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

BROAD RIVER REHAB

Part 3: Physician Certification, and Other Services.

Am I covered?

Joel VanEaton, BSN, RN, RAC-CTA, Master Teacher:
Executive Vice President of Compliance and Regulatory Affairs

Renee Kinder, MS, CCC-SLP, RAC-CT:
Executive Vice President of Clinical Services

Agenda

CMS 100-2 Chapter 8: Part 3

Agenda

- Practical Matter Review
- Physician Certification and Recertification
- Covered Extended Care Services
- Covered Extended Care Days
- Medical and Other Health Services Furnished to SNF Patients
- Q&A

Practical Matter Again

- As a “practical matter,” daily skilled services can be provided only in a SNF if they are not available on an outpatient basis in the area in which the individual resides or transportation to the closest facility would be:
  - An excessive physical hardship;
  - Less economical; or
  - Less efficient or effective than an inpatient institutional setting.
- Considers the following:
  - The Availability of Alternative Facilities or Services
  - Whether Available Alternatives Are More Economical in the Individual Case
  - Whether the Patient’s Physical Condition Would Permit Utilization of an Available, More Economical Care Alternative
- The “practical matter” criterion should never be interpreted so strictly that it results in the automatic denial of coverage for patients who have been meeting all of the SNF level of care requirements, but who have occasion to be away from the SNF for a brief period of time. While most beneficiaries requiring a SNF level of care find that they are unable to leave the facility, the fact that a patient is granted an outside pass or short leave of absence for the purpose of attending a special religious service, holiday meal, family occasion, going on a car ride, or for a trial visit home, is not, by itself evidence that the individual no longer needs to be in a SNF for the receipt of required skilled care. Where frequent or prolonged periods away from the SNF become possible, the A/B MAC (A) may question whether the patient’s care can, as a practical matter, only be furnished on an inpatient basis in a SNF. Decisions in these cases should be based on information reflecting the care needed and received by the patient while in the SNF and on the arrangements needed for the provision, if any, of this care during any absences.

Physician Certification and Recertification of Extended Care

- CMS 100-1 Chapter 4 - https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ge101c04.pdf
- Payment for covered posthospital extended care services may be made only if a physician or a physician extender makes the required certification, and where services are furnished over a period of time, the required recertification regarding the services furnished.
- The SNF must obtain and retain the required certification and recertification statements. The A/B MAC (A) may request them to assist in determining medical necessity when necessary.
- The SNF will determine how to obtain the required certification and recertification statements. There is no requirement for a specific procedure or form as long as the approach adopted by the facility permits verification that the certification and recertification requirement is met.
- Certification or recertification statements may be entered on or included in forms, notes, or other records that would normally be signed in caring for a patient, or on a separate form. Except as otherwise specified, each certification and recertification is to be separately signed.

Physician Certification and Recertification of Extended Care

- The routine admission order established by a physician is not a certification of the necessity for post-hospital extended care services for purposes of the program. There must be a separate signed statement indicating that the patient will require on a daily basis SNF covered care.
- In addition, only physicians may certify outpatient physical therapy and outpatient speech-language pathology services.
- A certification or recertification statement must be signed by the attending physician or a physician on the staff of the skilled nursing facility who has knowledge of the case, or by a physician extender (that is, a nurse practitioner (NP), a clinical nurse specialist (CNS) or a physician assistant (PA)) who does not have a direct or indirect employment relationship with the facility, but who is working in collaboration with the physician.

Physician Certification and Recertification of Extended Care

- If the SNF's failure to obtain a certification or recertification is not due to a question of the necessity for the services, but to the physician's or physician extender's refusal to certify on other grounds (e.g., an objection in principle to the concept of certification and recertification), the SNF cannot charge the beneficiary for covered items or services. Its provider agreement precludes it from doing so.
- If a physician or physician extender refuses to certify, because, in his/her opinion, the patient does not, as a practical matter, require daily skilled care for an ongoing condition for which he/she was receiving inpatient hospital services (or for a new condition that arose while in the SNF for treatment of that ongoing condition), the services are not covered and the facility can bill the patient directly. The reason for the refusal to make the certification must be documented in the SNF's records.
- Certifications must be obtained at the time of admission, or as soon thereafter as is reasonable and practicable. Consider the circumstances surrounding an interrupted stay.

Physician Certification and Recertification of Extended Care

- The certification must clearly indicate that posthospital extended care services were required to be given on an inpatient basis because of the individual's need for skilled care on a daily basis for an ongoing condition for which he/she was receiving inpatient hospital services prior to transfer to the SNF (or for a new condition that arose while in the SNF for treatment of that ongoing condition).
- Alternatively, the initial certification can simply affirm that the individual has been correctly assigned one of the case-mix classifiers that CMS designates as representing the required SNF level of care, i.e., the administrative level of care presumption under the SNF PPS.
- The recertification statement must contain an adequate written record of the reasons for the continued need for extended care services, the estimated period of time required for the patient to remain in the facility, and any plans, where appropriate, for home care. The recertification statement made by the physician does not have to include this entire statement if, for example, all of the required information is in fact included in progress notes.
- If the circumstances require it, the first recertification and any subsequent recertifications must state that the continued need for extended care services is for a condition requiring such services which arose after the transfer from the hospital and while the patient was

Physician Certification and Recertification of Extended Care

- The first recertification must be made no later than the l4th day of inpatient extended care services. A skilled nursing facility can, at its option, provide for the first recertification to be made earlier, or it can vary the timing of the first recertification within the l4-day period by diagnostic or clinical categories. Subsequent recertifications must be made at intervals not exceeding 30 days.
- Skilled nursing facilities are expected to obtain timely certification and recertification statements. However, delayed certifications and recertifications will be honored where, for example, there has been an isolated oversight or lapse.
- Skilled nursing facilities do not have to transmit certification and recertification statements to the A/B MAC (A); instead, the facility must itself certify, in the admission and billing form that the required physician certification and recertification statements have been obtained and are on file.

Covered Extended Care Services

- Patients covered under hospital insurance are entitled to have payment made on their behalf for covered extended care services.
- An **inpatient** is a person who has been admitted to a skilled nursing facility or swing bed hospital for bed occupancy for purposes of receiving inpatient services. A person is considered an inpatient if formally admitted as an inpatient with the expectation that they will remain at least overnight and occupy a bed even though it later develops that they can be discharged and do not actually use a bed overnight.
- Nursing care provided by or under the supervision of a registered professional nurse is covered.
- However, the services of a private-duty nurse or other private-duty attendant are not covered. Private-duty nurses or private-duty attendants are registered professional nurses, licensed practical nurses, or any other trained attendant whose services ordinarilyare rendered to, and restricted to, a particular patient by arrangement between the patient and the private-duty nurse or attendant. Such persons are engaged or paid by an individual patient or by someone acting on their behalf, including a SNF that initially incurs the cost and looks to the patient for payment for such noncovered services.
- Where the SNF acts on behalf of a patient, the services of the private-duty nurse or other attendant under such an arrangement are not extended care services regardless of the control which the SNF may exercise with respect to the services rendered by such private-duty nurse or attendant.

50.3 - Physical, Therapy, Speech-Language Pathology and Occupational Therapy \Furnished by the Skilled Nursing Facility or by Others Under Arrangements With the Facility and Under Its Supervision

- Physical therapy (PT), speech-language pathology (SLP), and occupational therapy (OT) services must be provided by the SNF or by others under arrangements with the SNF for beneficiaries in either a covered Part A stay or a non-covered stay in the SNF (see Pub. 100-04, Medicare Claims Processing Manual, Chapter 6, §20.5, for a more detailed discussion of therapy services under consolidated billing, the SNF "bundling" requirement).
- Bundling of therapy services to the SNF is not required for beneficiaries residing in a non-certified portion of the same institution that also includes a participating distinct part SNF.
- See Chapter 7, SNF Part B Billing, §10 in the Medicare Claims Processing Manual, for a clarification of bill types used to make this distinction clear in billing. For a discussion of skilled therapy (that is, PT, SLP, and OT) services in the context of the SNF level of care criteria, see §§30.4ff. of this chapter

50.4 - Medical Social Services to Meet the Patient's Medically Related Social Needs

Medical social services are those social services, which contribute meaningfully to the treatment of a patient's condition.

Such services include, but are not limited to:

- a. Assessment of the social and emotional factors related to the patient's illness, his or her need for care, response to treatment, and adjustment to care in the facility;
- b. Appropriate action to obtain case work services to assist in resolving problems in these areas; and
- c. Assessment of the relationship of the patient's medical and nursing requirements to his or her home situation, financial resources, and the community resources available to him or her in making the decision regarding their discharge.

Covered Extended Care Services

- Drugs and biologicals for use in the facility, which are ordinarily furnished by the facility for the care and treatment of inpatients, are covered.
- Such drugs and biologicals are not limited to those routinely stocked by the skilled nursing facility but include those obtained for the patient from an outside source, such as a pharmacy in the community. Drugs and biologicals are included in the SNF PPS except for those Part B drugs specifically excluded.
- Since the provision of drugs and biologicals is considered an essential part of skilled nursing care, a facility must assure their availability to inpatients in order to be found capable of furnishing the level of care required for participation in the program.
- When a facility secures drugs and biologicals from an outside source, their availability is assured only if the facility assumes financial responsibility for the necessary drugs and biologicals, i.e., the supplier looks to the facility, not the patient, for payment.

Covered Extended Care Services

- See instruction in the Medicare Benefit Policy Manual, Chapter 1, “Inpatient Hospital Services,” §30.1, “Drugs Included in the Drug Compendia,” which also apply to drugs furnished to SNF inpatients. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c01.pdf
- However, drugs not included, or approved for inclusion, in the drug compendia are nevertheless covered in a SNF if such drug:
  - 1. Was furnished the patient during their prior hospitalization;
  - 2. Was approved for use in the hospital by the hospital’s pharmacy and drug therapeutics (or equivalent) committee;
  - 3. Is required for the continuing treatment of the patient in the skilled nursing facility; and
  - 4. Is reasonable and necessary.
- Under the limited circumstances mentioned in items 1 through 4 above, a combination drug approved by a hospital pharmacy and drug therapeutics committee may also be covered as an extended care service.

Covered Extended Care Services

- Rules for drugs and biologicals applicable to hospital inpatients found in the Medicare Benefit Policy Manual, Chapter 1, “Inpatient Hospital Services,” §§30, 30.3, and 30.5, also apply to inpatients of SNFs. They are:
  - General information concerning drugs and biologicals furnished to inpatients;
  - Combination drugs; and
  - Drugs for use outside the SNF.
- Instructions in the Medicare Benefit Policy Manual, Chapter 1, “Hospital Inpatient Services,” §40 - “Supplies, Appliances, and Equipment,” also apply to SNF inpatients.
- The medical services of an intern or resident-in-training under an approved teaching program of a hospital with which the facility has in effect the required transfer agreement are covered under hospital insurance
- The medical and surgical services furnished to the facility’s patients by interns and residents-in-training of a hospital with which the facility has a transfer agreement are covered under medical insurance if the services are not covered under hospital insurance.

Covered Extended Care Services

- Other services that are necessary to the health of the patients are covered if the services are generally provided by, or under arrangements made by, skilled nursing facilities.
- Items or services that would not be included as inpatient hospital services if furnished to an inpatient of a hospital are also excluded from coverage as extended care services.
- Supplies and nursing services connected with minor surgery performed in a skilled nursing facility that does not require the use of an operating room or any special equipment or supplies associated with such a room would be covered extended care services and paid as part of inpatient SNF PPS.
- The services of respiratory therapists are now covered under Part A when provided under arrangements made directly between the SNF and any qualified respiratory therapist, regardless of whether the therapist is employed by the SNF's transfer agreement hospital.

Covered Extended Care Days

- **See** https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c03pdf.pdf
- **Post-hospital extended care benefit days available in a benefit period** - A patient having hospital insurance coverage is entitled to have payment made on his/her behalf for up to 100 days of covered inpatient extended care services in each benefit period.
- **Definition of an inpatient benefit day** (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ge101c03.pdf) - a beneficiary is considered an inpatient in in a SNF only if the beneficiary's care in the SNF meets certain skilled level of care standards. Specifically, the beneficiary must need and receive a skilled level of care while in the SNF. This means that in order to have been an “inpatient” for benefit period purposes while in a SNF, the beneficiary must have required and received skilled services on a daily basis which could, as a practical matter, only have been provided in a SNF on an inpatient basis. A beneficiary would remain an SNF “inpatient”, thus prolonging his or her current benefit period, for as long as the beneficiary continues receiving a skilled level of care in the SNF--even if Part A payment has ended due to the beneficiary’s exhaustion of SNF benefits.
- **Late discharge** - When a patient chooses to continue to occupy SNF accommodations beyond the checkout time for personal reasons, the hospital or SNF may charge the beneficiary for the continued stay. Such a stay beyond the checkout time, for the comfort or convenience of the patient, is not covered under the program, and the SNF's agreement to participate in the program does not preclude charging the patient.

Covered Extended Care Days

- **Late discharge (cont.)** - Where the patient's medical condition is the cause of the stay past the checkout time (e.g., the patient needs further services, is bedridden and awaiting transportation to their home or in the case of a hospital, transfer to a skilled nursing facility, or dies in the SNF or hospital), the stay beyond the discharge hour is covered under the program and the hospital or SNF may not charge the patient. The imposition of a late checkout charge by a hospital or SNF does not affect the counting of days for:
  - Ending a benefit period;
  - The number of days of inpatient care available to the individual in a SNF
- **Leave of absence** - For billing purposes, the day on which the patient began a leave of absence is treated as a day of discharge and is not counted as an inpatient day unless the patient returns to the facility by midnight of the same day. The day the patient returns to the SNF from a leave of absence is treated as a day of admission and is counted as an inpatient day if the patient is present at midnight of that day.

Covered Extended Care Days

- **Discharge or death on first day of entitlement or participation** - For SNF services, Medicare does not pay for accommodations on the day of discharge or death. A day of utilization is not counted in these situations, even though a benefit period begins.
- **Inpatient service days counting toward benefit maximums -** Post-hospital extended care services count toward the maximum number of benefit days payable per benefit period only if:
  - Payment for the services is made, or
  - Payment for the services would be made if a request for payment were properly filed, the physician certified that the services were medically necessary, and the provider submitted all necessary evidence.

Medical and Other Health Services Furnished to SNF Patients

- The medical and other health services listed below are covered under Part B when furnished by a participating SNF either directly or under arrangements to inpatients who are not entitled to have payment made under Part A (e.g., benefits exhausted or 3-day prior-stay requirement not met). Services payable under Part B are:
  - Diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests • X-ray, radium, and radioactive isotope therapy, including materials and services of technicians • Surgical dressings, and splints, casts, and other devices used for reduction of fractures and dislocations • Prosthetic devices (other than dental) which replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices • Leg, arm, back, and neck braces, trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition • Outpatient physical therapy, outpatient speech language pathology services, and outpatient occupational therapy (see Pub. 100-02, Medicare Benefit Policy Manual, Chapter 10, "Covered Medical and Other Health Services," §220.1.4) • Screening mammography services • Screening pap smears and pelvic exams • Influenza, pneumococcal pneumonia, and hepatitis B vaccines • Some colorectal screening • Prostate screening • Ambulance services • Hemophilia clotting factors • Epoetin Alfa (EPO) for ESRD beneficiaries when given in conjunction with dialysis.

Medical and Other Health Services Furnished to SNF Patients

- The medical and other health services listed below are covered under Part B when furnished by a participating SNF either directly or under arrangements to inpatients who are not entitled to have payment made under Part A (e.g., benefits exhausted or 3-day prior-stay requirement not met). Services payable under Part B are:
  - Diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests • X-ray, radium, and radioactive isotope therapy, including materials and services of technicians • Surgical dressings, and splints, casts, and other devices used for reduction of fractures and dislocations • Prosthetic devices (other than dental) which replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices • Leg, arm, back, and neck braces, trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition • Outpatient physical therapy, outpatient speech language pathology services, and outpatient occupational therapy (see Pub. 100-02, Medicare Benefit Policy Manual, Chapter 10, "Covered Medical and Other Health Services," §220.1.4) • Screening mammography services • Screening pap smears and pelvic exams • Influenza, pneumococcal pneumonia, and hepatitis B vaccines • Some colorectal screening • Prostate screening • Ambulance services • Hemophilia clotting factors • Epoetin Alfa (EPO) for ESRD beneficiaries when given in conjunction with dialysis.

Medical and Other Health Services Furnished to SNF Patients

- The medical and other health services listed below are covered under Part B when furnished by a participating SNF either directly or under arrangements to inpatients who are not entitled to have payment made under Part A (e.g., benefits exhausted or 3-day prior-stay requirement not met). Services payable under Part B are:
  - Diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests • X-ray, radium, and radioactive isotope therapy, including materials and services of technicians • Surgical dressings, and splints, casts, and other devices used for reduction of fractures and dislocations • Prosthetic devices (other than dental) which replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices • Leg, arm, back, and neck braces, trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition • Outpatient physical therapy, outpatient speech language pathology services, and outpatient occupational therapy (see Pub. 100-02, Medicare Benefit Policy Manual, Chapter 10, "Covered Medical and Other Health Services," §220.1.4) • Screening mammography services • Screening pap smears and pelvic exams • Influenza, pneumococcal pneumonia, and hepatitis B vaccines • Some colorectal screening • Prostate screening • Ambulance services • Hemophilia clotting factors • Epoetin Alfa (EPO) for ESRD beneficiaries when given in conjunction with dialysis.

Medical and Other Health Services Furnished to SNF Patients

- Diagnostic x-ray and radiological therapy may be provided directly by a SNF if, as part of its compliance with the conditions of participation, the SNF has a radiological department, which meets the same standards required of a hospital furnishing such services under the program, or if the SNF meets the portable x-ray supplier standards.
- Portable x-ray services provided by a SNF under arrangements are covered only if furnished by an approved supplier.
- When a SNF furnishes laboratory services directly, it must have a Clinical Laboratory Improvement Act (CLIA) number or a CLIA certificate of waiver. SNFs may bill for laboratory services rendered under arrangement for tests NOT on the CLIA waived list.
- Some Ambulance services are covered. See https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c10.pdf and https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c06.pdf for more specific guidance.

70.3 - Inpatient Physical Therapy, Occupational Therapy, and Speech-Language Pathology Services

- Under Part A, physical therapy, occupational therapy, and speech pathology services are included in the SNF PPS rate for cost reporting periods beginning on or after July 1, 1998.
- For inpatient Part B residents and outpatient services, payment for such services is under a fee schedule. The SNF must bill for physical therapy, occupational therapy, or speech-language pathology services for Part A residents beginning with its first cost reporting period that starts on or after July 1, 1998, and for Part B for services furnished on or after July 1, 1998.
- The SNF (rather than an outside provider/supplier such as an approved clinic or rehabilitation agency, or a participating hospital) bills Medicare. Payment is made directly to the SNF. The patient is responsible only for applicable Part A coinsurance or the Part B deductible and coinsurance amounts.

See also the Medicare Benefit Policy Manual, Chapter 1, “Inpatient Hospital Services.”

70.4 - Services Furnished Under Arrangements With Providers

- The SNF may arrange with others to furnish covered services such as physical therapy, occupational therapy, or speech-language pathology services. The SNF (rather than an outside provider/supplier, another SNF or a HHA) bills Medicare, and payment is made directly to the SNF.
- When such arrangements are made, SNF receipt of payment for the arranged services (as with services provided directly) relieves the beneficiary or any other person of further liability to pay for them. See Pub. 100-01, Medicare General Information, Eligibility, and Entitlement Manual, chapter 5, section 10.3, for a general discussion of services furnished “under arrangements.”

70.4 - Services Furnished Under Arrangements With Providers (cont)

- The specific details of the ensuing payment arrangement between the SNF and the outside supplier (such as the actual payment amount and timeframe) represent a private, "marketplace" transaction that is negotiated between the parties themselves and falls outside the purview of CMS. *This means, for example, that payments by the SNF to an outside supplier for bundled services furnished to the SNF's Part A resident under an arrangement made with the outside supplier are not governed by the specific Medicare fee schedule amounts or claims processing timeframes that would apply to services billed to Medicare separately under Part B*; however, in order for the arrangement itself to be valid, the SNF must, in fact, make payment to its supplier for services rendered. See Pub. 100-04, Medicare Claims Processing Manual, chapter 6, sections 10.4ff. for additional information on arrangements between SNFs and their suppliers.

- The arrangement must also comply with the fraud and abuse laws (see *Pub. 100-01, Medicare General Information, Eligibility, and Entitlement Manual, chapter 1, section 20.3, and* Pub. 100-04, Medicare Claims Processing Manual, chapter 6, section 80.5). Questions about the interpretation and enforcement of the statutory anti-kickback provisions in section 1128B(b) of the Social Security Act should be directed to the attention of the Industry Guidance Branch in HHS's Office of the Inspector General (OIG); see the regulations at 42 CFR Part 1008 and the OIG website at https://oig.hhs.gov/compliance/advisory-opinions/index.asp.

QUESTIONS?

Find Out More

Contact Us:

Jeff Moyers: Vice President, Business Development
jmoyers@broadriverrehab.com
(828) 319-9618

Tricia Wood: Vice President, Business Development (Southern US)
twood@broadriverrehab.com
(919) 844-4800

Sign up for our Blog www.broadriverrehab.com

Ask Our Experts https://www.broadriverrehab.com/expert/

Broad River Rehab Reflections are the third Thursday of each month. **December – 2022 Physician Fee Screen Final Rule**