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BROAD RIVER REHAB

Part I: Access to Medicare Part A Benefits In a SNF

What do I need to know?

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Agenda

CMS 100-2 Chapter 8: Part 1

Agenda

- Access to Medicare Benefits
- 3-Day Stay
- 30-Day Transfer
- COVID QHS and Benefit Period Waivers
- Medical Appropriateness Exception
- Payment Bans

Access to Medicare Part A Benefits

- The term “extended care services” means the following items and services furnished to an inpatient (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ge101c03.pdf) of a skilled nursing facility (SNF) either directly or under arrangements as noted in the list below:
  - Nursing care provided by or under the supervision of a registered professional nurse;
  - Bed and board in connection with furnishing of such nursing care;
  - Physical or occupational therapy and/or speech-language pathology services furnished by the skilled nursing facility or by others under arrangements with them made by the facility;
  - Medical social services;
  - Such drugs, biologicals, supplies, appliances, and equipment, furnished for use in the skilled nursing facility, as are ordinarily furnished by such facility for the care and treatment of inpatients;
  - Medical services provided by an intern or resident-in-training of a hospital with which the facility has in effect a transfer agreement (see §50.7) under an approved teaching program of the hospital, and other diagnostic or therapeutic services provided by a hospital with which the facility has such an agreement in effect, and
  - Other services necessary to the health of the patients as are generally provided by skilled nursing facilities, or by others under arrangements.

Access to Medicare Part A Benefits

- Post-hospital extended care services furnished to inpatients of a SNF or a swing bed hospital are covered under the hospital insurance program (HETS and MSP CMS 100-5 Chap. 3).
- The beneficiary must have been an inpatient of a hospital for a medically necessary stay of at least 3 consecutive calendar days.
- Time spent in observation or in the emergency room prior to (or in lieu of) an inpatient admission to the hospital does not count toward the 3-day qualifying inpatient hospital stay
- For purposes of the SNF benefit's qualifying hospital stay requirement, inpatient status commences with the calendar day of hospital admission.
- The beneficiary must also have been transferred to a participating SNF within 30 days after discharge from the hospital, unless there is a Medical Appropriateness Exception
- The beneficiary must require SNF care for a condition that was treated during the qualifying hospital stay, or for a condition that arose while in the SNF for treatment of a condition for which the beneficiary was previously treated in the hospital.
- In determining whether the daily skilled care needed by an individual can, as a "practical matter," only be provided in a SNF on an inpatient basis,

Access to Medicare Part A Benefits

- Extended care services include SNF care for beneficiaries involuntarily disenrolling from Medicare Advantage plans as a result of a Medicare Advantage plan termination when they do not have a 3-day hospital stay before SNF admission, if admitted to the SNF before the effective date of disenrollment.
- Under SNF PPS, covered SNF services include post-hospital SNF services for which benefits are provided under Part A (the hospital insurance program) and all items and services which, prior to July 1, 1998, had been paid under Part B (the supplementary medical insurance program) but furnished to SNF residents during a Part A covered stay other than items and services that are excluded from consolidated billing.
- In the Balanced Budget Act of 1997, Congress mandated that payment for the majority of services provided to beneficiaries in a Medicare covered SNF stay be included in a bundled prospective payment made through the Part A Medicare Administrative Contractor (MAC) to the SNF. These bundled services had to be billed by the SNF to the Part A MAC in a consolidated bill. No longer would entities that provided these services to beneficiaries in a SNF stay be able to bill separately for those services. https://www.cms.gov/Medicare/Billing/SNFConsolidatedBilling

The Three-Day Stay

- In order to qualify for post-hospital extended care services, the individual must have been an inpatient of a hospital for a medically necessary stay of at least three consecutive calendar days.
  - The hospital discharge must have occurred on or after the first day of the month in which the individual attained age 65 or,
  - became entitled to health insurance benefits under the disability or chronic renal disease
  - The 3 consecutive calendar day stay requirement can be met by stays totaling 3 consecutive days in one or more hospitals. In determining whether the requirement has been met, the day of admission, but not the day of discharge, is counted as a hospital inpatient day.
  - Time spent in observation or in the emergency room prior to (or in lieu of) an inpatient admission to the hospital does not count toward the 3-day qualifying inpatient hospital stay
  - To be covered, the extended care services must have been for the treatment of a condition for which the beneficiary was receiving inpatient hospital services (including services of an emergency hospital) or a condition which arose while in the SNF for treatment of a condition for which the beneficiary was previously hospitalized. In this context, the applicable hospital condition need not have been the principal diagnosis that actually precipitated the beneficiary's admission to the hospital but could be any one of the conditions present during the qualifying hospital stay.
  - In addition, the qualifying hospital stay must have been medically necessary.

The Three-Day Stay

- Even if a beneficiary's care during a qualifying hospital stay becomes less intensive during the latter part of the stay, the date of hospital "discharge" in this context is still considered to be the day that the beneficiary physically leaves the hospital, and the level of care being furnished at that particular point is not a determining factor as long as some portion of the stay included at least 3 consecutive days of medically necessary inpatient hospital services.
- The 3-day hospital stay need not be in a hospital with which the SNF has a transfer agreement. However, the hospital must be either a Medicare-participating hospital or an institution that meets at least the conditions of participation for an emergency services hospital
- A nonparticipating psychiatric hospital need not meet the special requirements applicable to psychiatric hospitals.
- Stays in Religious Nonmedical Health Care Institutions are excluded for the purpose of satisfying the 3-day period of hospitalization.

The Three-Day Stay

- While a 3-day stay in a psychiatric hospital satisfies the prior hospital stay requirement, institutions that primarily provide psychiatric treatment cannot participate in the program as SNFs. Therefore, a patient with only a psychiatric condition who is transferred from a psychiatric hospital to a participating SNF is likely to receive only non-covered care. In the SNF setting, the term “non-covered care” refers to any level of care less intensive than the SNF level of care that is covered under the program.
- An inpatient stay of 3 or more days in a hospital outside the United States may nevertheless satisfy the prior inpatient stay requirement for post-hospital extended care services within the United States as long as the foreign hospital can qualify as an “emergency hospital”
- If a stay of 3 or more days in a hospital outside the United States is being considered to satisfy the prior inpatient stay requirement, the SNF will submit required documentation to the A/B MAC. The MAC will decide whether the prior stay requirements were met and inform the provider.

30-Day Transfer

- Post-hospital extended care services represent an extension of care for a condition for which the individual received inpatient hospital services. Extended care services are “post-hospital” if initiated within 30 days after discharge from a hospital stay that included at least three consecutive days of medically necessary inpatient hospital services.
  - In determining the 30-day transfer period, the day of discharge from the hospital is not counted in the 30 days.
  - The 30-day period begins on the day following actual discharge from the hospital and continues until the individual is admitted to a participating SNF and requires and receives a covered level of care.
  - **For example:** a patient discharged from a hospital on August 1 and admitted to a SNF on August 31 was admitted within 30 days.
  - An individual who is admitted to a SNF within 30 days after discharge from a hospital but does not require a covered level of care until more than 30 days after such discharge, does not meet the 30-day requirement. (In certain circumstances the 30-day period may be extended)
  - Conversely, as long as a covered level of care is needed and initiated in the SNF within the specified timeframe, the timely transfer requirement is considered to be met even if actual Medicare payment does not commence until later (for example, in a situation where another payment source that is primary to Medicare has assumed financial responsibility for the initial portion of the SNF stay).

30-Day Transfer

- If an individual whose SNF stay was covered upon admission is thereafter determined not to require a covered level of care for a period of more than 30 days, payment could not be resumed for any extended care services he or she may subsequently require, even though he or she has remained in the facility, until the occurrence of a new qualifying hospital stay. In the absence of a new qualifying hospital stay, such services could not be deemed to be “post-hospital” extended care services.
- If an individual who is receiving covered post-hospital extended care, leaves a SNF and is readmitted to the same or any other participating SNF for further covered care within 30 days after the day of discharge, the 30-day transfer requirement is considered to be met. The same is true if the beneficiary remains in the SNF to receive custodial care following a covered stay, and subsequently develops a renewed need for covered care there within 30 consecutive days after the first day of noncoverage. Thus, the period of extended care services may be interrupted briefly and then resumed, if necessary, without hospitalization preceding the resumption of SNF coverage.

COVID-19 QHS and Benefit Period Waivers

3-Day Stay/Benefit Period

- **SE 20011: Medicare FFS Response to the PHE on the COVID-19 pages 12-15.** https://www.cms.gov/files/document/se20011.pdf
  - **Three-Day Stay or QHS waiver:** CMS is waiving the requirement for a 3-day prior hospitalization for coverage of a SNF stay, which provides temporary emergency coverage of SNF services (including SNF-level swing-bed services in rural hospitals and CAHs) without a QHS, for those people who experience dislocations, or are otherwise affected by COVID-19.
  - **Benefit period waiver:** For certain patients who recently exhausted their SNF benefits, the waiver authorizes a one-time renewal of benefits for an added 100 days of Part A SNF coverage without first having to start a new benefit period (this waiver will apply only for those patients who have been delayed or prevented by the emergency itself from commencing or completing the process of ending their current benefit period and renewing their SNF benefits that would have occurred under normal circumstances).

Medical Appropriateness Exception

20.2.2 Medical Appropriateness Exception

- 20.2.2.1 Medical Needs Are Predictable
- 20.2.2.2 Medical Needs Are Not Predictable
- 20.2.2.3 SNF Stay Prior to Beginning of Deferred Covered Treatment
- 20.2.2.4 Effect of Delay in Initiation of Deferred Care
- 20.2.2.5 Effect on Spell of Illness

Medical Appropriateness Exception

An elapsed period of more than 30 days is permitted for SNF admissions where the patient's condition makes it medically inappropriate to begin an active course of treatment in a SNF immediately after hospital discharge, and it is medically predictable at the time of the hospital discharge that he or she will require covered care within a predeterminable time period.

The fact that a patient enters a SNF immediately upon discharge from a hospital, for either covered or noncovered care, does not necessarily negate coverage at a later date, assuming the subsequent covered care was medically predictable.

Medical Appropriateness Exception

Medical Needs Are Predictable:

This exception to the 30-day requirement recognizes that for certain conditions, SNF care can serve as a necessary and proper continuation of treatment initiated during the hospital stay, although it would be inappropriate from a medical standpoint to begin such treatment within 30 days after hospital discharge. Since the exception is intended to apply only where the SNF care constitutes a continuation of care provided in the hospital, it is applicable only where, under accepted medical practice, the established pattern of treatment for a particular condition indicates that a covered level of SNF care will be required within a predeterminable time frame.

Accordingly, to qualify for this exception it must be medically predictable at the time of hospital discharge that a covered level of SNF care will be required within a predictable period of time for the treatment of a condition for which hospital care was received and the patient must begin receiving such care within that time frame.

An example of the type of care for which this provision was designed is care for a person with a hip fracture. Under the established pattern of treatment of hip fractures it is known that skilled therapy services will be required subsequent to hospital care, and that they can normally begin within four to six weeks after hospital discharge, when weight bearing can be tolerated. Under the exception to the 30-day rule, the admission of a patient with a hip fracture to a SNF within 4 to 6 weeks after hospital discharge for skilled care, which as a practical matter can only be provided on an inpatient basis by a SNF, would be considered a timely admission.

Medical Appropriateness Exception

Medical Needs Are Not Predictable

When a patient's medical needs and the course of treatment are not predictable at the time of hospital discharge because the exact pattern of care required and the time frame in which it will be required is dependent on the developing nature of the patient's condition, an admission to a SNF more than 30 days after discharge from the hospital is not justified under this exception to the 30-day rule.

For example, in some situations the prognosis for a patient diagnosed as having cancer is such that it can reasonably be expected that additional care will be required at some time in the future. However, at the time of discharge from the hospital it is difficult to predict the actual services that will be required, or the time frame in which the care will be needed.

Similarly, it is not known in what setting any future necessary services will be required; i.e., whether the patient will require the life-supporting services found only in the hospital setting, the type of care covered in a SNF, the intermittent type of care which can be provided by a home health agency, or custodial care which may be provided either in a nursing home or the patient'splace of residence. In some instances such patients may require care immediately and continuously; others may not require any skilled care for much longer periods, perhaps measured in years. Therefore, since in such cases it is not medically predictable at the time of the hospital discharge that the individual will require covered SNF care within a predeterminable time frame, such cases do not fall within the 30-day exception

Medical Appropriateness Exception

SNF Stay Prior to Beginning of Deferred Covered Treatment

In some cases where it is medically predictable that a patient will require a covered level of SNF care within a predeterminable time frame, the individual may also have a need for a covered level of SNF care within 30 days of hospital discharge. In such situations, this need for covered SNF care does not negate further coverage at a future date even if there is a noncovered interval of more than 30 days between the two stays, provided all other requirements are met.

However, this rule applies only where part of the care required involves deferred care, which was medically predictable at the time of hospital discharge. If the deferred care is not medically predictable at the time of hospital discharge, then coverage may not be extended to include SNF care following an interval of more than 30 days of noncovered care

Where it is medically predictable that a patient will require a covered level of SNF care within a specific time frame, the fact that an individual enters a SNF immediately upon discharge from the hospital for noncovered care does not negate coverage at a later date, assuming the requirements of the law are met

Medical Appropriateness Exception

Effect of Delay in Initiation of Deferred Care

As indicated, where the required care commences within the anticipated time frame, the transfer requirement would be considered met even though more than 30 days have elapsed.

However, situations may occur where complications necessitate delayed initiation of the required care and treatment beyond the usual anticipated time frame (e.g., skilled rehabilitative services which will enable an amputee patient to use a prosthetic device must be deferred due to an infection in the stump).

In such situations, the 30-day transfer requirement may still be met even though care is not started within the usual anticipated time frame, if the care is begun as soon as medically possible and the care at that time is still reasonable and necessary for the treatment of a condition for which the patient received inpatient hospital care.

Medical Appropriateness Exception

Effect on Spell of Illness

In the infrequent situation where the patient has been discharged from the hospital to his or her home more than 60 days before he or she is ready to begin a course of deferred care in a SNF, a new spell of illness begins with the day the beneficiary enters the SNF thereby generating another 100 days of extended care benefits (see Pub. 100-01, Medicare General Information, Eligibility, and Entitlement Manual, Chapter 3, section10.4.1).

Another qualifying hospital stay would not be required, providing the care furnished is clearly related to a hospital stay in the previous spell of illness and represents care for which the need was predicted at the time of discharge from such hospital stay.

Payment Bans

- CMS may impose a denial of payment for new admissions (DPNA) against a SNF when CMS finds that 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. 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.
- Imposition of a payment ban on SNF **new admissions**. The following definition of "**new admission**" to a SNF applies:
  - 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.

Payment Bans

- "**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.
- 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.

Payment Bans

- There may 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 impose 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.
- **Beneficiary Notification**: 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. SNFs failing to provide this notification will be held liable for all Part A services covered under SNF PPS.

Payment Bans

- 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.
- Readmissions 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.

Payment Bans

- Sanctions Lifted: Procedures for Beneficiaries Admitted During the Sanction Period
  - 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 SNF PPS payment purposes, the period between the actual date of admission and the last day the sanction was in effect should be billed as non-covered days.
- Payment Under Part B During a Payment Ban on New Admissions
  - 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.

Payment Bans

- Impact of Consolidated Billing Requirements
  - 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.
- Impact on Spell of Illness
  - 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.

QUESTIONS?

Find Out More

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Broad River Rehab Reflections are the third Thursday of each month. **October – CMS 100-2 Chapter 8 Part 2: Daily Skilled Services. What are They?**