"A ***Knowledgeable*** and ***Compassionate*** partner"

BROAD RIVER REHAB

BRR Insiders™ Summer Series 2025
Denial of Payment for New Admissions

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ACCREDITED PROVIDER
AMERICAN NURSES CREDENTIALING CENTER

APPROVAL STATEMENT DISCLOSURE

- This nursing continuing professional development activity was approved by Broad River Rehab, an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation.
- This course has been approved for 0.5 contact hours.

CONFLICT OF INTEREST DISCLOSURE

- Broad River Rehab is not charging for this educational offering and has no financial or other conflicts of interest regarding this program.

SUCCESSFUL COMPLETION REQUIREMENTS

- **Live, virtual**
  - In order to obtain nursing contact hours, you must participate in the entire program, participate in audience polling and/or Q&A and complete the evaluation.

DISCLOSURE OF THE EXPIRATION DATE FOR AWARDING CONTACT HOURS FOR ENDURING PROGRAMS

- Contact hours for this program will not be awarded after 1 week

Learning Objectives

Denial of Payment for New Admissions

- Understand the language of DPNA
- Recognize when a DPNA is required
- Identify "new admissions"
- Specify facility requirements under a DPNA

Resources

- CMS 100-2 Chapter 8
- CMS 100-4 Chapter 6
- Palmetto GBA DPNA Resource
- CFR 42 Chapter 16

Denial of Payment for New Admissions : Basics

- Under the Social Security Act at Sections 1819(h) and 1919(h) and CMS' regulations at 42 CFR 488.417, CMS may impose a Denial of Payment for New Admissions (DPNA) against a Skilled Nursing Facility (SNF) when a facility is not in substantial compliance with requirements of participation.
- Further, the regulations require CMS to impose a DPNA when a SNF
  - (1) fails to be in substantial compliance for three months after the last day of the survey identifying the noncompliance, or
    (2) is found to have provided **substandard quality of care** on the last three consecutive standard surveys.

Denial of Payment for New Admissions : Basics

- A/B MACs (A) are responsible for applying these payment sanctions to new SNF admissions resulting from adverse survey findings.
- The SNFs under a denial of payment sanction are still considered Medicare-participating providers.
- Beneficiaries enrolled through cost-based HMOs are subject to the same requirements as fee-for-service beneficiaries.

Denial of Payment for New Admissions : Basics

- **Substandard Quality of Care:** One or more deficiencies related to the requirements of participation under:
  - “Resident rights”,
  - “Freedom from abuse, neglect, and exploitation”
  - “Quality of care”;
  - “Pharmacy services”,
  - “Administration”,
  - “Infection control”,
- Which constitutes either:
  - Immediate jeopardy to resident health or safety; **J, K, L**
  - A pattern of or widespread actual harm that is not immediate jeopardy; **H, I**
  - A widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm. **F**

Denial of Payment for New Admissions : Basics

Severity	Scope		
	Isolated	Pattern	Widespread
Immediate jeopardy to resident health or safety	**J** 50 points* (75 points)	**K** 100 points* (125 points)	**L** 150 points* (175 points)
Actual harm that is not immediate jeopardy	**G** 20 points	**H** 35 points (40 points)	**I** 45 points (50 points)
No actual harm with potential for more than minimal harm that is not immediate jeopardy	**D** 4 points	**E** 8 points	**F** 16 points (20 points)
No actual harm with potential for minimal harm	**A** 0 point	**B** 0 points	**C** 0 points

Note: Figures in parentheses indicate points for deficiencies that are for substandard quality of care.

Source: Centers for Medicare & Medicaid Services

Denial of Payment for New Admissions : “New”

- **New Admission Means:**
  - Resident who is admitted to the facility on or after the effective date of a denial of payment remedy **and**, if previously admitted, has been discharged before that effective date.
  - Residents admitted before the effective date of the denial of payment, and taking temporary leave, are not considered new admissions, nor subject to the denial of payment.

Denial of Payment for New Admissions : “New”

- **New Admission and “Temporary Leave”:**
  - Is defined as residents who leave temporarily for any reason.
  - This definition would include both beneficiaries who are out of the SNF at midnight **but** who later return to the SNF and beneficiaries who require inpatient hospitalization **and** return to the SNF directly upon hospital discharge.
  - If residents were **not** subject to a denial of payment when they went on temporary leave, they are **not**, upon their return, considered new admissions for the purposes of the denial of payment.
  - A beneficiary is considered discharged when he/she leaves the facility with no expectation of return, e.g., a beneficiary transferred to another SNF or discharged to home, etc.

Denial of Payment for New Admissions : “New”

- **New Admission and “Temporary Leave”:**
  - Beneficiaries admitted before the effective date of the denial of payment and taking temporary leave, whether to receive inpatient hospital care, outpatient services, or as therapeutic leave, are **not** considered new admissions, and are **not** subject to the denial of payment upon return.
  - This policy applies even if there are multiple hospitalizations and returns to the SNF during the period sanctions are in effect.
  - However, a resident who is discharged to a different SNF and is later readmitted to the original SNF, currently under a payment ban, **will be subject to the denial of payment sanction**. Similarly, a beneficiary who is discharged from an acute care hospital to a long-term rehabilitation hospital, a wing bed, or a hospice **would be considered a new admission upon return to the original SNF**.

Denial of Payment for New Admissions : Readmissions

- **Readmission and transfers:**
  - When determining if the beneficiary was admitted prior to the imposition of the ban, the actual status of the beneficiary rather than the primary payor is the determining factor.
  - Therefore, there may be situations where the beneficiary is a private pay patient or a dual eligible who was receiving Medicaid benefits prior to the imposition of the payment ban.
  - If this private pay patient or dual eligible goes to the hospital for needed care, and meets the Medicare Part A criteria upon return to the SNF, the readmission is exempt from the denial of payment sanction.

Denial of Payment for New Admissions : Readmissions

- **Readmission and transfers:**
  - It is **very important** to safeguard the beneficiary while applying necessary sanctions to the provider.
  - It is certainly possible that a beneficiary may remain at a facility under sanction for a period of time and later transfer to a second SNF.
  - The 30-day transfer requirement will be applied in the same way it would be for a beneficiary transferring between two SNFs that are not under sanction. Part A coverage will be available to the second SNF for all remaining days in the benefit period as long as the beneficiary:
    - 1. Had a qualifying hospital stay
    - 2. Was admitted to a Medicare-certified bed in the first (sanctioned) SNF within 30 days of the hospital discharge, and
    - 3. Is receiving a covered level of care at the time of transfer.

Denial of Payment for New Admissions : Hospice

- **New Admission vs. Hospice:**
  - Hospices contract with SNFs for services related to the beneficiary's terminal condition. These bills are not processed by the A/B MAC (A) or (HHH). However, there will be situations where a beneficiary is admitted as a hospice patient, but later requires daily skilled care unrelated to the terminal condition.
  - If the beneficiary was initially admitted as a hospice patient prior to the date sanctions were imposed, and meets the requirements for Part A coverage; sanctions will not be applicable.
  - Benefits will be paid under SNF PPS from the first date the beneficiary qualifies for Medicare Part A for care unrelated to the terminal condition. The facility must complete the Medicare-required assessments from the start of care for the unrelated condition.

Denial of Payment for New Admissions : Notifications

- **Before admitting a beneficiary**, the SNF must notify the beneficiary or responsible family member that sanctions have been imposed and explain how the sanctions will affect the beneficiary's benefits.
- This Notice of Non-Coverage also applies to former residents that had been discharged with no expectation of return and are being readmitted after the imposition of the payment ban.
- The beneficiary notice **must** meet the following criteria:
  - It must be in writing
  - It must explain the reason sanctions were imposed.
  - It must explain the beneficiary's liability for the cost of SNF services during the period the payment ban is in effect.
  - It must explain that Medicare Part A benefits may be available if the beneficiary chooses a different Medicare-participating SNF that is not under sanction.

Denial of Payment for New Admissions : Notifications

- In situations where the beneficiary is subject to the payment ban, but the provider fails to issue the proper beneficiary liability notice, **the provider is liable for all services normally covered under the Medicare Part A benefit**.
- Payment sanctions are applied to days that would otherwise be Part A-payable; i.e., the care is covered but no payment will be made to the provider.
- If the Medicare participating SNF assumes responsibility for the beneficiary's costs during the sanction period, it will be considered the same as a program payment, and the days will count towards the 100-day benefit period.
- In other words, since the beneficiary is receiving benefits, the days will be considered Part A days and charged against the beneficiary's benefit period.

Denial of Payment for New Admissions : Notifications

- The SNF may collect any applicable copayment amounts.
- These days will be charged against the beneficiary's utilization as is currently done with other types of technical denials (i.e., late filing, late denial notices to the patient, etc.).
- If the SNF issues the appropriate beneficiary liability notice, and the beneficiary agrees to make payment either personally or through a private insurer, the days will not be charged towards the 100-day benefit period.

Denial of Payment for New Admissions : Post Ban

- **Admissions during the DPNA**
  - For new admissions to certified beds, Medicare payments for eligible beneficiaries should begin on the date the sanction is lifted.
  - The beneficiary must meet technical eligibility requirements (e.g., a 3-day hospital stay, etc.), services must be reasonable and necessary, and the beneficiary must be receiving skilled care.
  - The **date the sanction is lifted** is considered the first day of the Part A stay.
  - For Part A PPS payment purposes, the period between the actual date of admission and the last day the sanction was in effect should be billed as noncovered days.

Denial of Payment for New Admissions : MDS

- The imposition of sanctions does not waive the SNF's responsibility to perform assessments in accordance with the clinical schedule defined in the SOM. Comprehensive admission assessments are still due within 14 days of admission to the SNF. Facility staff must also maintain the schedule for quarterly and annual assessments and perform SCSAs and SCPAs when clinically appropriate.
- Medicare-required assessments are also necessary for all beneficiaries in the SNF whose stays are not subject to the payment ban. If, during the sanction period, **staff do not perform** Medicare-required assessments for beneficiaries in covered Part A stays, **no payment is made** and the SNF must submit a claim using the HIPPS default rate code and an occurrence code 77 indicating provider liability, in order to ensure that the beneficiary's spell of illness (benefit period) is updated.

Denial of Payment for New Admissions : MDS

- Since Part A benefits are NOT available for beneficiaries admitted after the effective date of the payment ban the facility is not required to perform Medicare PPS assessments.
- Medicare payments can begin no earlier than the date the sanction is lifted
- For Medicare PPS assessment scheduling purposes, the date the sanction is lifted should be considered day 1.
  - For example: if the sanctions are lifted effective June 15 The assessment reference date for the Medicare 5-day assessment must be set between June 15 and June 22 (i.e., the eighth day of the covered stay).

Denial of Payment for New Admissions : MDS

- An SNF may choose to perform the Medicare-required assessments during the sanction period, but is not required to do so. Generally, a facility should continue to do the Medicare PPS assessments if SNF staff believe the sanction was in error and may be lifted retroactively. In this case, the SNF would be able to bill Medicare at the correct rate.
- Also, remember the guidelines for missed assessments in the RAI Manual Chapter 6. There are instances when the SNF may bill the default code when a PPS assessment does not exist in iQIES. These exceptions are:
  - 4. The SNF is notified on an untimely basis of the revocation of a payment ban

Denial of Payment for New Admissions : Physician Certification

- The SNFs under a payment ban are still participating providers, and remain subject to Medicare coverage requirements.
- Providers are still responsible for evaluating whether beneficiaries meet the Medicare Part A medical necessity and level of care requirements for Medicare Part A coverage, and for obtaining the required **physician certifications** even though Medicare payment cannot be made for the admission.
- The SNFs are also required to obtain physician certifications upon notification that a sanction was lifted. The date of notification will be considered day 1 when verifying the timeliness of the physician certification.

Denial of Payment for New Admissions : Part B

- **Payment under Part B**
  - Facilities subject to a payment ban may continue to bill services for beneficiaries who are not in a Part A stay in the same way as any other SNF.
  - However, services that would have been payable to the SNF as Part A benefits in the absence of a payment sanction **must not** be billed to either the A/B MAC (A) or the A/B MAC (B) as Part B services.

Denial of Payment for New Admissions : Consolidated Billing

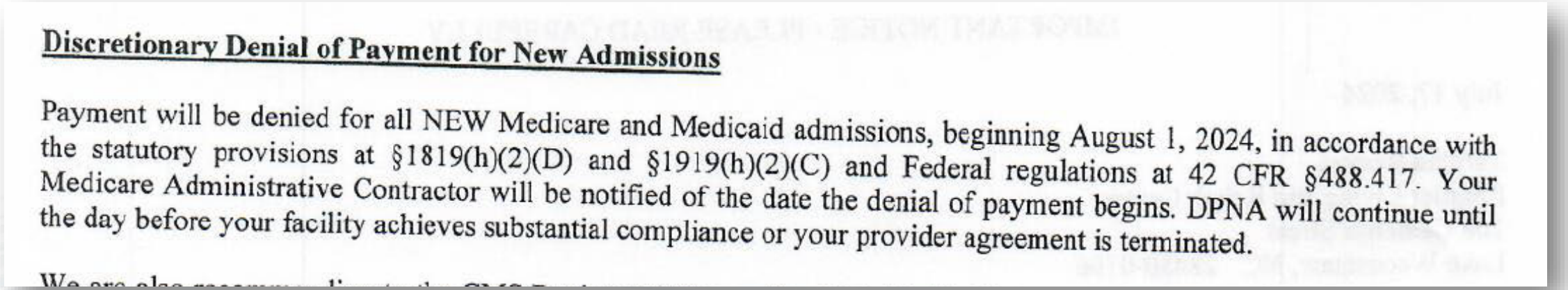
- **Effect on Consolidated Billing**
  - The SNF **may not charge** the beneficiary or family members for any services that, in the absence of a payment sanction, would have been covered under the SNF PPS.
  - **However**, the beneficiary is entitled to reimbursement for those services excluded from the SNF PPS rate.
  - Services excluded from consolidated billing such as outpatient hospital emergency care and related ambulance service should be billed by the provider/supplier actually furnishing services, and not by the SNF.

Denial of Payment for New Admissions : Benefit Period

- **Impact on the Benefit Period**
  - The SNF days during the sanction period will be used to track breaks in the benefit period.
  - A beneficiary's care in an SNF met the skilled level of care standards if a Medicare SNF claim for the services provided in the SNF was denied on grounds other than that the services were not at a skilled level of care.
  - If the patient is receiving a skilled level of care the benefit period cannot end.

Next Steps

- Communication is essential. The whole IDT needs to be aware of the imposition of a DPNA and when it has been rescinded.



Discretionary Denial of Payment for New Admissions

Payment will be denied for all NEW Medicare and Medicaid admissions, beginning August 1, 2024, in accordance with the statutory provisions at §1819(h)(2)(D) and §1919(h)(2)(C) and Federal regulations at 42 CFR §488.417. Your Medicare Administrative Contractor will be notified of the date the denial of payment begins. DPNA will continue until the day before your facility achieves substantial compliance or your provider agreement is terminated.

- Understand the definition of “New admission” and how it applies to your resident population.
- Work together during the DPNA to ensure that all compliance requirements are met.

Questions?

Don’t Forget!

2025 BRR Reflections

- **August 14th** - BRR Reflections – SNF PPS FY 2026 Final Rule

2025 BRR Insiders™ Summer Series (CMS 100-2 Chapter 8 Refresher)

All sessions are from 12:00 pm – 21:30 pm EST, 0.5 hours NAB and ANCC

- **August 8th** – Consolidated Billing (Joel VanEaton)
- **August 22nd** – Direct Nursing Skilled Services and Indirect Nursing Skilled Services (Shannon Hayes)