. The grouper will then generate an appropriate four-digit PDPM code. To supplement the four-digit codes, the SNF will add a one-digit assessment indicator using codes determined by Medicare to indicate the reason for the MDS assessment before submitting the claim for payment. The five digits make up the Health Insurance Prospective Payment System (HIPPS) code. The SNF will enter the HIPPS code on the CMS 1450 UB-04 claim form in the

Healthcare Common Procedure Coding System (HCPCS) code field that corresponds with the Revenue Code 022. The components of this code are used within the pricer (see paragraph 5.5.2) to determine payment. SNFs will code the fifth digit using Medicare MDS assessment codes to indicate either initial, PPS discharge, or Interim Payment Assessments (IPA).

5.4.6 For untimely assessments, if the SNF does an off-schedule assessment, or in some cases no patient assessment at all, the SNF will submit the claim with a default rate code ZZZZZ and the SNF will be reimbursed at the lowest PDPM pricing.

5.5 SNF PPS Payment Method

5.5.1 TRICARE reimbursement will follow Medicare's SNF PPS methodology and assessment schedule for all TRICARE patients (including those Active Duty Service Members (ADSMs) using Supplemental Care benefits, Transitional Assistance Management Program (TAMP) beneficiaries, and Continued Health Care Benefit Program (CHCBP) beneficiaries) admitted at Medicare-certified SNFs (or Medicaid-certified pediatric SNFs), with specific exceptions as noted later in this section SNF PPS will apply to TRICARE beneficiaries who satisfy the qualifying coverage requirements of the TRICARE SNF benefit.

5.5.2 The PPS payment rates will cover all costs of furnishing covered SNF services (routine, ancillary, and capital-related costs). For items that Medicare pays outside the SNF PPS consolidated billing rules (e.g., professional services of physicians, chemotherapy), TRICARE will also pay outside the SNF PPS rate utilizing the appropriate TRICARE reimbursement system. The CB provisions of the SNF PPS are provided at https://www.cms.gov/Medicare/Billing/SNFConsolidatedBilling/index.html.

5.5.3 Claims will be paid at 100% of the PPS rate.

5.5.4 Claims processors shall regularly monitor and download the latest Medicare SNF PPS Pricer software from the Medicare website: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PCPricer/SNF.html and replace the existing pricer with the updated pricer within 10 calendar days of download. 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.

5.5.5 The pricer will provide the contractor the calculated rate for a one day stay for the claim's dates of service. Contractors shall multiply the PPS amount calculated by the pricer by the number of revenue 022-line units on the claim to come up with the complete amount for that HIPPS claim line.

5.5.6 Claims processors will not need to split claims when a SNF admission crosses 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.

5.6 Additional SNF Data

5.6.1 The SNF Wage Index file, may be found at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/WageIndex.html.

5.6.2 The SNF PPS base rates will be posted for each PDPM category annually. Contractors shall not wait for issuance of these routine changes for implementation, because the SNF rate, wage index, and these updates are built into the SNF PPS pricer.

5.7 Miscellaneous Policy

5.7.1 Medicare is the primary payer for all dual eligibles during the first 100 days of SNF care per benefit period. For all care after 100 days, TRICARE becomes the primary payer for Medicare-eligible beneficiaries who have no other health insurance. TRICARE is also the primary payer for non-Medicare-eligible TRICARE beneficiaries who do not have other health insurance 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.

5.7.2 TRICARE will follow Medicare's policy per Section 4432(b) of the Balanced Budget Act of 1997 (BBA 1997) on the Consolidated Billing (CB) requirement applicable to all SNFs providing Medicare services. More information can be found at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/ConsolidatedBilling.html and at https://www.cms.gov/Medicare/Billing/SNFConsolidatedBilling/index.html.

5.7.3 With regard to payment for the lower PDPM classification groups, TRICARE will follow the SNF level of care criteria as provided in the Medicare Benefit Policy Manual, Chapter 8. If individual reviews are required by Medicare, the contractor will be responsible to conduct the review for TRICARE primary-payer patients to ensure that they meet criteria for skilled services and the need for skilled services as defined in 42 CFR 409.32, Subpart D. In determining "medical necessity", the contractor shall use generally acceptable criteria such as InterQual.

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

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

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

5.7.7 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 as described in Chapter 6, Section 8. 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.

5.7.8 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.

5.8 Preauthorization

SNF care received in the United States (U.S.) and U.S. territories will require preauthorization if TRICARE is the primary payer. The TDEFIC contractor shall preauthorize care beginning on day 101, when TRICARE becomes primary payer for dual eligible beneficiaries without other health insurance. TRICARE contractors, at their discretion, shall conduct concurrent or retrospective review for TRICARE Select or TRICARE For Life (TFL) patients when TRICARE is the primary payer. There will be no review when TRICARE is the secondary payer. The existing referral and authorization procedures for Prime beneficiaries will remain unaffected.

6.0 EXCLUSION

6.1 CAH swing beds are excluded from the SNF PPS methodology.

6.2 VA facilities are excluded from the SNF PPS methodology unless there is a SNF Participation Agreement or MOU in place establishing that they will be reimbursed with the SNF PPS methodology.

6.3 Children under age 10 at the time of admission to a SNF that are not assessed using the MDS are exempt from the SNF PPS methodology. The TRICARE contractor shall negotiate these reimbursement rates utilizing their best business practices.

6.4 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.)

7.0 EFFECTIVE DATE

This policy section is effective for dates of service on or after October 1, 2019.

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