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Skilled Nursing Facility: Coverage and Documentation

6/10/2025

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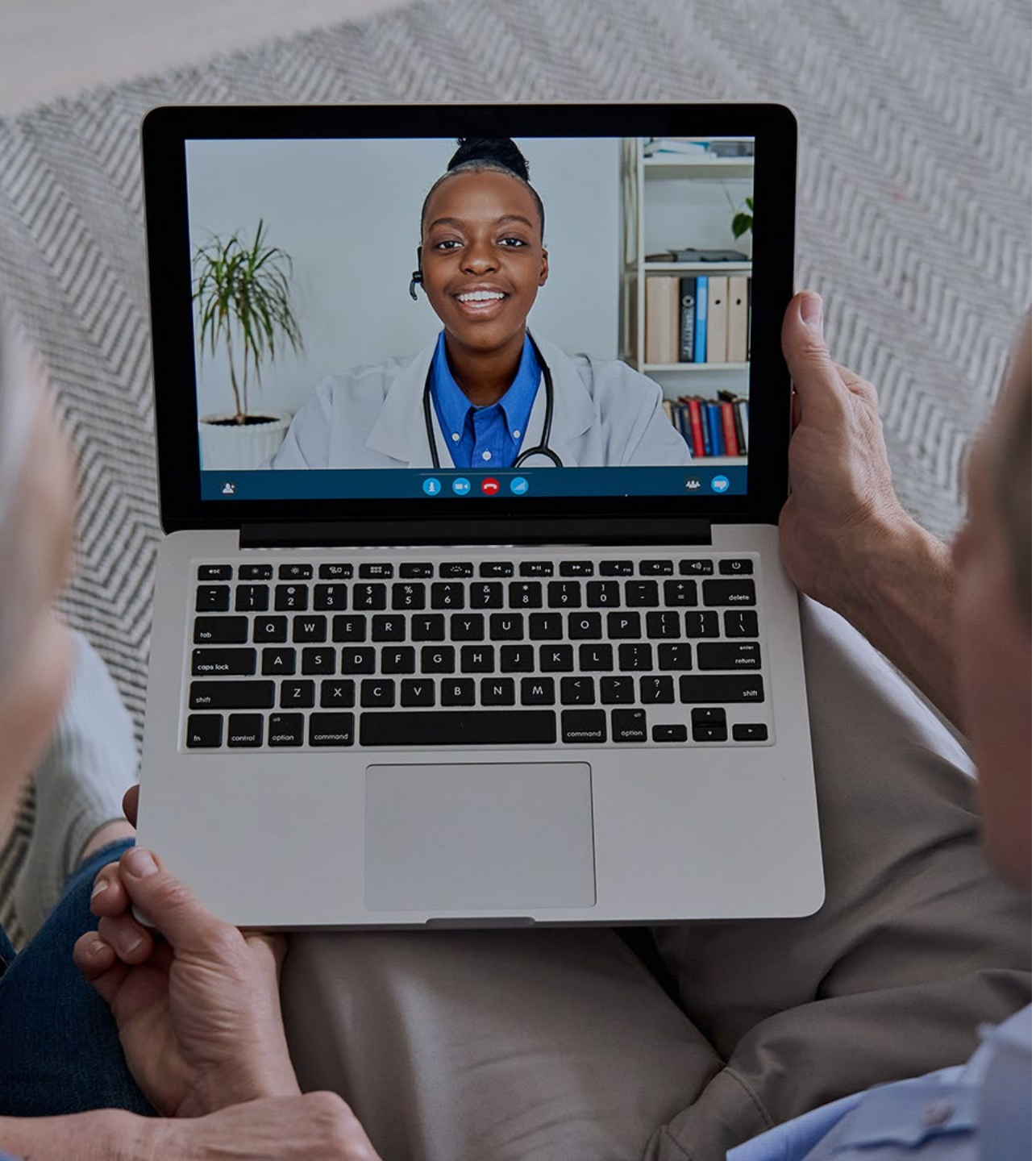

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Today's Presenters

- Case Management Associates
  - Phillip Harpenau
  - Brittany Small

Agenda

- SNF Five-Claim Review
- Coverage Requirements for Skilled Nursing Facility
- Skilled Services
- Elements of Review
- Patient Driven Payment Model (PDPM)
- Review Findings and Trends Identified
- Resources & References
- Questions

SNF Five-Claim Review

Probe and Educate (P&E)

- Focus of review
  - Developed to create a better understanding of 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 P&E for each SNF
  - Education offered is based on claim review errors identified

Coverage Requirements for Skilled Nursing Facility

Preadmission Requirements

- Consecutive three-day medically necessary hospital stay
  - Observation days do not qualify toward three day stay
- Transfer to 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 time of hospital discharge that beneficiary will require covered care within pre-determinable period
- Services for treatment of
  - Condition(s) beneficiary was receiving for inpatient hospital services, or;
  - Condition that arose while in SNF for treatment of condition for which beneficiary was previously hospitalized

30-Day Transfer

- Beneficiary admitted to SNF within 30 days after hospital qualifying stay
  - In determining 30-day transfer period, date of discharge from hospital not counted in 30 days
  - 30-day period begins day following discharge from hospital and continues until beneficiary admitted to participating SNF and requires and receives 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 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 rehabilitation services, even if they have no capacity to learn

Examples of Skilled Nursing Services

- IV or IM injections and IV feeding
- Enteral feeding for 26% 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

- Only minutes that respiratory therapist or respiratory nurse spends with resident recorded on MDS
- Respiratory therapy time includes
  - Resident evaluation/assessment, treatment administration and monitoring, and setup and removal of treatment equipment
  - Minimum of 15 minutes during all seven days of lookback period
- Not included in time
  - Administration of metered-dose and/or dry powder inhalers
  - Resident self-administration of 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 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 history and physical by physician
  - Physician certification and recertification
  - Discharge planning

- Refer to: CMS IOM Publication 100-02, *Medicare Benefit Policy Manual, Chapter 8, Section 30.2.2.1*

Certification/Recertification Requirements

- Timing of certification and recertification
  - **Date of admission** is considered day one
  - **Certification** must be made no later than the 14th day
  - **First recertification** must be made no later than the 14th day
  - **Recertification period** starts on date signed, even if signed same day as certification
  - **Subsequent recertification** would be due 30 days from the first recertification date

Certification/Recertification Requirements

- **Initial Certification**
  - Individual's need for daily skilled nursing care or other skilled rehabilitation services
  - Services can only practically be provided in SNF or swing-bed hospital on inpatient basis
  - Services are for an ongoing condition for which individual received inpatient care in hospital
  - Dated signature of certifying physician or NPP
- **Recertification**
  - Continued need for post hospital SNF care and any plans for discharge
  - Estimated time to remain in SNF
  - Plans for home care, if any
  - Need of services for condition that arose after admission to SNF
  - Dated signature of recertifying physician or NPP

Therapy Plans of Care (Not Certified)

- Certification of plan of care requires a dated signature by MD/NPP on plan of care or some other document

- Acceptable documentation when therapy plan of care is not certified/recertified
  - Valid SNF certification/recertification form or required elements found in medical records
  - Physician's/NPP progress note indicating plan is for therapy
  - Physician/NPP order for therapy services

- Refer to: CMS IOM 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 days and total number of therapy minutes performed
  - Therapy evaluations and discharge summaries
  - Progress notes can also be used to show therapy services provided are skilled
- **Therapy start date:** date most recent therapy regimen started including the initial therapy evaluation
- **Therapy end date:** date most recent therapy regimen ended
  - Last date the resident received skilled therapy

- Refer to: CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 15, Section 220.3.E

Patient Driven Payment Model (PDPM)

What Is the PDPM?

- SNF Part A services are paid under a prospective payment system (PPS) called PDPM, which took effect 10/1/2019
  - Payment determined through combination of five payment components: PT, OT, SLP, 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 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 hospital to SNF
  - Would not apply if they are a failed home discharge or transfer from another SNF

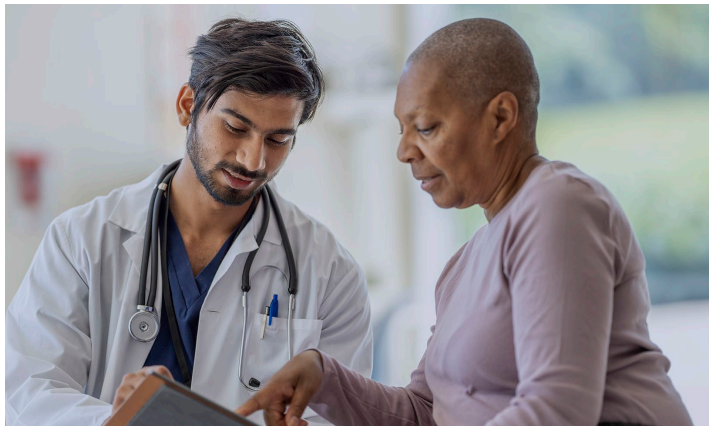
- Refer to: Administrative Level of Care Presumption under the PDPM

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



Incorrect use of primary diagnoses

Incorrect use of active diagnoses

Collaboration with third-party consultants

Resources & References

Skilled Nursing Facility – Resources

- CMS IOM 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 IOM Publication 100-04, *Medicare Claims Processing Manual*
  - Chapter 1, General Billing Requirements
  - Chapter 6, Inpatient Part A Billing and SNF Consolidated Billing
- CMS IOM 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

- 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)
- Minimum Data Set 3.0 Resident Assessment Instrument User's Manual v1.19.1 (cms.gov) (Effective 10/1/2024)

Skilled Nursing Facility – Resources

- 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
- MLN® Call: *SNF PPS – Patient Driven Payment Model*
- MLN® Educational Tool: *CMS Skilled Nursing Facility Billing Reference - MLN006846*
- FFS SNF ABN

PDPM Resources

- Patient Driven Payment Model Overview
- 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 (PDF)

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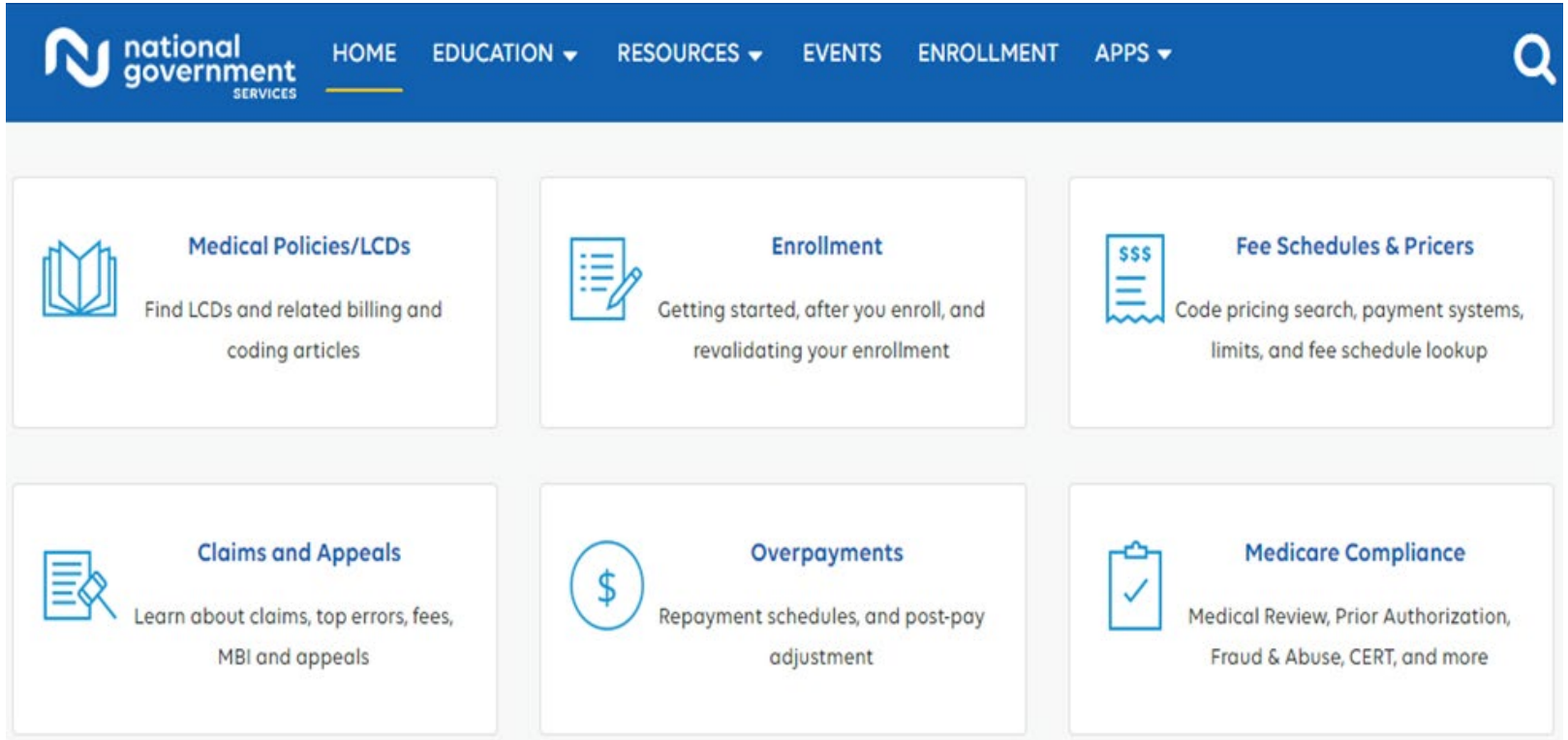

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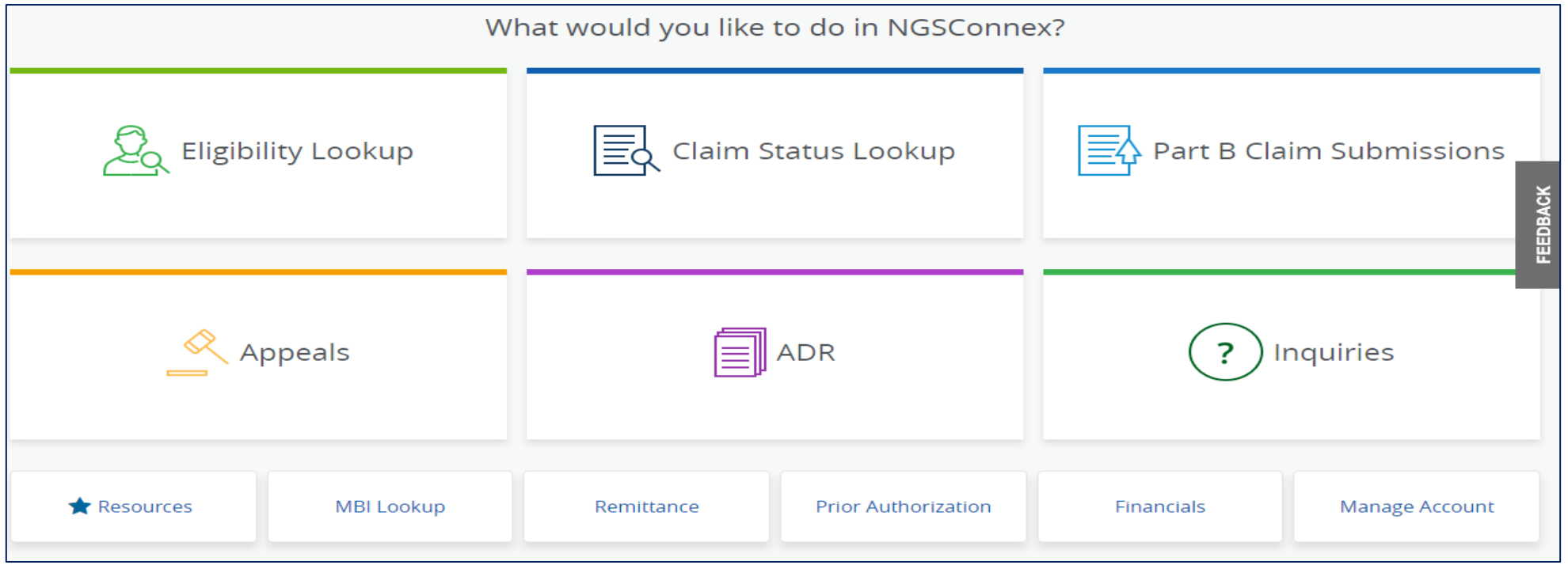

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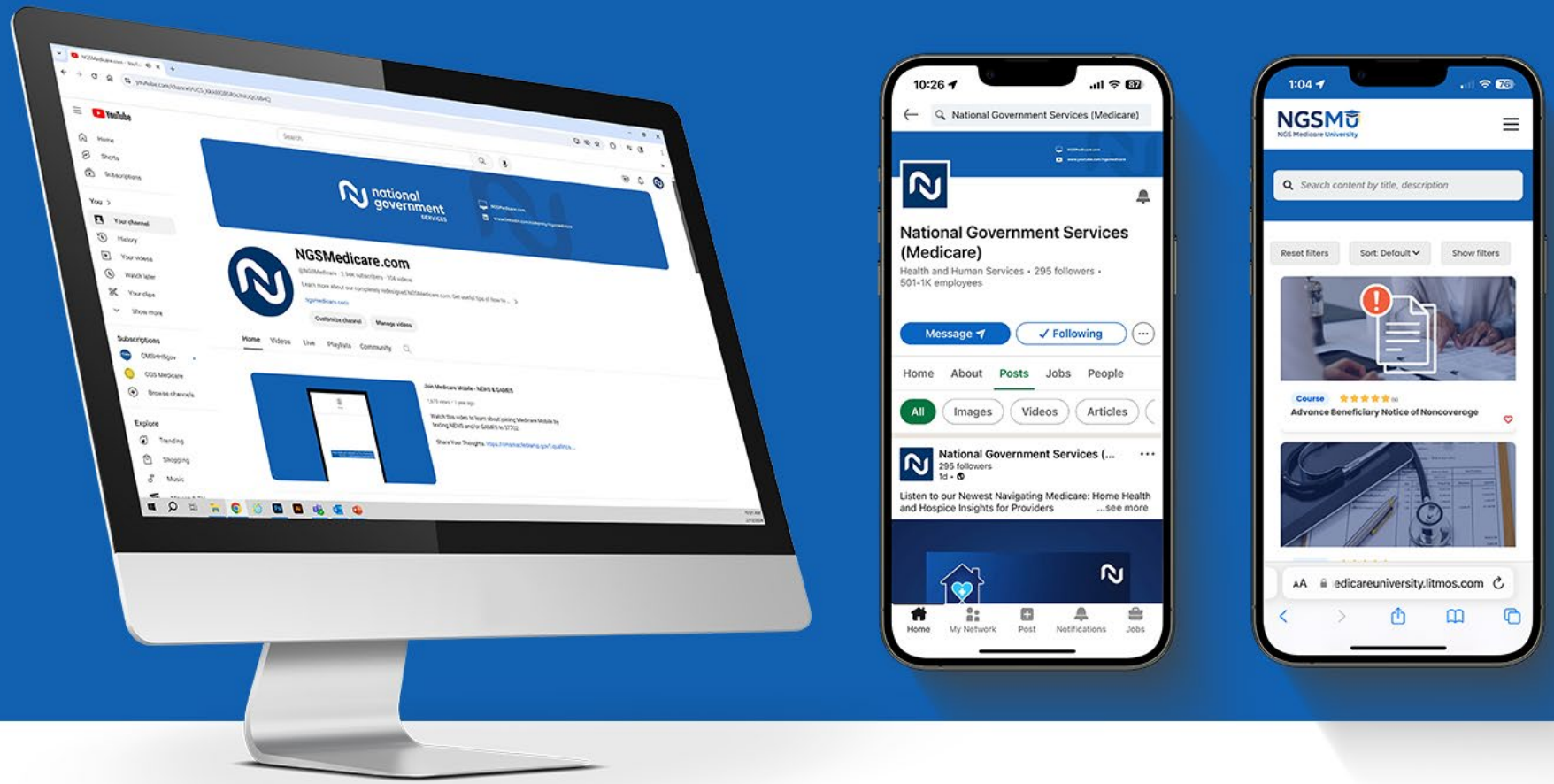
Appealing a Medical Review Decision

- 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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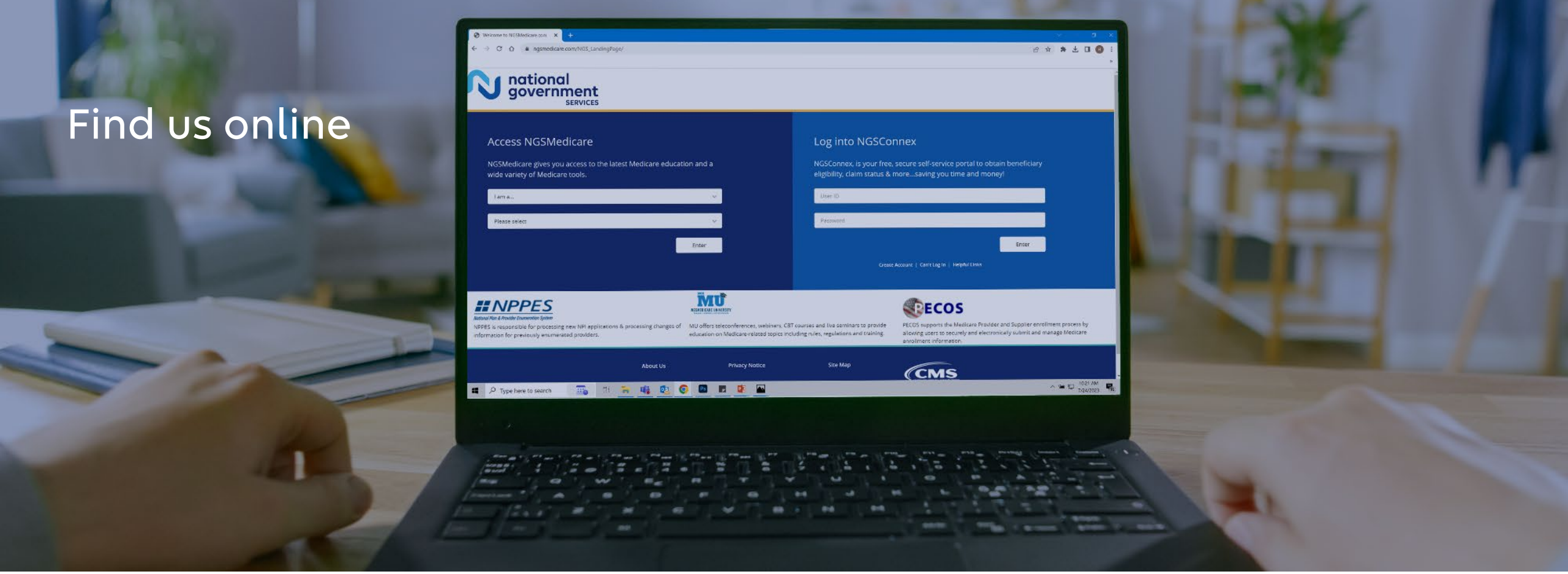

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