BlueCross BlueShield of South Carolina and
BlueChoice® HealthPlan of South Carolina

SKILLED NURSING FACILITIES

WHAT YOU NEED TO KNOW

Published by Provider Relations and Education, Your Partners in Outstanding Quality, Satisfaction and Service

Revised: January 2023

TABLE OF CONTENTS

INTRODUCTION

The purpose of this document is to give you an overview of procedures, requirements and guidelines for skilled nursing facilities (SNFs).
As a reminder, please verify benefits and eligibility. Please visit My Insurance Manager℠ on our website, **www.SouthCarolinaBlues.com** or **www.BlueChoiceSC.com**, to determine the patient liability, benefit maximums and prior authorization requirements.

Definition of a SNF

An SNF is an inpatient health care facility with the staff and equipment to provide skilled nursing care, such as intravenous injections. It also provides rehabilitation and other related health services to patients who need nursing care but do not require hospitalization.

Network Participation

Providers can use the Doctor & Hospital Finder to verify network access for Blue Cross and Blue Shield Plans nationwide. This feature can help you determine whether your SNF is in network for a particular member's plan, no matter which Blue Plan you participate in or which Blue Plan holds the member's health plan.

To access the Doctor & Hospital Finder, log in to our secure web-based provider portal, My Insurance Manager. From the Resources tab, select BlueCross Doctor & Hospital Finder or BlueChoice HealthPlan Doctor & Hospital Finder.

Plan Notification Requirement

Most BlueCross and BlueChoice® members have managed care requirements in their contracts. These requirements make sure inpatient stays are medically necessary, appropriate and in accordance with the member's group contract.

The preferred method for submitting prior authorization requests for members is through My Insurance Manager. We resolve a high percentage of web requests immediately and provide precertification numbers instantly. If you do not have access to the web, refer to the member's ID card for the telephone number to report admissions.

Medical Necessity

We may consider skilled nursing coverage medically necessary when all of these criteria are met:

- Services require an SNF level of care (LOC) and cannot be provided in a less intensive setting.
- Services require the skills of qualified technical or professional health personnel, such as registered nurses, licensed practical (vocational) nurses, physical therapists, occupational therapists, speech language pathologists or audiologists.
- These skilled nursing or skilled rehabilitation personnel directly provide or generally supervise services to assure the safety of the patient and to achieve the medically desired result.
- Services are provided under a plan of care established and periodically reviewed by a physician.
- Services are appropriate for the treatment of the illness or injury with the expectation that the condition of the patient will improve in a reasonable and generally predictable period of time. Or the services must be necessary for the establishment of a safe and effective maintenance program.

For more information, review our medical policy CAM 338.

Authorization Requirements for SNF Stays

SNF stays require authorization prior to admission. The member must meet medical necessity criteria for approval.

All SNF admissions are subject to concurrent review. They must meet medical necessity criteria and continued stay criteria. We may ask for this information and/or documentation as part of the continued stay/concurrent review:

- Documentation of progress toward long- and short-term goals
- Expected length of treatment
- Additional supporting documentation:
  - Nursing assessments and progress notes
  - Rehabilitation therapy assessments and progress notes
  - Physician orders and progress notes

You can get prior authorization through My Insurance Manager or by calling the appropriate Plan's call center:

- For BlueCross members, call 800-334-7287.
- For BlueChoice members, call 800-950-5387 and select option 6.
- For Federal Employee Program members, call 800-334-3238.
- For State Health Plan (Medi-Call) members, call 800-925-9724.

How Should You File SNF Claims?

Submit an Institutional Claim Entry using My Insurance Manager. This is the preferred method of receiving claims filed to our Plans.

My Insurance Manager Procedures for Institutional Claim Entry

From the Patient Care menu, select Institutional Claim Entry. The Plan Information screen appears first, giving information about the submitter (i.e., the user account information). Choose a Plan, indicate if the plan is the primary payer and input the date of service. Select Continue.

On the Provider Information screen, the billing information will pre-populate according to the location affiliated with your user profile. Select the link to Choose a Billing Provider if the default billing location is not shown or if you are entering a claim for another location associated with the provider ID. Select an attending provider ID type (primary ID [NPI], secondary ID) and enter the correlated information. Select Continu

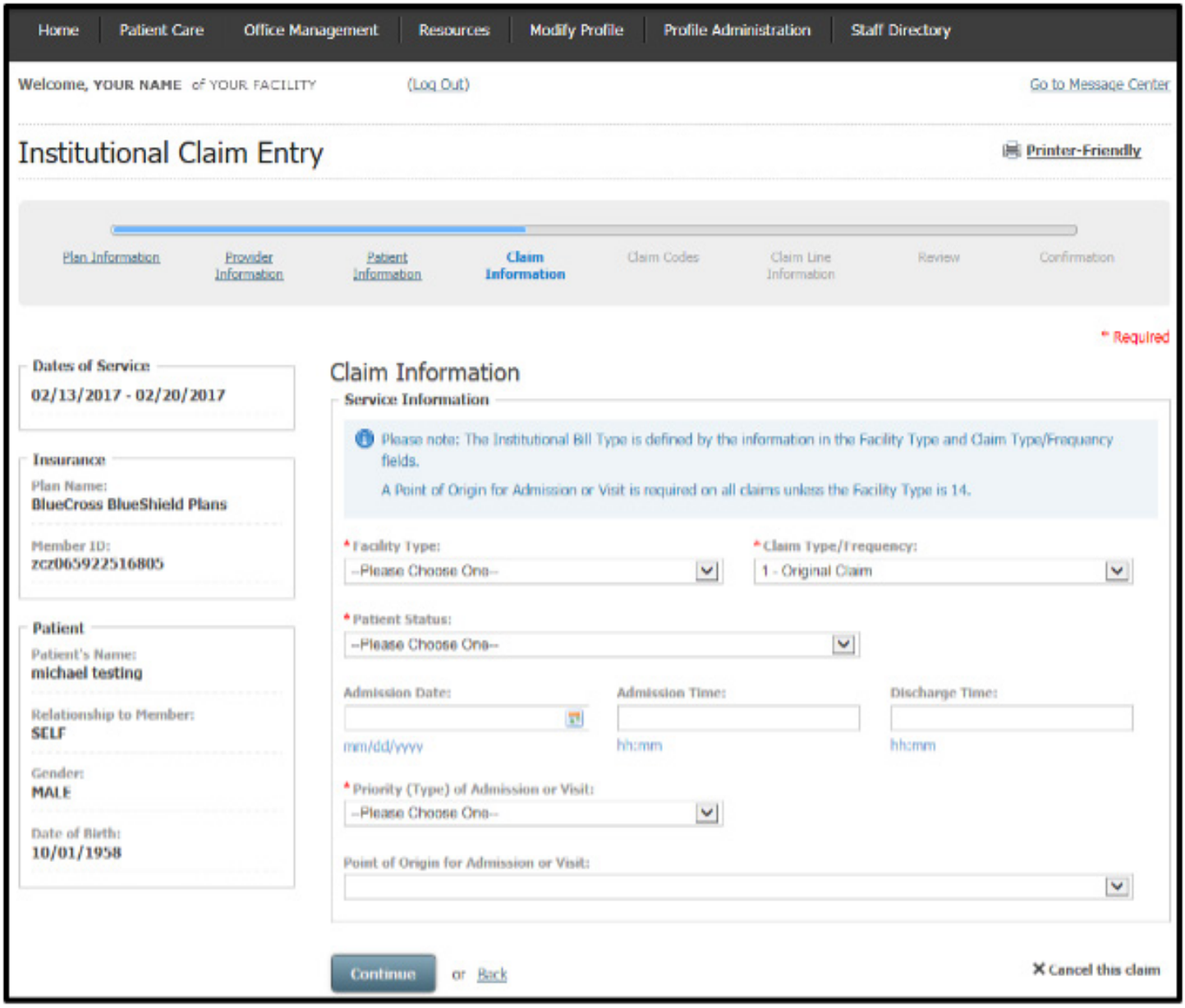
On the Patient Information screen, add the required patient data elements as a one-time entry or use the Patient Directory. Select a patient to have this information auto-filled using a selected patient from the Patient Directory. In the Patient Account Number field, enter the patient's unique number your practice or practice management software has assigned. You can create a patient account number if one does not exist.

The next institutional claim entry screen is Claim Information. Options to select a facility type include:

- 21-Skilled Nursing-Inpatient (including Medicare Part A).
- 22-Skilled Nursing-Inpatient (Medicare Part B only).
- 23-Skilled Nursing-Outpatient.
- 28-Skilled Nursing-Swing Beds.

Enter claim type/frequency (26 options), patient status (40 options), and priority (type) of admission or visit to have preestablished data fields included in the professional claim entry process. A point of origin for admission or visit is required on the claim. Select Continue, as shown in Example 1.

Example 1: My Insurance Manager Claim Information Screen



Include the diagnosis and condition code data on the Claim Codes screen. Follow the link to add diagnosis codes as needed. All inpatient claims and encounters require an admitting diagnosis code, a reason for visit code and an E-code.

In the Claim Lines section of the Claim Line Information entry, add the Revenue Code. Select a Procedure Code Type (HCPCS code, HIPPS SNF rate code or ICD-10-CM code). The dates of service and diagnosis codes are automatically filled from previous entries during the institutional claim entry process. Enter the Line Charge Amount, the Unit Type (days, unit) and the number of Units. If appropriate, expand to see Drug Identification fields by selecting the show/hide link. When entering prescription drug information, be sure to accurately capture the National Drug Code (NDC) number, as it is a requirement of BlueCross and BlueChoice plans. Then select Continue.

From the Claim Review screen, examine your entries for the institutional claim. Submit the institutional claim or return to any previous screen using the Back link or choosing a screen title from the progress bar. To add claim-level information, select Add Additional Claim Information. To add information that applies to an individual claim line, select the Add link on the line to which the information applies. There is an option to cancel this claim at the bottom of each screen of the claim entry process. Once you're satisfied with the information entered, select Submit. The Claim Confirmation screen will show a claim number.

You can now create a new claim or view claim status.

UB-04 Paper Claim Form Procedures for Institutional Claim Entry

You can also bill all services, including those typically rolled up in the charge for the per diem, on the UB-04 form.

SNF providers must be able to distinguish between revenue codes and CPT® codes when billing for outpatient services. Revenue codes identify a specific accommodation, ancillary service or billing calculation. They come from the National Uniform Billing Committee (NUBC) Official UB-04 Data Specifications Manual. CPT codes the American Medical Association issues are part of a coding structure for medical procedures.

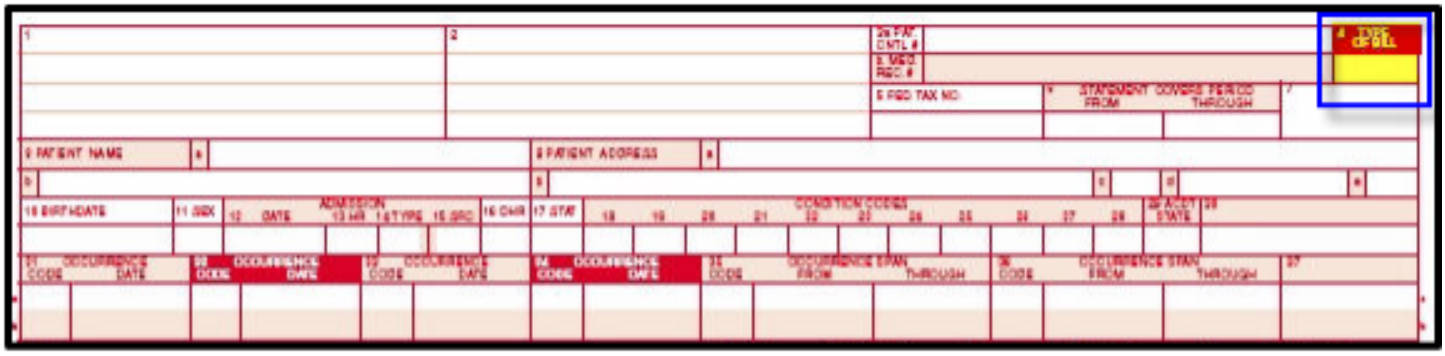
We require complete patient information in the applicable UB-04 fields:

- Billing Provider Name, Address, Telephone
- Billing Provider Designated Pay To Address
- Patient Name
- Patient Address
- Patient Date of Birth
- Patient Sex
- Admission Date

You must also complete the Type of Admission and Point of Origin for Admission fields. Type of admission can be emergency, urgent, elective, newborn, trauma center and "information not available." Eligible points of origin for admission are physician referral, clinic referral, transfer from hospital, transfer from SNF and "information not available."

When completing the UB-04 Type of Bill (TOB) field, use 21X for an SNF inpatient, 22X for an SNF outpatient-certified bed or 23X for an SNF outpatient noncertified bed (see Example 2). You should enter remarks — such as Medicare secondary payer claim, LOC, adjustments, etc. — when applicable (see Example 3).

Example 2: UB-04 Type of Bill Field



Example 3: UB-04 Remarks Field

The SNF may bill for ancillary services. The SNF can bill for other services, per the Level of Coverage (LOC) Reimbursement Exclusions, only if there is agreement between the SNF and the Plan to add these to the LOC per diem.

When a provider provides physical, speech or occupational therapy in an outpatient setting, enter the appropriate two-character CPT modifier code for these services with the HCPCS code for each date of service. Modifiers for therapy services are GN – speech language pathology (SLP), GO – occupational therapy (OT) and GP – physical therapy (PT). The SNF consolidates and bills therapy services regardless of where the services were provided. Therapy services must be bundled back to the SNF.

Note: When a Medicare patient exhausts his or her Part A benefits or did not meet the Medicare coverage criteria, submit claims to Medicare for Part B services. Claims for Part B services Medicare processes should automatically cross over for secondary payment.

How Are SNF Claims Reimbursed?

We reimburse SNFs a per diem that we base upon the authorized LOC. Our BlueCross, BlueChoice, state, federal and Health Care Exchange products are contracted per the LOC description.

When submitting BlueCard claims, the SNF must indicate on the UB04 claim form the LOC it feels best matches services the member's Home Plan authorizes. Therefore, patient status will determine the appropriate reimbursement rate.

Skilled nursing providers do not have contracted fee schedules for reimbursement. We base reimbursement on the LOC the patient received either by the per-diem or per-hour method (for outpatient therapy).

Levels of Care (LOCs)

Generally, we cover care in an SNF if the member meets all of these four factors:

1. The patient requires skilled nursing services or skilled rehabilitation services, i.e., services that professional or technical personnel must perform or supervise; a physician orders and renders for a condition for which the patient received inpatient hospital services; or for a condition that arose while receiving care in a SNF for a condition for which he or she received inpatient hospital services.
2. The patient requires these skilled services on a daily basis.
3. As a practical matter, considering economy and efficiency, you provide only the daily skilled services on an inpatient basis in a SNF.
4. The services you deliver are reasonable and necessary for the treatment of a patient's illness or injury, i.e., they are consistent with the nature and severity of the individual's illness or injury, the individual's particular medical needs, and accepted standards of medical practice. The services must also be reasonable in terms of duration and quantity.

Level I (Standard Services)

- Semiprivate rooms
- 24-hour nursing service/supplies
- Pharmacy: routine medications/supplies/supplemental nourishment
- Dietary/nutritional services
- Routine oxygen
- Laboratory tests and services, including interpretation
- Radiology tests and services, including interpretation
- Standard durable medical equipment (DME)
- Family/caregiver/patient education
- Social services and comprehensive discharge planning
- Preadmission assessments
- Comprehensive, interdisciplinary care planning
- Written treatment and therapy evaluations you provide to the care manager or medical director within 72 hours of admission, as indicated
- Measurable clinical goals, including realistic time frames
- On-site care plan meetings with care management teams, as indicated
- Progress evaluations, as the care manager requests
- Quality assessment and improvement program
- Transportation

Level II

- All standard services under Level I
- Therapy evaluations (physical, occupation, speech) as indicated upon admission
- Therapy treatments: up to two hours per day, five days per week
- Education: by nursing and/or rehabilitation staff
- Wound care: up to two treatments per day, single site, surgical, amputation, burns, decubitus — Stage 3 or greater
- Pain management

BlueCross BlueShield of South Carolina and
BlueChoice® HealthPlan of South Carolina

216585-07-2024