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Skilled Nursing Facility Medicare Basics

Nov 2018



Helpful Resources:

JudyWilhide.com. "Resources"

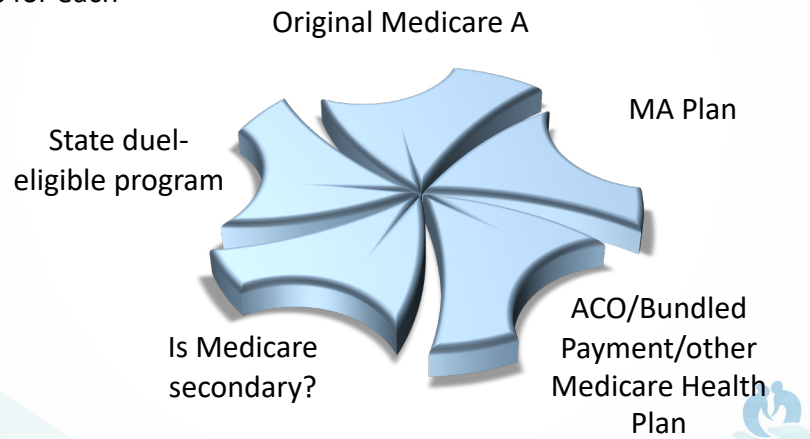
SNF PPS Medicare Information // MA Plan Information //

- [SNF skilled services defined: Ch 8 Medicare Benefit Policy Manual](#)
- [Regulatory Requirement for Physician Certification in a SNF: Section 30, Chapter 4, Medicare General Information Manual](#)
- [CMS Booklet describing the SNF benefit](#)
- [FY2014 SNF & CB Final Rule](#)
- [FY2015 SNF & CB Final Rule](#)
- [FY2016 SNF & CB Final Rule](#)
- [FY2017 SNF & CB Final Rule](#)
- [FY2018 SNF & CB Final Rule](#)
- [FY2019 SNF & CB Final Rule](#)
- [CMS SNF PPS Website](#)
- [Find your MAC, RAC, ZPIC: CMS Interactive Map](#)
- [Oct 16 CMS educational tool: SNF PPS Schedule](#)
- [SNF Open Door Forum](#)
- [REVISED 8/25/14 CMS MedLearn Article: SNF Physician Certification for skilled Care Requirements Pub 8/2014](#)
- [\(Published 3/27/17\): HHS OIG Document - Measuring Compliance](#)

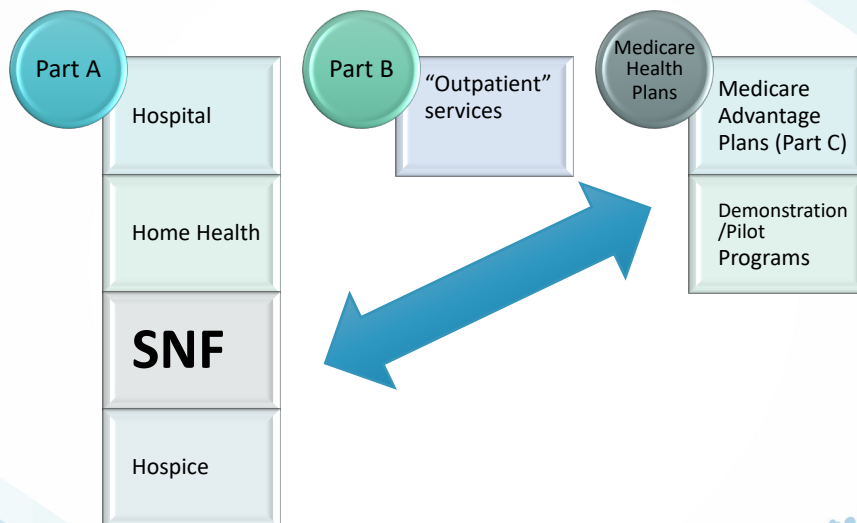


How does resident receive Medicare?

Must confirm coverage rules for each



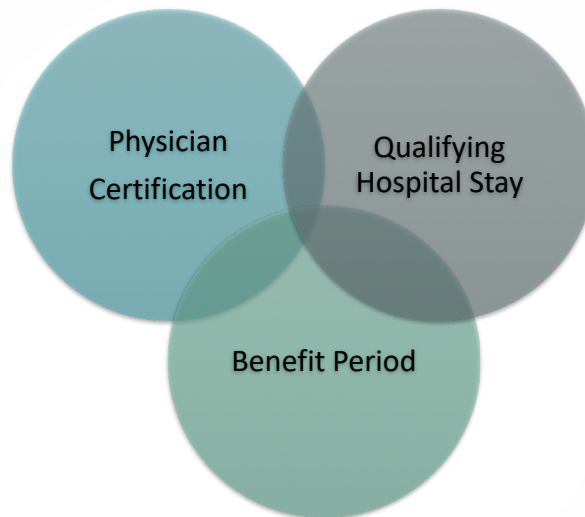
SNF Medicare Options



MA Plan

- Medicare pays a fixed amount for care each month to MA Plan insurance company.
- Each can charge different out-of-pocket costs and have different rules for how to get services and **HOW TO GET PAID**
 - Different payment requirements
 - RUGs
 - Levels
 - Pre-Auth
 - In Network

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Technical Requirements



3 Day Qualifying Stay

- Required for Original Medicare
- Must be consecutive
- Must be an ***inpatient***
- ER, outpatient midnights *do not count*

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Hospice Revocation in Hospital



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SNF 100 Day Benefit Period (after qualifying hospital stay)

May use up to 100 days per benefit period if level of care requirement met

If part of a benefit period used and skilled need re-arises within 30 days from last SNF day, may resume same benefit period with access to remaining days

If SNF need arises between 31 & 60 days from last SNF day, may only access remaining days upon completion of another 3 day qualifying stay in hospital

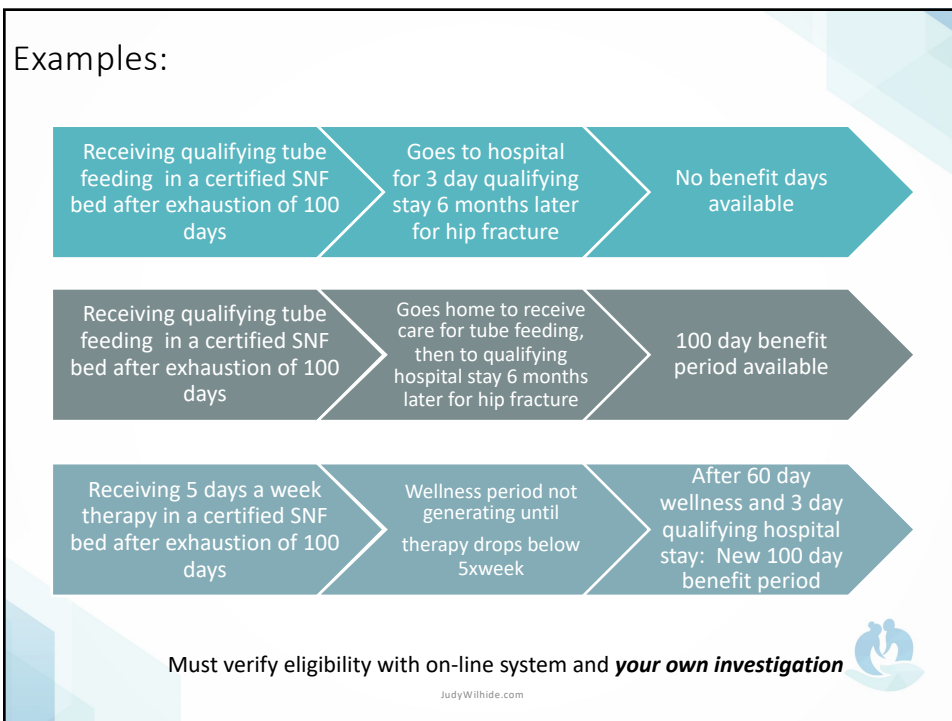
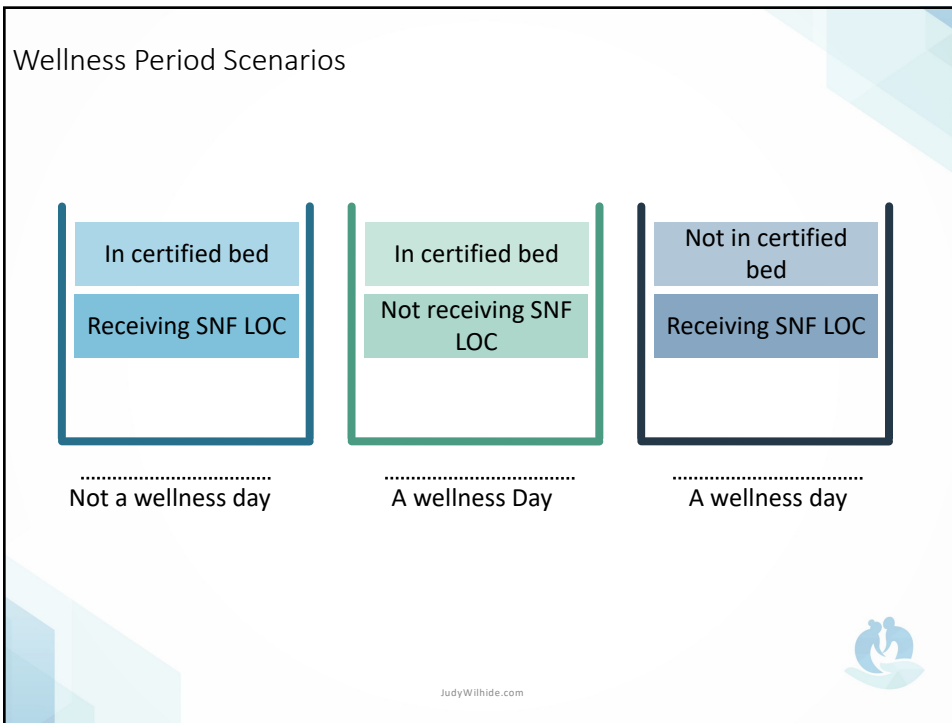
If SNF need arises after 60 day wellness, may access new 100 day benefit period with 3 day hospital stay

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60 Day Wellness Period

- 60 consecutive days in which resident is not in a certified bed receiving at least a SNF level of care
 - Medicare and/or Medicaid certified bed in NF or higher (hospital)

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30 day transfer requirements

1

Must be admitted to certified bed within 30 days of qualifying hospital stay

2

If cut from Medicare with benefit days remaining, may access the rest of the current benefit period if skilled need rearises within 30 days of last Medicare day.

If resident is admitted meeting SNF criteria, but Medicare is **secondary**, Medicare day 1 can be >30 days from discharge.

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Medical Appropriateness Exception

May begin Part A stay > 30 days after hospital d/c when the patient's condition makes it medically inappropriate to begin SNF stay immediately after hospital discharge.

Must be medically predictable at hospital discharge that SNF care will be required within a pre-determinable time period. Physician must document estimated time period and reason for delay

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SNF & Hospice Benefit

May access both simultaneously

As long as reason for SNF services is totally unrelated to reason for Hospice services

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MD Cert Requirements

Initial Cert	SNF services are required on an inpatient basis because of the resident's need for skilled nursing or rehabilitation care on a continuing basis for the condition(s) for which s/he was receiving inpatient hospital services prior to his/her transfer to the SNF.
Subsequent	<ul style="list-style-type: none"> • Continued need for extended care services, • Estimated period of time required for skilled care • Any plans for home care, • Need for SNF care is for a condition related to hospital stay or which arose during the SNF stay

No requirement for a certain form

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Physician Certification of Need for Skilled Care

MD, PA, NP may sign Medicare certification of need for skilled care


If discharged and readmitted, re-start certification schedule

Delayed certs honored when isolated oversight /lapse with explanation

Faxed signatures accepted

May only bill if written certification present

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Required Timetable:

Initial Certification:
On admission or "as soon thereafter as practical."

First Recertification:
On or before day 14 of the stay.

Subsequent Recertifications:
Not more than 30 days from date of last certification.

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If all blocks are not filled out or checked, it is not a valid certification

If signature, date, credentials illegible, it will be denied.

May send a signature log

The claim will be denied upon medical review

Is order "Admit to skilled care" required?

No

There is no requirement for this order

Palmetto will deny if they don't see this order

Yes

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The great Palmetto Insanity

- Palmetto for a long time has been denying SNF claims because there is no order to admit to skilled care. They cite Fed Reg title 42 483.40 when denying.
- The Qualified Independent Contractor (QIC) at the second level of appeal will overturn Palmettos' 1st two denials.

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§ 483.40 Physician services.

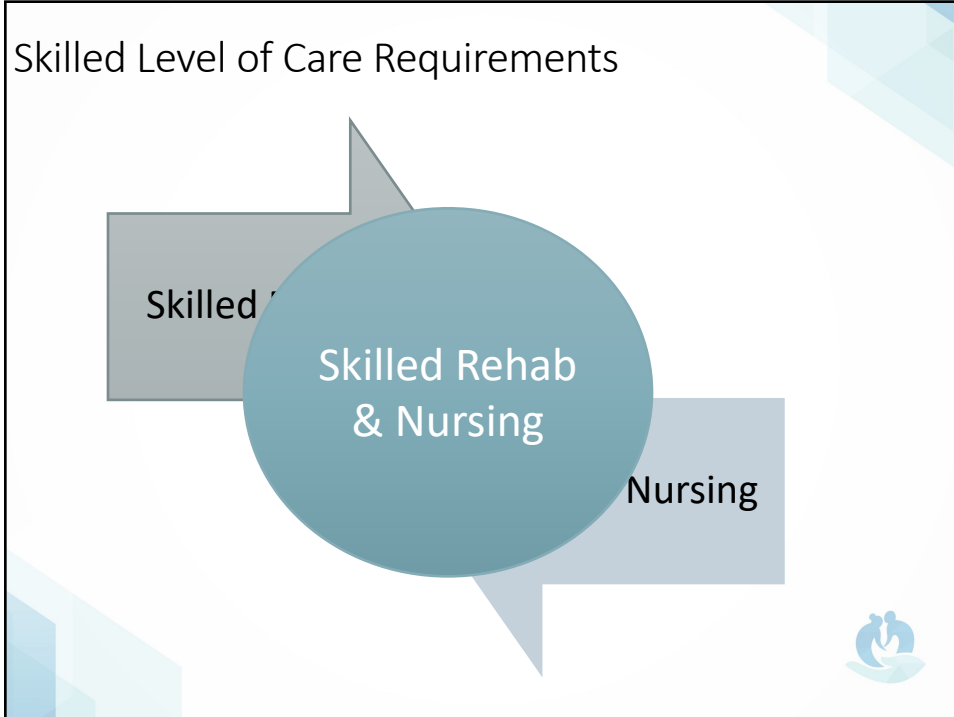
A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician.

**PICK YOUR
BATTLES**
Not everything is
worth flipping out over.

Palmetto is clearly insane.
But, it is prudent to write "Admit to
Skilled Care" for all Part A residents.
It's not worth the fight.

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Care in a SNF is covered if all of the following four factors are met:

1. Requires skilled nursing services or rehab **for any condition**
 - For which the patient ***received inpatient hospital services*** or
 - That ***arose while receiving care in a SNF*** for a condition for which he received inpatient hospital services

Nursing/Rehab services are considered skilled when they are so inherently complex that they can be safely and effectively performed only by, or under the supervision of an RN/LPN or Therapist/Assistant

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Care in a SNF is covered if all of the following four factors are met:

2. The patient requires these skilled services on a daily basis
 - 5 days a week rehab
 - 7 days a week nursing
3. As a practical matter, considering economy and efficiency, the daily skilled services can be provided only on an inpatient basis in a SNF
 - May have short LOA during Part A stay for brief period of time

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- Skilled rehabilitative therapy must be required 5 calendar days a week to meet SNF criteria.
- Therapy that is purposefully spread out over five days just to make it look like the “five day a week” criteria is met will be prohibited.

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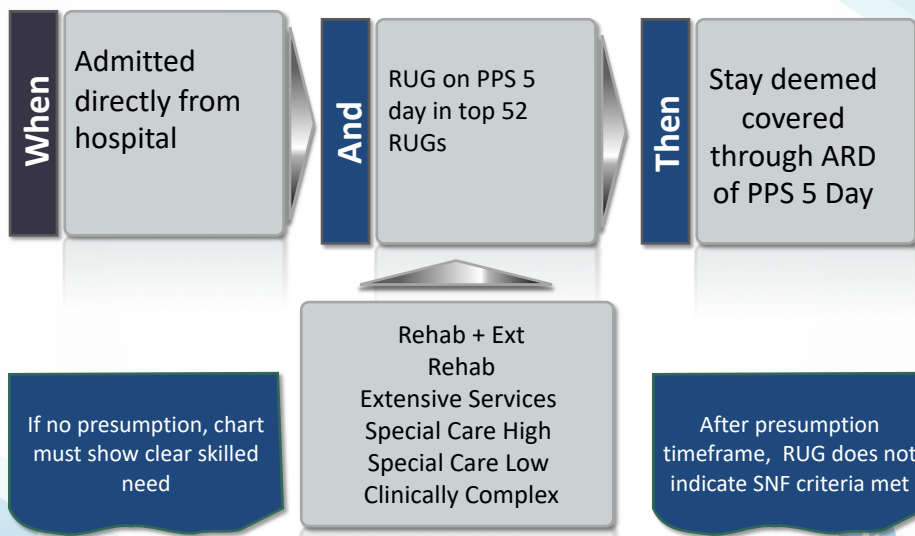
Care in a SNF is covered if all of the following four factors are met:

4. The services *delivered are* reasonable and necessary for the treatment of a patient's illness or injury,
 - *are* consistent with the nature and severity of illness or injury, particular medical needs, and accepted standards of medical practice.

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Presumption of Coverage



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30.2.1 - Skilled Services Defined

- Skilled nursing/rehab:
 - **Require** skills of qualified health personnel such as RN, LPN(LVN), PT, OT, SLP, COTA, PTA due to the **nature of the service** and
 - **Must be provided** directly by or under the general supervision of these skilled nursing/rehab personnel to assure the safety of the patient and to achieve the medically desired result.
- *Skilled care may be necessary to improve current condition, to maintain current condition, or prevent or slow further deterioration of the patient's condition.*

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30.2.2 - Principles for Determining Whether a Service is Skilled

While a particular medical condition is a valid factor in deciding if skilled services are needed, a patient's diagnosis or prognosis should never be the sole factor in deciding that a service is skilled.

Are skilled nurses/therapists **providing the service** because it is **beyond the scope** of unskilled (CNA/Rehab Tech) staff?

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Therefore the patient's medical record must document as appropriate:

- *H&P exam, (including the response or changes in behavior to previously administered skilled services);*
- *Skilled services provided;*
- *Patient's response to the skilled services provided during the current visit;*
- *Plan for future care based on the rationale of prior results.*
- *Detailed rationale that explains the need for the skilled service in light of the patient's overall medical condition and experiences;*
- *Complexity of the service to be performed;*
- *Any other pertinent characteristics of the beneficiary.*

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• *Medical record documentation must be accurate, and avoid vague or subjective descriptions of the patient's care that would not be sufficient to indicate the need for skilled care.*

• *For example, the following terminology does not sufficiently describe the reaction of the patient to his/her skilled care:*

- *Patient tolerated treatment well*
- *Continue with POC*
- *Patient remains stable*

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Record should contain:

- *Objective documented measurements of:*
 - *physical outcomes of treatment should be provided and/or*
 - *a clear description of the changed behaviors due to education programs*
- *So that all concerned can follow the results of the provided services.*

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30.2.3 - Specific Examples of Some Skilled Nursing or Skilled Rehabilitation Services

30.2.3.1 - Management and Evaluation of a Patient Care Plan

- Constitutes skilled services when they require the involvement of skilled personnel to
 - Meet medical needs,
 - Promote recovery, and
 - Ensure medical safety.
- Clinical record must clearly establish that there was a **likely potential for serious complications** without skilled management

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30.2.2 - Principles for Determining Whether a Service is Skilled

EXAMPLE:

- An 81-year-old woman who is aphasic and confused, has hemiplegia, CHF, A-fib, post CVA, is incontinent, has a Stage 1 PrU, and is unable to communicate and make her needs known.
- Even though no specific service provided is skilled, the patient's condition requires daily skilled nursing involvement to manage a plan for the total care needed, to observe the patient's progress, and to evaluate the need for changes in the treatment plan.
- *The medical condition of the patient must be described and documented to support the goals for the patient and the need for skilled nursing services.*

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Mgt/Eval of Care Plan

- Example from BPM:
- Pt is recovering from pneumonia, lethargic, disoriented, has residual chest congestion, is confined to bed as a result of his debilitated condition, and requires restraints at times.
- MD orders frequent changes in position, coughing, and deep breathing.
- While the residual chest congestion alone would not represent a high risk factor, the patient's immobility and confusion represent complicating factors which, when coupled with the chest congestion, could create high probability of a relapse.

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Observation & Assessment

- Pt with CHF may require continuous close observation to detect signs of decompensation, abnormal fluid balance, or adverse effects resulting from medication(s) that serve as indicators for adjusting therapeutic measures.
- Documentation must describe the skilled services that require the involvement of nursing personnel to promote the patient's recovery and medical safety in view of the patient's overall condition, to maintain current condition, or to prevent or slow further deterioration.

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Observation & Assessment

- If patient did not develop a further acute episode or complication, the skilled observation services still are covered so long as there was a reasonable probability for such a complication or further acute episode.
 - "Reasonable probability" = "likely possibility"
- *Information from the patient's medical record must document that there is a reasonable potential for a future complication or acute episode sufficient to justify the need for continued skilled observation and assessment.*

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Observation & Assessment: When it's not skilled

- Must be a reasonable potential that skilled observation/assessment will result in **changes to the treatment of the patient**
- It's not reasonable and necessary **where these characteristics are part of a longstanding pattern** of the patient's waxing and waning condition which by themselves do not require skilled services and **there is no attempt to change the treatment to resolve them.**

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Teaching and Training Activities

- Teaching and training activities, which require skilled nursing or skilled rehabilitation personnel to teach a patient how to manage their treatment regimen, would constitute skilled services.
- *Documentation must thoroughly describe all efforts that have been made to educate the patient/caregiver, and their responses to the training.*

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IM or IV injections or feedings	Direct skilled nursing services
Tube feeding at least 26 % calories/501 cc per day	
Naso-pharyngeal and tracheotomy aspiration	
Insertion, sterile irrigation, and replacement of suprapubic catheters	
MD Rx Heat treatments as part of active treatment	
Treatment of decubitus ulcers, Stage 3 or worse, or a widespread skin disorder	
Application of dressings with prescription medications and aseptic techniques	
Rehabilitation nursing procedures	
Initial phases of oxygen therapy	
Early post op colostomy care in present of complications	

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Services that are NOT skilled:

Routine care of:

- Oral meds, eye drops, ointments, oxygen

- Colostomy/ileostomy

- Indwelling catheter/incontinence


- Plaster casts/braces

- ADL assist/exercises

- Minor skin issues/turning/repositioning

- Dressings for uninfected post op/chronic/palliative skin problems

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Skilled therapy services must meet all of the following conditions:

Directly and specifically related to an active written treatment plan based on initial evaluation by qualified therapist after admission to the SNF and prior to the start of therapy services in the SNF that is approved by the physician after any needed consultation with the qualified therapist.

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- **EXAMPLE:** A patient with Parkinson's disease may require the services of a PT to determine the type of exercises that are required to maintain his present level of function. The initial evaluation of the patient's needs, the designing of a maintenance program which is appropriate to the capacity and tolerance of the patient and the treatment objectives of the physician, the instruction of the patient or supportive personnel (e.g., aides or nursing personnel) in the carrying out of the program, would constitute skilled physical therapy ***and must be documented in the medical record***

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It's not the condition, it's **what we are doing about it** that determines need for skilled care.



Would the person be safe in a lower level of care, without RN/Therapist Oversight?

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Review:

- There must be documentation of medical instability or the probability of change in the resident's condition.
- Evidence of risks/potential complications requiring careful supervision.
- Evidence skilled licensed personnel are assessing/supervising care.

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Medical Review:

- Many different payers may ask for the clinical record to verify the HIPPS on the claim.
- Monitor MAC website for information and guidance on Original Part A medical review

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PEPPER provides provider-specific Medicare data statistics for discharges/services vulnerable to improper payments. PEPPER can support a hospital or facility's compliance efforts by identifying where it is an outlier for these risk areas. This data can help identify both potential overpayments as well as potential underpayments. [Show your support.](#)

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<p>HOSPICES</p> <ul style="list-style-type: none"> • User's Guide (PDF, 6th Edition) • Training & Resources • PEPPER Distribution - Get Your PEPPER • Map of Hospice PEPPER Retrievals by State 	<p>INPATIENT PSYCHIATRIC FACILITIES</p> <ul style="list-style-type: none"> • User's Guide (PDF, 7th Edition) • Training & Resources • PEPPER Distribution - Get Your PEPPER 	<p>INPATIENT REHABILITATION FACILITIES</p> <ul style="list-style-type: none"> • User's Guide (PDF, 7th Edition) • Training & Resources • PEPPER Distribution - Get Your PEPPER
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PEPPER

PEPPER Resources Portal

Please complete the following fields to access your PEPPER. A provider's PEPPER is only available to that individual provider's Chief Executive Officer, President, Administrator or Compliance Officer.

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First Name Last Name Provider Name

Email Provider City Provider State / Territory

Confirm Email Provider Type

CMS certification number (also referred to as Provider Number or PTAN)

Enter either a Patient Control Number *or* a Medical Record Number (found at form locators 03a or 03b on the UB04 claim form) from a claim of a traditional fee-for-service Medicare beneficiary who received services during the specified time period ("from" or "through" date between July 1-Sep. 30, 2016 for providers except HHAs and PHPs; between Oct. 1-Dec. 31, 2016 for HHAs and PHPs). Validation code (Patient Control Number or Medical Record Number)

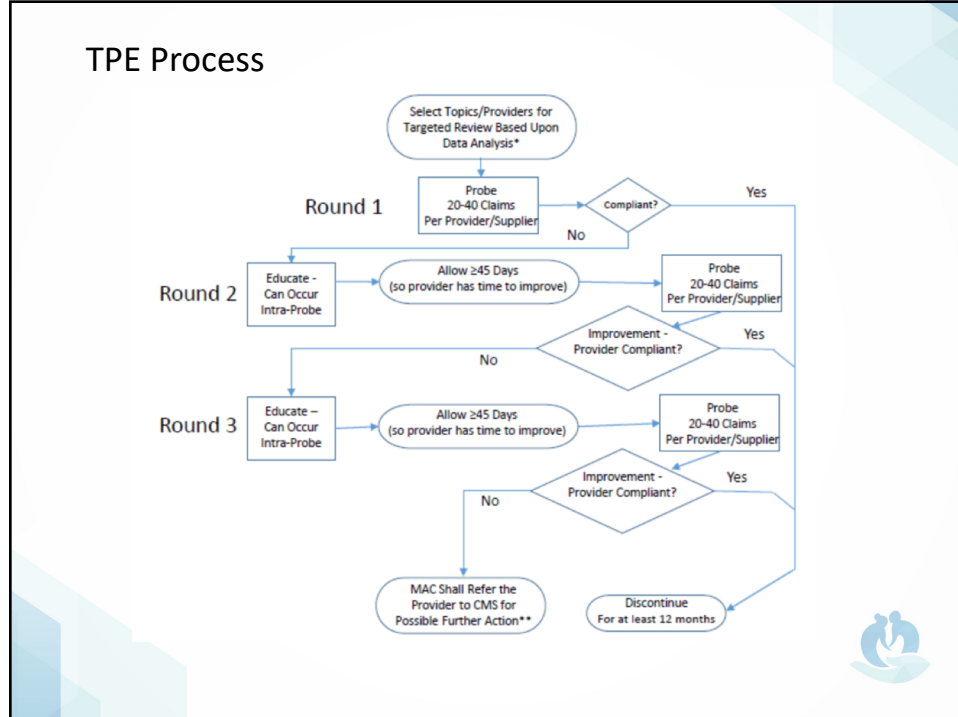


Targeted Probe and Education (TPE) Palmetto

- The CMS has seen positive results during pilot testing in hospitals and home health, using TPE strategy, the key elements of which include:
 - Replace all current medical record reviews in the MAC's Improper Payment Reduction Strategy (IPRS) with **up to three rounds of a pre-payment Targeted Probe & Educate** process.
- If high denial rates continue after three rounds, the MAC shall refer for additional action, which may include:
 - Extrapolation
 - Referral to the Zone Program Integrity Contractor (ZPIC) or Unified Program Integrity Contractor (UPIC)
 - Referral to the RAC
 - 100% pre-pay review, etc.

CR 10249. 9/15/17





TPE: Continued

- The MAC, rather than CMS, will select the topics for review (based on existing data analysis procedures)
- The MAC can target the strategy on the providers most likely to be submitting non-compliant claims, rather than reviewing 100% of the providers
- Limit the sample for each probe “round” to a minimum of twenty (20) and a maximum of forty (40) claims
- **Policy:** The MACs shall conduct all medical record review following the TPE strategy. Automated reviews and prior authorization directed by CMS are outside of the TPE strategy.

TPE: Continued

- The MAC shall have the discretion to define provider/supplier compliance, which may vary based on the item/service reviewed.
- **NOTE:** It is the intent of the education that the focus will be on improving specific issues without allowing other problems to develop and provide opportunities for the provider/supplier to be able to have questions answered.
- After each round of 20-40 claim reviews, the MAC shall conduct a 1:1 educational intervention with the provider/supplier that reinforces compliant parameters and reiterates issues identified in the round, to avoid any shifts from the non-compliant factors.



TPE: Continued

- The MACs shall conduct 1:1, intra-probe educational intervention when easily curable errors are identified, even if the probe round is not completed.
- The MACs shall request and accept new documentation from providers/suppliers when easily curable errors are identified at any time during the current round of probe reviews.



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Targeted Probe & Educate (TPE) Provider Contact

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[Change Request 10249](#) (PDF, 241 KB) implemented the [Targeted Probe & Educate \(TPE\)](#) process, effective October 1, 2017. Palmetto GBA will mail a letter to those providers that have been selected for TPE review. The letter outlines the reason for selection, and provides an overview of the TPE process and contact information.

It is imperative when responding to the TPE Additional Documentation Request (ADR) that you include the name and number of your designated contact person. Our medical reviewer will contact your designated person prior to the conclusion of each TPE round to discuss the review summary.



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Targeted Probe and Educate (TPE) Process

- Palmetto GBA will identify areas with the greatest risk of inappropriate program payment. RU and RV
- Palmetto GBA selects providers for the TPE process based on the following:
 - Analysis of billing data indicating aberrancies that may suggest questionable billing practices or
 - On targeted review and is transitioned to the TPE process based on error rate results or
 - On service specific review error rate results
- Palmetto GBA will mail a letter to those who have been selected for TPE review. The letter will outline the reason for selection, and will provide an overview of the TPE process and contact information.




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Targeted Probe and Educate (TPE) Process

- TPE consists of up to three rounds of review with 20-40 claims sample selected (pre or post payment) for each round
- Subsequent rounds will begin 45-56 days after individual provider education is completed. Discontinuation of review may occur if appropriate improvement and compliance is achieved during the review process.
- An Additional Document Request (ADR) will be generated for each claim selected
 - For pre-pay reviews, Palmetto GBA has 30 days from the date the documentation is received to review the documentation, and make a payment decision
 - For post-pay reviews, Palmetto GBA has 60 days from the date the documentation is received to review the documentation, and make a payment decision




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Targeted Probe and Educate (TPE) Process

- **Note:** Non-response denials count as an error when calculating the error rate. Palmetto GBA recommends using eServices, our secure online web portal to submit documentation in response to medical review ADRs and when/if additional documentation is requested throughout the review process.
- Prior to the conclusion of each round, the medical reviewer will call all providers with moderate to high error rate to discuss the summary of the errors found.
- At the conclusion of each round, a letter with the review results will be mailed. The letter will include the number of claims reviewed, the number of claims allowed in full, and the number of claims denied in full or in part.
- When high denial rates continue after three rounds of TPE, Palmetto GBA will send a referral to CMS for additional action.



Questions/Discussion



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