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2023 Spring Virtual Conference

SNFs: Medicare Here, Now and Tomorrow

5/17/2023

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NGS Medicare University
Meaningful | Informative | Simplified

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Today's Presenters

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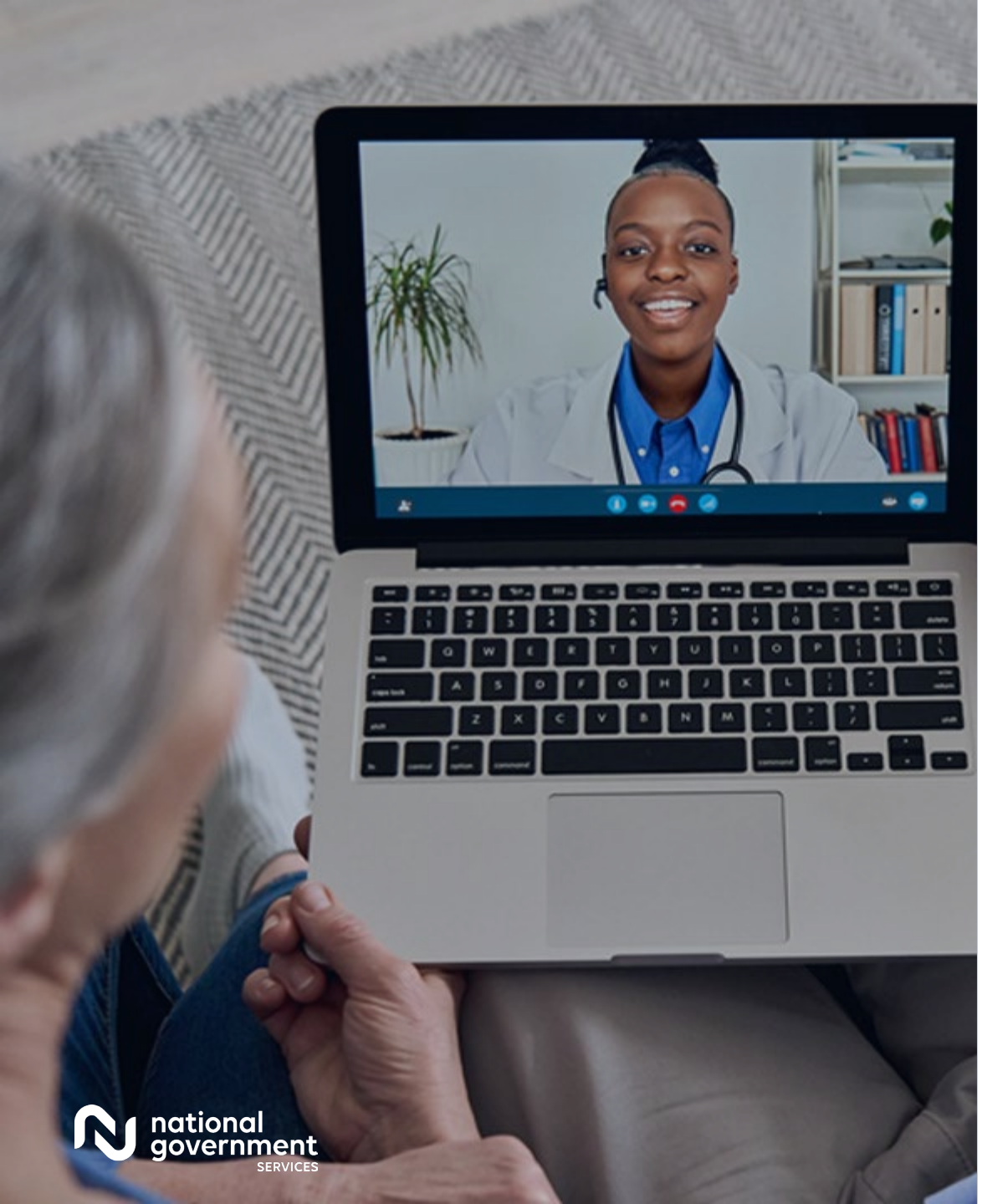

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Agenda

- End of PHE Changes
- MAO Plan Beneficiaries
- Top Claim Issues for SNFs
- Documentation Requirements
- Resources and Wrap UP
- Questions

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End of PHE Changes

Expired Waivers

- Three-day Prior Hospitalization Waiver
- One-time Renewed SNF Coverage
- Nurse Aide Training for Nursing Homes
- Provider Enrollment-Expedited Enrollment
- Provider Enrollment- Opt-Out Enrollment
- Provider Enrollment-State Licensure

Three-Day Prior Hospitalization

- During PHE
  - Three-day prior hospitalization not required for SNF coverage
- After PHE ends on 5/11/2023
  - This requirement resumes
    - ✓ Medicare coverage requirements
    - ✓ One or more hospitals-consecutive days
    - ✓ Use midnight-to-midnight rule
    - ✓ Does not count time spent in observation or ED before admission
    - ✓ May be waived in certain scenarios
    - ✓ MAO plan, 1876 Cost or Pace Plans
    - ✓ Shared Savings Program Accountable Care Organizations (ACOs)

One-time Renewed SNF Coverage

- During PHE
  - CMS allowed beneficiaries whose skilled services were interrupted by circumstances directly related to PHE to continue skilled care without first completing a 60-day period of wellness to begin a new benefit period
- After PHE ends on 5/11/2023
  - This requirement resumes and beneficiaries are once again limited to a maximum of 100 days of skilled care per benefit period

Nurse Aide Training

- After PHE ends
  - All nursing aide training emergency waivers for states and facilities end
  - Facilities have four months (i.e., until 9/10/2023) to have all nurse aides who are hired prior to end of PHE complete a state-approved Nurse Aide Training and Competency Evaluation Program (NATCEP/CEP)
  - Nurse aides hired after 5/11/2023 have up to four months from hire date to complete this requirement

Provider Enrollment

- During PHE
  - CMS established toll-free hotlines for physicians, non-physician practitioners and Part A-certified providers and suppliers who had established isolation facilities to enroll and receive temporary Medicare billing privileges
- After PHE ends
  - Such hotlines are shut down

Provider Enrollment-Expedited Enrollment

- During PHE
  - CMS expedited any pending or new PE applications
- After PHE ends
  - CMS resumes normal PE application processing timeframes

Provider Enrollment- Opt-Out Enrollment

- During PHE
  - Allowed practitioners to cancel their opt-out status early
  - Allowed MACs to accept opt-out cancellation requests via email, fax, or phone call to the hotline
  - Providers were not required to submit a written notification to cancel their opt-out status
- After PHE ends
  - Opted-out practitioners will not be able to cancel their opt-out statuses earlier than the applicable regulation 42 CFR 405.445 allows

Provider Enrollment-State Licensure

- During PHE
  - Allowed licensed physicians and other practitioners to bill Medicare for services provided outside of their state of enrollment.
- After PHE
  - CMS regulations continue to allow for a total deferral to state law
    - ✓ Thus, there is no CMS-based requirement that a provider must be licensed in its state of enrollment

Required Facility Reporting

- Facilities are required to report COVID-19 cases in their facility to the CDC National Health Safety Network (NHSN) weekly
- Will strengthen COVID-19 surveillance locally and nationally; monitor trends in infection rates
- A critical component of the national COVID-19 surveillance system
- Will also be posted online for the public
- Enforcement actions for facilities' noncompliance
- Effective until 12/31/2024

Required Facility Reporting

- Enforcement actions for facilities' noncompliance
  - Civil money penalty of $1,000 for the first occurrence
  - $500 added to the previously imposed civil money penalty for each subsequent occurrence

Required Facility Reporting

- Facilities requirement
  - Notify residents, representatives, and family of status of Covid-19 in facility
    - ✓ Includes any new cases of Covid-19
- Effective until 12/31/2024

Medicare Appeals

- During PHE
  - Allowed extensions to file an appeal
  - Allowed MACs to process an appeal even with incomplete Appointment of Representation forms
  - Process requests for appeal that didn't meet the required elements, but instead use information that was available
- After PHE ends
  - **Appeals must meet the existing regulatory requirements**

Cost Reporting

- 60-day extension of due date
  - If significantly affected by extraordinary circumstances
    - ✓ Impacts of the PHE
- Submit request to your MAC

Testing for Staff and Residents

- Testing for Staff and Residents
  - Including individuals providing services under arrangement and volunteers
- Will enhance efforts to keep COVID-19 from entering and spreading through facilities
- Applicable one year beyond the expiration of the PHE for COVID–19.

Vaccines

- During PHE
  - For beneficiaries in a Part A-covered SNF stay, CMS exercised “enforcement discretion,” which allowed Medicare-enrolled immunizers, including but not limited to pharmacies working within US, to bill directly and receive direct payment from Medicare for vaccinating Medicare SNF residents
  - Will end on 6/30/2023
- Beginning on 1/1/2024
  - For beneficiaries in a Part A-covered SNF stay, payment for Remdesivir is subject to SNF consolidated billing and is not separately billable to Part B

Medicare Advantage Organization (MAO) Plan Beneficiaries

Medicare Advantage (MA) Plan Information-Only Billing

- SNFs must submit inpatient claims to FFS Medicare for beneficiaries enrolled in MAO plans who are receiving skilled care
  - To update benefit period in CWF
  - This is true even though MAO plan is responsible for payment
- Claim coding
  - TOB 22X or 18X
  - CC 04
  - Room and board charges
  - Revenue code 0022
  - MDS code (applicable or default)

Disenrollment from MA while in SNF Inpatient

- Qualifying hospital stay requirement is waived
- Eligible for the number of days remaining out of the 100-day benefit period for that stay minus the days Original Medicare would've covered while the beneficiary was an MA plan enrollee
- Report Condition Code 58
- Skilled Nursing Facility Billing Reference
- CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 6
  - Section 90- Medicare Advantage (MA) Beneficiaries

Disenrollment from a MA Plan After SNF Discharge

- Must meet all FFS requirements for SNF stay
  - Includes three-day qualifying stay
- SNFs may charge beneficiaries SNF coinsurance
- Report CC 58

Beneficiary Disenrolls From MAO Plan Before SNF Admission

- Beneficiary disenrolls from MA Plan before SNF admission
- Beneficiary must meet all requirements for Medicare FFS, including qualifying three-day hospital stay
- Report Condition Code 58

SNFs – Billing for MAO Plan Enrollees

- Submit IP informational claim to traditional Medicare:
  - Covered TOB (not 210)
  - Covered days/charges
  - Room & board charges
  - CC 04
  - Assessment information
- Required as long as beneficiary remains skilled
  - Even after benefits exhaust
    - ✓ Reference: CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 6, Section 90

SNFs – Billing for MAO Plan Enrollees

- If option code C MAO plan enrollee no longer requires skilled care
  - SNF discharges using a beneficiary status code 04
  - Informational claims are not required (since nonskilled)
  - If beneficiary again requires skilled care after a period of nonskilled care, SNF submits a new admission claim for Medicare to continue spell of illness

Top Claim Issues for SNFs

Top Claim Issues

- RTP 38117
  - All inpatient SNF and non PPS bills must be processed in sequence.
  - There is a prior claim for this admission pending in our system.
    - ✓ Resubmit
- RTP 38119
  - This claim reports DOS that are part of a continuing stay.
  - We have not received the claim immediately preceding the DOS on this bill.
    - ✓ Resubmit

Top Claim Issues

- Rejection U5233
  - The services on this claim fall within or overlap an MA HMO enrollment period.
    - ✓ Resubmit
- Denial 55S03
  - Information provided does not support the need for SNF care.
    - ✓ Appeal

First Level of Appeal Tips

- Make all appeal requests on time in writing or via electronic portal with us within 120 days of our claim determination date
- First Level of Appeal processing time is 60 days; do not send duplicate appeal requests within that timeframe.
- Ensure your appeal request includes point of contact information to assist our Appeals Department in the appeal process.
- Include all relevant supporting documents with your first appeal request.
- Respond promptly to document requests

Documentation Requirements

Skilled Nursing Facility Level of Care

- All factors must be met:
  - Beneficiary requires skilled nursing services or skilled rehabilitation services
    - ✓ Must be performed by or under supervision of professional or technical personnel
    - ✓ Ordered by physician
    - ✓ Rendered for condition for which beneficiary received inpatient hospital services **or** rendered for a condition that arose while receiving SNF care for a condition for which he/she received inpatient hospital services
- Must be documented in beneficiary's medical record

Skilled Nursing Facility Level of Care

- Beneficiary requires these skilled services on daily basis
- As practical matter, daily skilled services can be provided only on inpatient basis in SNF setting
- Services delivered are reasonable and necessary for treatment of beneficiary's illness or injury
  - Consistent with
    - ✓ Nature and severity of beneficiary's illness or injury
    - ✓ Beneficiary's particular medical needs
    - ✓ Accepted standards of medical practice
  - Reasonable in terms of duration and quantity
- Must be documented in beneficiary's medical record

Skilled Nursing Facility Level of Care

- If any of these factors are not met, SNF stay not covered
  - Even though it might include delivery of some skilled services (example-intermittent rather than daily skilled services needed)

Principles for Determining Whether Service Skilled

- Inherent complexity of service prescribed for beneficiary can only be performed safely and/or effectively by or under general supervision of skilled nursing or skilled rehabilitation personnel
  - Examples:
    - ✓ Administration of intravenous feedings and intramuscular injections
    - ✓ Insertion of suprapubic catheters
    - ✓ Ultrasound, shortwave, and microwave therapy treatments
- Must be documented in beneficiary's medical record

Principles for Determining Whether Service Skilled

- A/B MAC considers nature of service and skills required for safe and effective delivery of that service in deciding whether service is skilled
  - Beneficiary's diagnosis or prognosis should never be sole factor in deciding that service not skilled
  - Example: Rehabilitation services are primary services
    - ✓ Key issue - whether skills of therapist needed
    - ✓ Deciding factor not beneficiary's potential for recovery, but whether services needed require skills of therapist or could be provided by nonskilled personnel

Principles for Determining Whether Service Skilled

- Service ordinarily considered nonskilled could be considered skilled where special medical complications, skilled nursing or skilled rehabilitation personnel required to perform or supervise service or to observe beneficiary
  - Complications/special services involved must be documented by physicians' orders and notes as well as nursing or therapy notes
- Must be documented in beneficiary's medical record.

Principles for Determining Whether Service Skilled

- Example: Whirlpool baths
  - Do not ordinarily require skills of qualified physical therapist
  - Skills, knowledge, and judgment of qualified physical therapist might be required where beneficiary's condition complicated by circulatory deficiency, areas of desensitization, or open wounds
  - Documentation needs to support severity of circulatory condition that requires skilled care

Principles for Determining Whether Service Skilled

- Necessary to determine whether individual services skilled, or in light of beneficiary's total condition, were skilled management of services provided needed if many/all of specific services unskilled
- Must be documented in beneficiary's medical record

Principles for Determining Whether Service Skilled

- Example: An 81-year-old woman who is aphasic and confused, suffers from hemiplegia, congestive heart failure, and atrial fibrillation, has suffered a cerebrovascular accident, is incontinent, has a Stage 1 decubitus ulcer, and is unable to communicate and make her needs known.
  - Even though no specific service provided is skilled, beneficiary's condition requires daily skilled nursing involvement to manage a plan for the total care needed, to observe the beneficiary's progress, and to evaluate the need for changes in the treatment plan.
  - Medical condition of the beneficiary must be described and documented to support the goals for the beneficiary and the need for skilled nursing services

Principles for Determining Whether Service Skilled

- Importance of particular service to individual beneficiary, or frequency with which it must be performed, does not, by itself, make it skilled
  - EXAMPLE: Primary need of nonambulatory beneficiary may be frequent changes of position in order to avoid development of decubitus ulcers
    - ✓ However, since such changing of position does not ordinarily require skilled nursing or skilled rehabilitation personnel, it would not constitute skilled service, even though such services obviously necessary
- Must be documented in beneficiary's medical record.

Principles for Determining Whether Service Skilled

- Possibility of adverse effects from improper performance of otherwise unskilled service does not make it skilled service unless there documentation to support need for skilled nursing or skilled rehabilitation personnel
  - Example: Act of turning beneficiary - normally not skilled
    - ✓ Sometimes skills of nurse may be necessary to assure proper body alignment in order to avoid contractures and deformities
    - ✓ Reasons why skilled nursing or skilled rehabilitation personnel essential must be documented in beneficiary's medical record

Documentation to Support Skilled Care Determinations

- Documentation must show:
  - Skilled involvement required in order for services in question to be furnished safely and effectively
  - Services themselves reasonable and necessary for treatment of beneficiary's illness or injury
    - ✓ Consistent with nature and severity of individual's illness or injury, individual's particular medical needs, and accepted standards of medical practice
  - Services appropriate in terms of duration and quantity, and services promote documented therapeutic goals

Documentation to Support Skilled Care Determinations

- Document in medical record (as appropriate):
  - History and physical exam pertinent to care provided (including response or changes in behavior to previously administered skilled services)
  - Skilled services provided
  - Beneficiary's response to skilled services provided during current visit
  - Plan for future care based on rationale of prior results

Documentation to Support Skilled Care Determinations

- Detailed rationale explaining need for skilled service in light of beneficiary's overall medical condition and experiences
- Complexity of service to be performed
- Any other pertinent characteristics of beneficiary
- Documentation must be accurate and avoid vague/subjective descriptions of beneficiary's care that would not be sufficient to indicate need for skilled care

Resources

Resources

- CMS Current Emergencies
- MLN Connects® Newsletter: *COVID-19 Public Health Emergency (PHE) New Overview Fact Sheet — Feb 27, 2023*
- CMS Waivers, Flexibilities, and the Transition Forward from the COVID-19 Public Health Emergency
- Skilled Nursing Facility Center
- Daily Treatment Notes Requirement for Inpatient SNF Services
- CMS IOM Publication 100-02 *Medicare Benefit Policy Manual* , Chapter 8, Section 30
- CMS IOM Publication 100-04, *Medicare Claims Processing Manual,* Chapter 6, Inpatient Part A Billing and SNF Consolidated Billing

Self-Service

- NGSConnex
  - Use our free, secure, web-based application to verify beneficiary eligibility, determine the status of your appeals or claims, respond to medical ADRs, submit credit balance reports, find financial information and more! Be sure to sign up for NGSConnex and review our NGSConnex User Guide
- Eligibility
  - You can use the following resources to verify your beneficiary's Medicare entitlement eligibility (Part A, Part B, MAO plan enrollment, hospice, home health, MSP and more!):
  - Our NGSConnex system (under Apps) – Review our NGSConnex User Guide (under Education > Manuals and Guides) to learn how.
- Interactive Voice Response System
  - Our IVR system is available 24 hours a day, 7 days a week. Use it to verify beneficiary eligibility, determine the status of your appeals and claims, find information on checks, offsets, pricing, provider enrollment and more

Questions?

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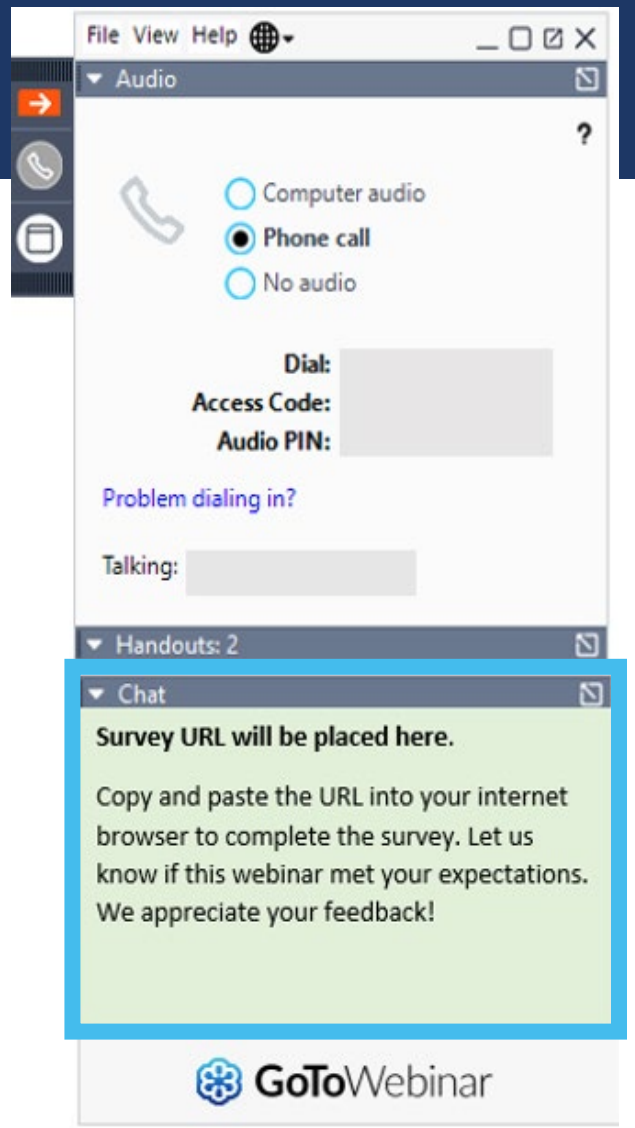

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