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Skilled Nursing Facility Roundtable Education and Discussion

February 14, 2024

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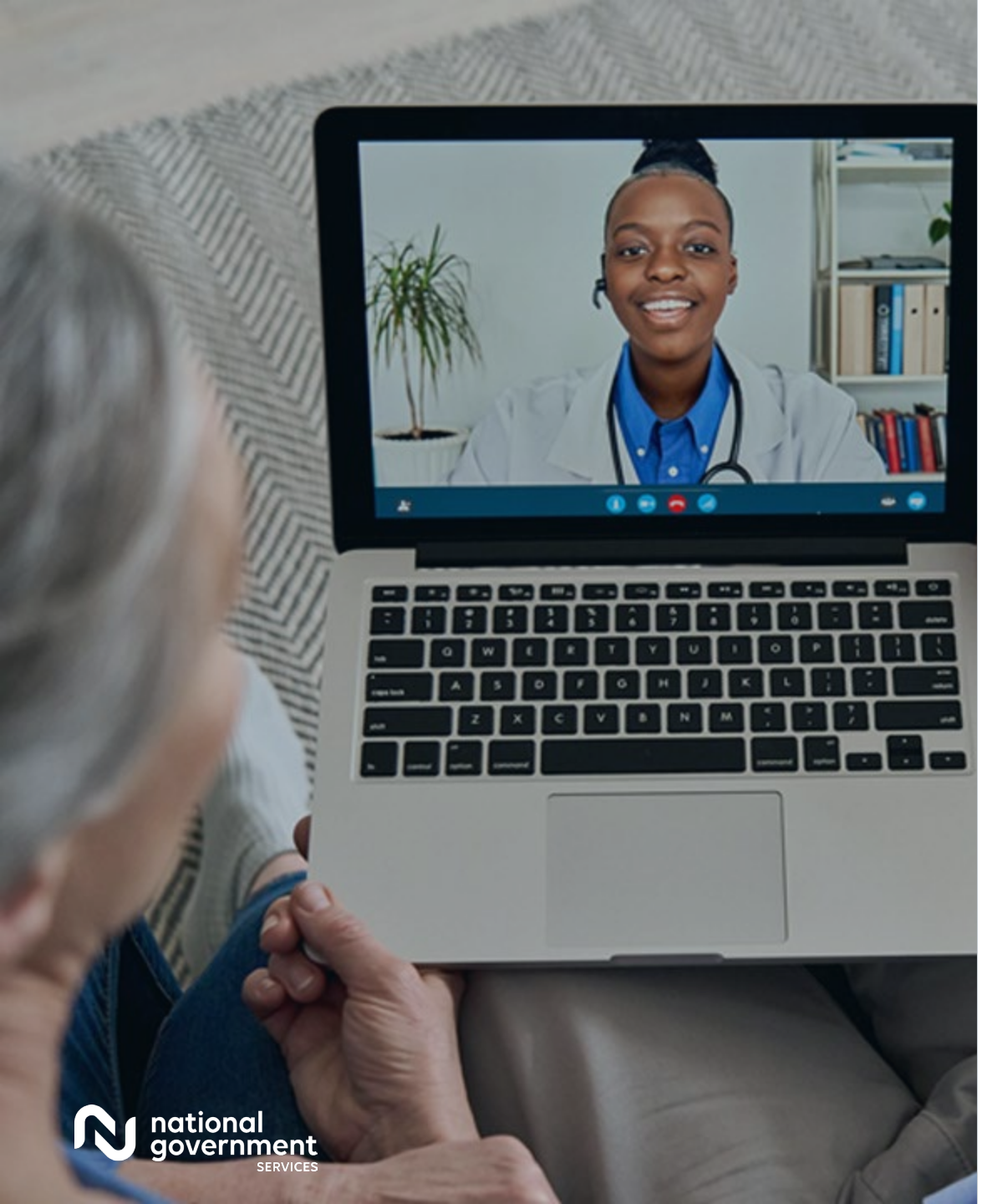

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Today's Presenters

Provider Outreach and Education Consultants, Medical Review Associates and Case Management Associates

- Brittany Small
- Megan Skelly
- Phillip Harpenau

Agenda

Welcome and Introductions
Phillip Harpenau

Overview of Audit
Phillip Harpenau

Additional Documentation Request (ADR)
Phillip Harpenau

Generalized SNF Education
Brittany Small

Review Findings and Trends Identified
Megan Skelly

SNF Education Resources
Phillip Harpenau

Question and Answer
NGS Panelists

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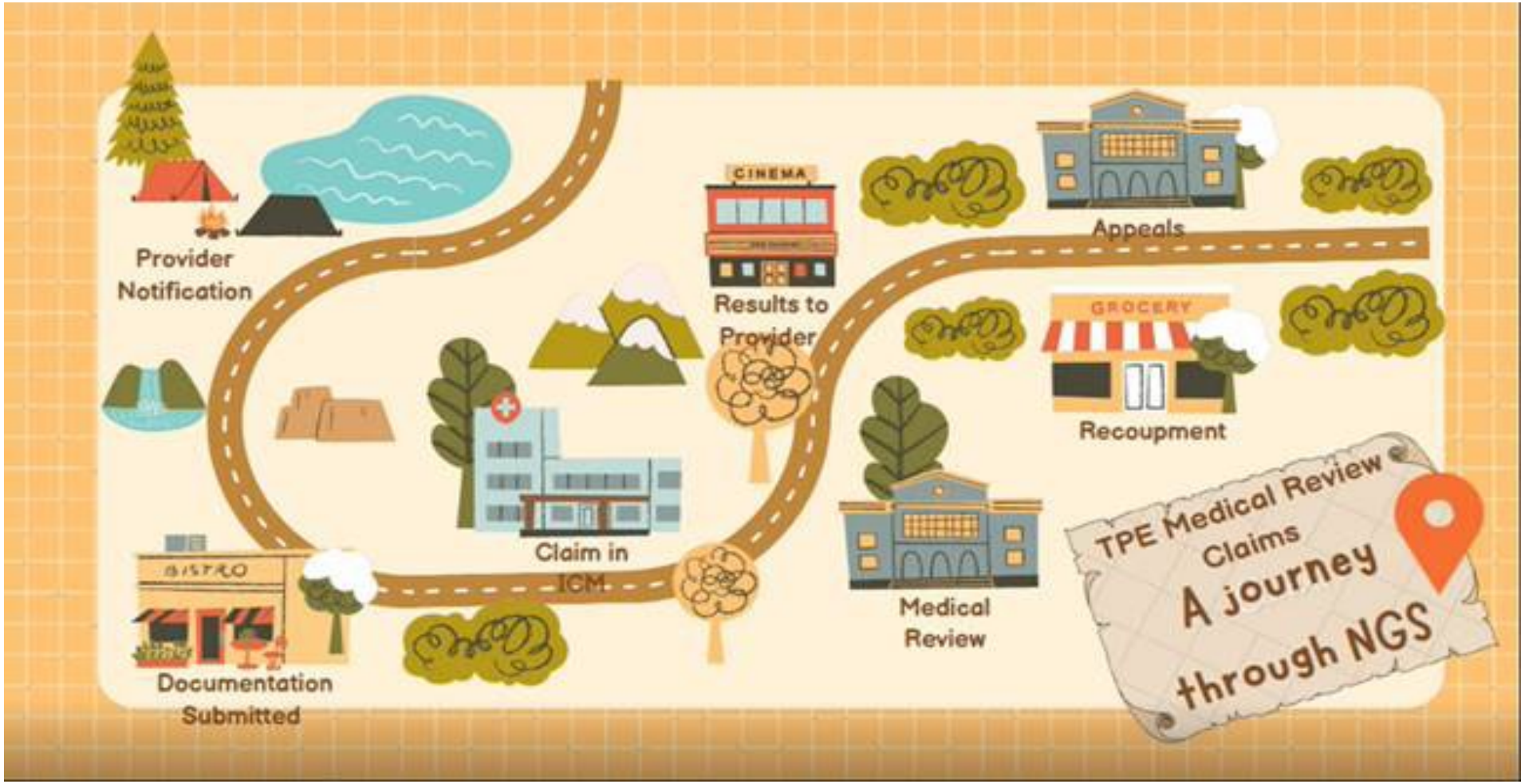
Additional Documentation Request (ADR)

What to do Once Receiving an ADR



ADRs for Pre-Pay Claims

- Fiscal Intermediary Standard System (FISS)
  - When a claim has been pulled for audit, the status of the claim will change in Direct Data Entry (DDE) to SB600 and then to SB6001
  - ADR letters are generated by FISS and can be found on pages seven and eight, but can only be accessed when the claim is in location SB6001
  - If the claim denies for 56900 (documentation not submitted timely), then the ADR will no longer be viewable

SNF Five-Claim Review

Probe and Educate

- Focus of review
  - Developed to create a better understanding of the Payment Driven Payment Model (PDPM) billing process
  - Review of first five claims billed from all SNFs
    - ✓ Claims eligible for review include DOS October 2019 – present (currently pre-pay)
    - ✓ All HIPPS codes are included
  - Complete one round of probe and educate (P&E) for each SNF
  - Education offered is based on the claim review errors identified

Coverage Requirements for Skilled Nursing Facility

Coverage Requirements: Skilled Nursing Facility

- Beneficiary must be entitled to Part A of Medicare and require skilled nursing and/or skilled rehabilitation services on a daily basis.
- Services are reasonable and necessary for treatment of the individual's illness or injury.
- Services must be furnished for a condition for which the individual was treated in a hospital or while the individual was in their SNF stay.
- Services can only be provided on an inpatient basis in a SNF.

Preadmission Requirements

- Consecutive three-day medically necessary hospital stay
  - Observation days do not qualify toward the three day stay.
- Transfer to a SNF within 30 days after hospital discharge
  - Exceptions include when
    - ✓ Post hospital SNF care is medically inappropriate within 30 days after hospital discharge
    - ✓ It is medically predictable at the time of hospital discharge that the beneficiary will require covered care within a predeterminable period
- Services for treatment
  - Condition(s) the beneficiary was receiving for inpatient hospital services, or;
  - A condition that arose while in the SNF for treatment of a condition for which the beneficiary was previously hospitalized.

30-Day Transfer

- Beneficiary admitted to a SNF within 30 days after a hospital qualifying stay
  - In determining 30-day transfer period, the day of discharge from the hospital is not counted in the 30 days.
  - The 30-day period begins the day following discharge from the hospital and continues until the beneficiary is admitted to a participating SNF and requires and receives a skilled level of care.

Skilled Services

Five Major Areas of Skilled Service

1. Evaluation
2. Treatment
3. Education
4. Observation
5. Skilled Case Management

Skilled Services

- Skilled nursing and skilled rehabilitation services must be needed and provided on a “daily basis”, **essentially seven days a week**.
  - Skilled rehabilitation services at least five days a week
- Skilled service must be of sufficient complexity and
  - Require the skills of qualified technical or professional health personnel.
  - Be provided directly by or under general supervision of skilled nursing or skilled rehabilitation personnel to assure safety of patient and to achieve medically desired result.

Skilled Therapy Indications in a SNF

- Skilled therapy treatment indicated when:
  - Injury or medical insult resulting in some degree of physical deficit
  - Requires a structured rehabilitation program
  - Must be measurable physical involvement
  - Only qualified physical therapist may perform Range of Motion (ROM) tests
  - ROM exercises constitute skilled physical therapy only if they are part of active treatment
  - Physical therapy notes must show impact on mobility and/or function
- Jimmo v. Sebelius Settlement Agreement Program Manual Clarifications Fact Sheet

Assessing Cognitive Ability

- Cognitive ability is a factor
  - Development of therapy programs require beneficiary to learn and retain knowledge.
    - ✓ Document evidence if functions taught by therapists are not retained because of cognitive deficits, these programs would not be reasonable and necessary.
    - ✓ Dementia patients can participate in rehab, even if they have no capacity to learn.

Examples of Skilled Nursing Services

- IV or IM injections and IV feeding
- Enteral feeding for 26 percent of daily Kcal requirements
- Nasopharyngeal and tracheostomy aspiration
- Suprapubic catheter care
- Complex wound care
- Post-operative colostomy care and education
- Respiratory care
- Bowel and bladder training programs

Examples of Non-Skilled Nursing Services

- Administration of routine oral medications
- General maintenance care of colostomy and ileostomy
- Routine care of indwelling bladder catheters
- Changes of dressings for uninfected wounds
- Prophylactic and palliative skin care
- Assistance in dressing, eating, toileting
- Periodic turning and positioning in bed

Skilled Respiratory Therapy

- Respiratory therapy: Only minutes that the respiratory therapist or respiratory nurse spends with the resident shall be recorded on the MDS.
- Respiratory therapy time includes:
  - Resident evaluation/assessment, treatment administration and monitoring, and setup and removal of treatment equipment.
  - Completed for a minimum of 15 minutes during all seven days of the lookback period.
- Not included in time:
  - Administration of metered-dose and/or dry powder inhalers.
  - The resident self-administers nebulizer treatments without supervision.
- Refer to the MDS 3.0 RAI Manual for more clarification.

Elements of Review

Documentation Requirements

- Level of care supported in the medical records should include:
  - Need for skilled services and patients' response
  - Complexity of services
  - Consistency with level of illness and medical needs
  - Promotion of documented goals
  - Plan for future care
- Submission of required documentation includes:
  - Therapy documentation
  - Supporting documentation
  - Initial H&P by physician
  - Physician certification and recertification
  - Discharge planning
- Refer to: CMS Internet-Only Manual Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 8, Section 30.2.2.1

Certification/Recertification Requirements

- Timing of the certification and recertification
  - The **date of admission** is considered Day 1.
  - The **certification** must be made no later than the 14th day.
  - The **first recertification** must be made no later than the 14th day.
  - The **recertification period** starts on date signed, even if it is signed same day as the certification.
  - The **subsequent recertification** would be due 30 days from the first recertification date.

Certification/Recertification Requirements [2]

Initial Certification

Individual's need for daily skilled nursing care or other skilled rehabilitation services

Services can only practically be provided in a SNF or swing-bed hospital on an inpatient basis

Services are for an ongoing condition for which the individual received inpatient care in a hospital

A dated signature of the certifying physician or NPP

Recertification

Continued need for post hospital SNF care and any plans for discharge

Estimated time to remain in the SNF

Plans for home care, if any

Need of services for a condition that arose after admission to the SNF

A dated signature of the recertifying physician or NPP

Therapy Plans of Care (Not Certified)

- Certification of the plan of care requires a dated signature by the MD/NPP on the plan of care or some other document.
- Acceptable documentation when the therapy plan of care is not certified/recertified:
  - A valid SNF cert/recert form or required elements found in the records
  - A physician's/NPP progress note indicating plan is for therapy
  - A physician/NPP order for therapy services
- Refer to: CMS Internet-Only Manual Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 8

Validating Therapy Treatments

- Documentation must support therapy services were skilled
  - Daily notes not required but recommended for validating treatment
  - Therapy sessions provided and billed must be at least 15 minutes in duration.
    - ✓ Matrix logs to verify the days and total number of therapy minutes performed
  - Therapy evaluations and discharge summaries
  - Progress notes can also be used to show the therapy services provided are skilled.
- Therapy **start** date: date the most recent therapy regimen started including the initial therapy evaluation
- Therapy **end** date: date the most recent therapy regimen ended
  - This is the last date the resident received skilled therapy
- Refer to: CMS Internet Only Manual Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 15, Section 220.3.E

Patient Driven Payment Model

What is the PDPM?

- SNF Part A services are paid under a prospective payment system (PPS) called the PDPM, which took effect October 1, 2019.
  - Payment determined through combination of five payment components: Physical Therapy, Occupational Therapy, Speech Language Pathology, Non-Therapy Ancillary (NTA) and Nursing components
- PDPM replaced the RUG-IV system
  - New way of calculating reimbursement
  - Under PDPM, therapy minutes removed as basis for payment in favor of resident classifications and anticipated resource needs
  - Assigns every resident a case-mix classification that drives the daily reimbursement rate

PDPM Assessment Schedule

Medicare MDS Assessment Type	Assessment Reference Date	Applicable Standard Medicare Payment Days
Five-day Scheduled PPS Assessment	Days 1–8	All covered Part A days until Part A discharge (unless IPA is completed)
Interim Payment Assessment (IPA)	Optional Assessment	ARD of the assessment through Part A discharge (unless another IPA assessment is completed)
PPS Discharge Assessment	PPS Discharge: Equal to the End Date of the Most Recent Medicare Stay (A2400C) or End Date	N/A

Administrative Presumption

- SNF PPS includes an administrative presumption whereby a beneficiary who is correctly assigned one of the designated, more intensive case-mix classifiers on the initial five-day Medicare-required assessment is automatically classified as meeting the SNF level of care definition, up to and including ARD, which must occur no later than the eighth day of the SNF stay.
  - Only applies to beneficiaries who come directly from the hospital to the SNF
  - Would not apply if they are a failed home discharge or transfer from another SNF
- Refer to: Administrative Level of Care Presumption under the PDPM

Look-Back Period

- Standard look-back period for MDS 3.0 is seven days, unless otherwise stated
- ARD serves as reference point for determining care and services captured on MDS assessment
- Anything that happens after ARD will not be captured on that MDS.
  - Seven-day look-back period starts the day ARD is completed and includes assessment information from six previous calendar days
  - Look-back period includes observations and events through the end of the day (midnight) of ARD
  - Example:
    - ✓ MDS Assessment completed on 5/5
    - ✓ The seven-day look-back includes 4/29 – 5/5

Review Findings and Trends Identified

Medical Review Trends Identified

IV supplement administration

Incorrect use of primary diagnoses

Collaboration with third-party consultants

Regulatory Guidelines and Resources

Skilled Nursing Facility – Resources

- CMS Internet-Only Manual Publication 100-02, *Medicare Benefit Policy Manual*
  - Chapter 3, Duration of Covered Inpatient Services
  - Chapter 8, Coverage of Extended Care (SNF) Services Under Hospital Insurance
  - Chapter 15, Covered Medical and Other Health Services
- CMS Internet-Only Manual Publication 100-04, *Medicare Claims Processing Manual*
  - Chapter 1, General Billing Requirements
  - Chapter 6, Inpatient Part A Billing and SNF Consolidated Billing
- CMS Internet-Only Manual Publication 100-08, *Medicare Program Integrity Manual*
  - Chapter 3, Verifying Potential Errors and Taking Corrective Actions
  - Chapter 6, Medicare Contractor Medical Review Guidelines for Specific Services

Skilled Nursing Facility – Resources (2)

- Outpatient Physical and Occupational Therapy Services (L33631)
- Billing and Coding: Outpatient Physical and Occupational Therapy Services (A56566)
- LCD for Speech-Language Pathology (L33580)
- Billing and Coding: Speech-Language Pathology (A52866)
- MDS 3.0 RAI Manual (v1.17.1)
- Minimum Data Set 3.0 Resident Assessment Instrument User's Manual v1.18.11 (cms.gov)
- MDS Scheduled Assessment Calendar

Skilled Nursing Facility – Resources (3)

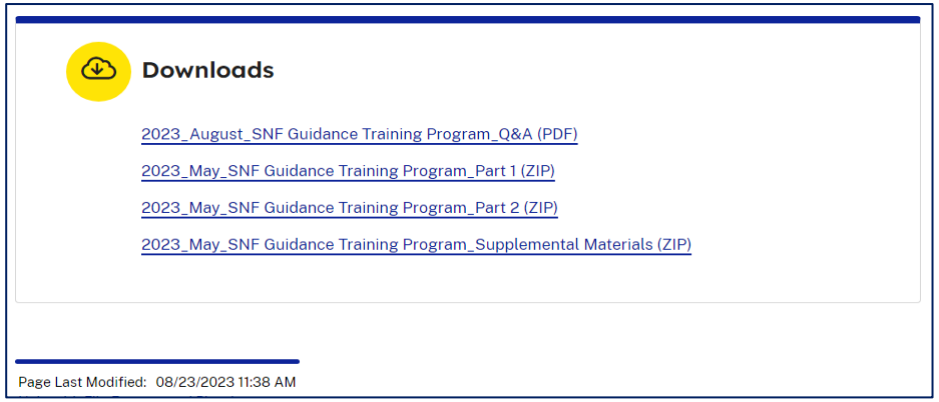
- Code of Federal Regulations
  - Section 409.30: Basic Requirements
  - Section 409.33: Examples of skilled nursing and rehabilitation services
  - Section 409.44: Skilled services requirements
  - Section 424.20: Requirements for Posthospital SNF Care
  - Section 483.30: Physician Services
- Jimmo v. Sebelius Settlement Agreement Program Manual Clarifications Fact Sheet
- CMS MLN: SNF PPS Patient Driven Payment Model

Recent Changes to SNF MDS RAI

- Refer to CMS.gov Skilled Nursing Facility (SNF) Quality Reporting Program (QRP) Training for guidance that currently affects reporting requirements associated with SNF Quality Reporting Program (QRP) that went into effect on October 1, 2023.

What is currently being offered?

- Web-Based Trainings
- Download Previous Trainings



Resident Assessment Instrument (RAI)

- CMS's RAI Version 3.0 Section Titles
  - A – Identification Information
  - B – Hearing, Speech, and Vision
  - C – Cognitive Patterns
  - D – Mood
  - E – Behavior
  - F – Preferences for Customary
  - Routine and Activities
  - GG – Functional Abilities and Goals
  - H – Bladder and Bowel
  - I – Active Diagnoses
  - J – Health Conditions
- Refer to
  - Minimum Data Set 3.0 Resident Assessment Instrument User's Manual v1.18.11 (cms.gov)
  - SNF Guidance Training Program Q&A (cms.gov)

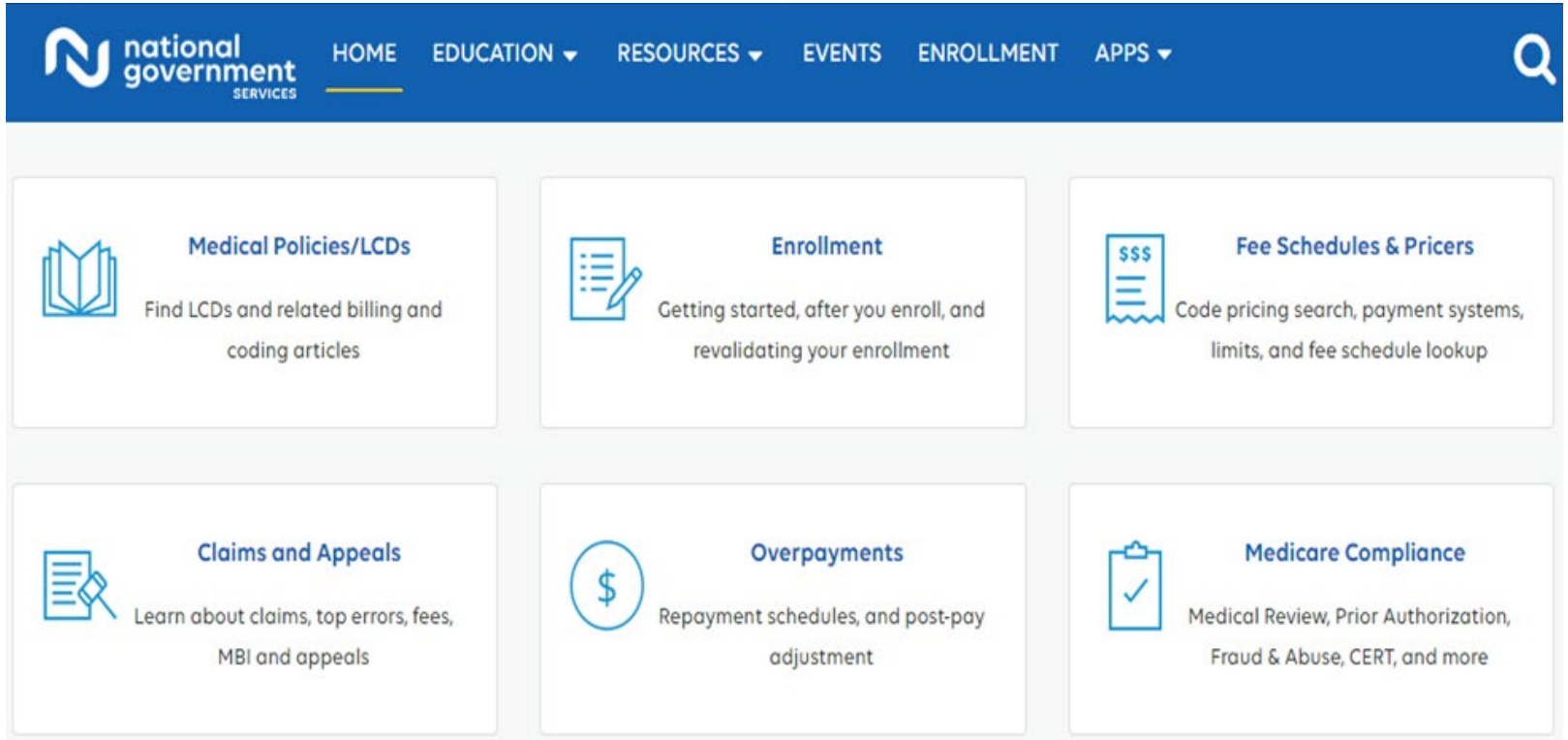
PDPM Resources

- Patient Driven Payment Model Overview-CMS.gov
- PDPM Patient Classification (ZIP)
- PDPM Functional and Cognitive Scoring (ZIP)
- Administrative Level of Care Presumption under the PDPM (PDF)
- NTA Comorbidity Score (PDF)
- MDS Changes (ZIP)
- PDPM Calculation Worksheet for SNFs

Valuable P&E Resources

NGS Website

Visit our website for valuable information



Education Tab:

- Help and FAQ's
- Medicare Topics, Medicare Monthly Review, Medicare University
- Manuals and Guides
- Provider FISS DDE User Guide
- News
- Self-Service Pulse

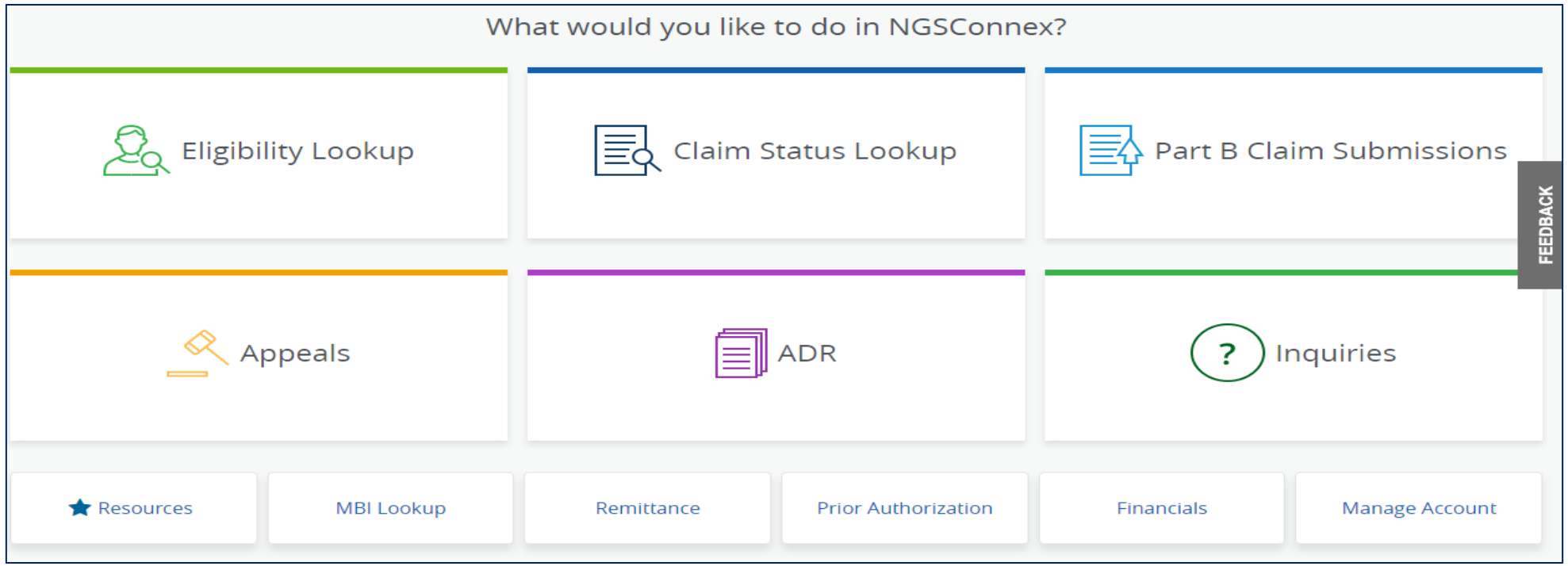
Resources Tab:

- Forms
- Tools and Calculators
- Contact Us
- EDI Enrollment and Solutions
- NGSConnex

NGSConnex Portal

- If you submit fee-for-service claims to National Government Services, you have the ability to respond to Medical Review ADRs and submit supporting documentation electronically via NGSConnex
- Not yet registered for NGS Connex? Visit our website and click 'Create Account' to register today.
- The NGSConnex User Guide has step by step instructions on use of the portal and video tutorials are available to you on our YouTube channel

NGSConnex Homepage



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Appealing a Medical Review Decision

- With the implementation of probe and educate, the process for appeal has not changed
- First level of appeal is the redetermination level
- 120 days from date of receipt of the initial determination notice
- Use NGSConnex to file appeal

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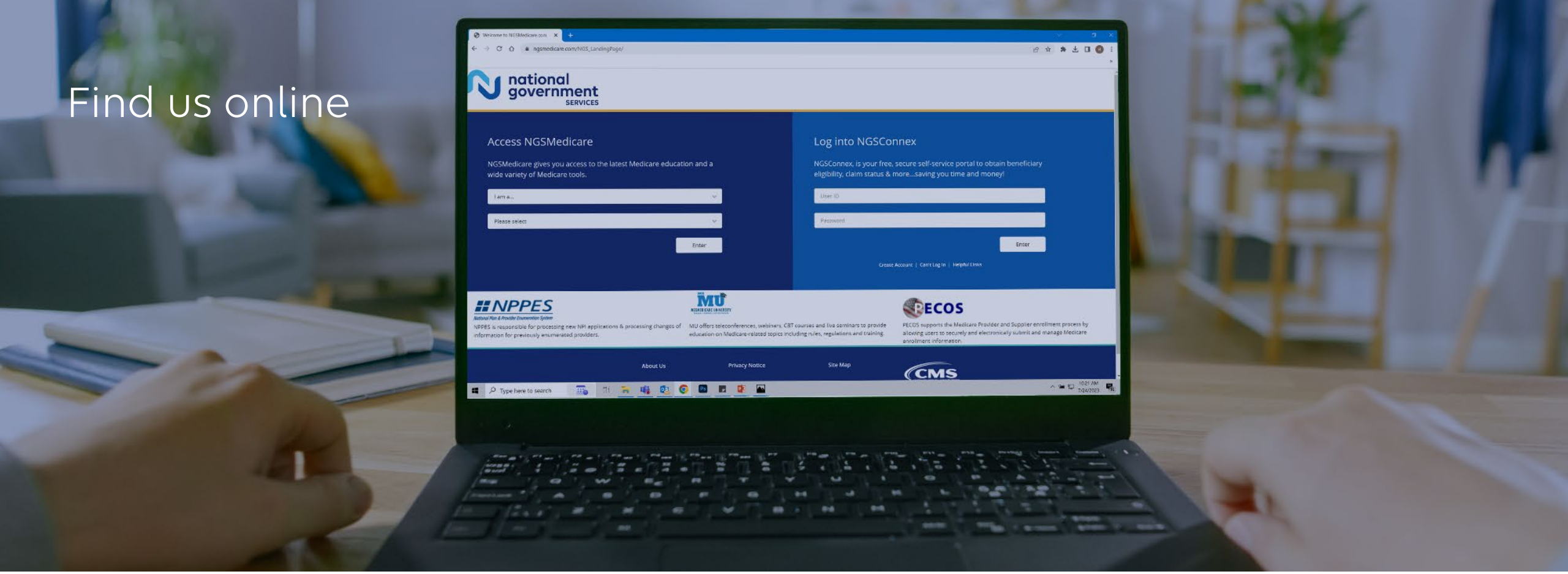

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Online resources, event calendar, LCD/NCD, and tools

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