CAH Swing Bed Management

Basis SB 101 - Medicare Requirements

Webinar Series – Part 1
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HEALTHCARE EDUCATION FOUNDATION OF WEST VIRGINIA

Mary Guyot Consulting
207-650-5830 (cell/text)
maryguyotconsulting@gmail.com

Disclaimer

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Section 1 (detailed)

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What is Swing Bed

❑ Background

- Swing Bed is a hospital-based skilled care program located in a Critical Access Hospital (CAH) with a Medicare provider agreement that includes Centers for Medicare & Medicaid Services (CMS) approval to furnish swing bed services, where they may use their up to 25 beds as needed to furnish either acute or Skilled Nursing Facility (SNF)-level care.

- Swing Bed may also be found in Rural delineated PPS Acute Hospitals, provided under a Medicare Agreement, but limited to a specific number of swing beds (most likely limited to 10).

- Swing bed utilization maximizes the efficiency of operations by meeting unpredictable demands for acute and long-term care.

- Both CAHs and Rural PPS hospitals must be substantially in compliance with SNF participation requirements and are surveyed on a regular basis as are SNFs.

What is Swing Bed

Definition

- Swing bed is a comprehensive post-acute inpatient program for the individual who has had an acute medical or surgical event as a result of an illness, injury or exacerbation of a disease process. The patient needs these skilled services for a medical condition that is either:
  - A hospital-related medical condition that they were admitted with and treated during a qualifying 3-day inpatient hospital stay or
  - A skilled need that developed while hospitalized, even if it was not the reason they were admitted to the hospital
  - The patient's physician has decided that the patient need daily skilled care. It must be given by, or under the supervision of, skilled nursing or therapy staff

Medicare Regulations & Notes

- To receive, and retain approval to furnish post-acute SNF-level care via a swing bed agreement, hospitals must:
  - Be **located in a rural area**, which includes all areas that are not delineated as urbanized by the U.S. Census Bureau based on the most recent census for which data is published (an urbanized area does not include an urban cluster)
  - Have a **Medicare provider agreement as a hospital or CAH (25 beds or less)**
  - Have **fewer than 100 beds** (excluding beds for newborns and intensive care-type units) – usually limited to 10 SB per PPS hospital
  - **Not have had a swing bed approval terminated within the 2 years** previous to submission of the current application for swing bed approval (this requirement applies to all swing bed providers, including CAHs)
  - Be in **substantial compliance with SNF participation requirements**
    - 42 CFR § 485.645 - Special requirements for CAH providers of long-term care services ("swing-beds")
    - To be discussed during the CoP webinar
  - The Act **provides for payment for post-hospital SNF** care furnished by a rural hospital that has swing-bed approval

Medicare Regulations & Notes

- "Swing-bed" is a **reimbursement term** that means the care and reimbursement for the care of a patient in a small rural hospital or CAH "swings" from acute care to post hospital skilled nursing care (SNF) for a short period but remaining in the acute hospital. **A CAH or PPS hospital may have a SNF unit and use SB but SB patients may not be placed in the SNF unit**

- Certification to provide swing-beds is an **approval separate from the certification to operate as a CAH** or PPS hospital

- When a survey of swing bed program identifies issues, any **deficiencies and Plan of Correction** must be documented separate from the hospital survey

- **Recerts are usually conducted at the same time** as the CAH or PPS hospital
  - Important to remain in compliance at all times and not just when expecting a survey

- If the SB program is **voluntarily terminated** by the hospital or by CMS, that action does not affect the acute hospitals services

- Swing beds **do not have to be located in a special section** of the hospital or CAH unless the hospital or CAH chooses to do so such as using limited beds in Med/Surg

Medicare Regulations & Notes

- Hospitals paid under the Acute Care Hospital Inpatient Prospective Payment System (IPPS) and CAHs with approval to furnish swing bed services **may use any acute care inpatient bed** within the hospital or CAH for the provision of swing bed services, **with the exception of acute care inpatient beds in:**
  - Excluded rehabilitation or psychiatric distinct part unit
  - An intensive care-type unit
  - Newborn unit

- **Pros to moving the patient to a specific area** are as follows:
  - Easier for the patient to understand the different expectations such as dressed in street clothes, no daily provider visits, expected to participate in functional therapy if applicable, easier for staff to remember to use the rehab model and appropriate documentation for skilled care…

- **Cons to moving the patient** = less efficient for staff, an extra room to clean, may be disorienting to some patients

- There is **no length of stay restriction** for a swing-bed patient whether they are in a PPS hospital or a CAH as long as the patient has Medicare days left to use and has skilled needs.

Medicare Regulations & Notes

- Federal **does not require** acute hospitals **to discharge to a nursing home** for SNF care (vs SB) even when the NH has available beds
  - Patients may be discharged to a nursing home from SB (be it SNF or long-term care) as part of discharge planning, but it is not required. Discharge back to the community is what we strive for.

- A **transfer agreement** with the acute hospital is not required for SB as it is for a SNF in a nursing home.

- A **medical order in the chart by the physician is required** to change status from acute care to swing-bed because the patient is being discharged from acute care status and admitted to skilled level of care.
  - This is **necessary for reimbursement purposes** with different bill type and reimbursement amount for PPS
  - No timely orders = no pay (may not be added later)

Key Similarities & Differences Between SB and SNF

- **Admission criteria and Medicare eligibility** are the same with a few exception (see next slide)

- **PASRR** (Pre-Admission Screening/Resident Review – see next slide) is not required for SB given their short stay and - applies for a Nursing Home which is also Medicaid certified (One would presume that if your hospital is also Medicaid certified for skilled care – PASRR may be a requirement) – see 2 slides further

- Covid-19 – See waivers during the pandemic

https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf

- **Cost to the patient** are the same for Medicare beneficiaries regardless of where they go (SB or SNF)
  - CAHs are paid based on cost – everything except Dialysis are inclusions and added to the cost report – do make sure that all charges are captured
  - PPS SB and SNFs are paid based on PDPM system (Patient Driven Payment Model) – based on MDS

- Usually **SB programs can take higher acuity patients** due to RN staffing and ED physicians availability vs NH SNF. CAH's can also take higher cost report compared to PPS SB and SNFs since they are not cost-based but rather on a per diem and some exceptions.

Exceptions To Be Aware Of:

- **SNF (and not SB)** have a 3-midnight waiver if they participate in the (Comprehensive Care for Joint Replacement) CJR bundling program (a Medicare program)
  - CJR is a payment model being tested for episodes of care related to total knee and total hip replacements (MS-DRG 469 and 470)
  - The model began April 1, 2016 and will run through December 31, 2020. CJR holds participant hospitals financially accountable for the quality and cost of an episode of care and incentivizes increased coordination among participating hospitals, physicians, and post acute care providers.
  - An episode of care begins with a patient's hospital admission, continues upon hospital discharge, and ends 90 days post discharge to cover the patient's complete period of recovery.
  - As of February 1, 2018, about 465 hospitals in 67 metropolitan statistical areas are participating in CJR.
  - See website below: Comprehensive Care for Joint Replacement (CJR) Model Frequently Asked Questions - https://innovation.cms.gov/Files/x/cjr-faq.pdf

  - Only SNFs with an overall star rating of three stars or better for at least 7 of the preceding 12 months of the rolling data used to create the quarterly approved list.
    - CAH SB programs do not have a star rating – PPS SB does have quality measures but a staffing system they have in the STAR rating does not apply to SB

PASRR - Preadmission Screening and Resident Review

- **There is no need for a PASRR from acute to SB**
- Preadmission Screening and Resident Review (PASRR) is a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long term care. PASRR requires that 1) all applicants to a Medicaid-certified nursing facility be evaluated for serious mental illness (SMI) and/or intellectual disability; 2) be offered the most appropriate setting for their needs (in the community, a nursing facility, or acute care settings); and 3) receive the services they need in those settings.

- PASRR is an important tool for states to use in rebalancing services away from institutions and towards supporting people in their homes, and to comply with the Supreme Court decision, Olmstead vs L.C. (1999), under the Americans with Disabilities Act, individuals with disabilities cannot be required to be institutionalized to receive public benefits that could be furnished in community-based settings. PASRR can also advance person-centered care planning by assuring that psychological, psychiatric, and functional needs are considered along with personal goals and preferences in planning long term care.

- In brief, the PASRR process requires that all applicants to Medicaid-certified Nursing Facilities be given a preliminary assessment to determine whether they might have SMI or (ID). This is called a "Level I screen." Those individuals who test positive at Level I are then evaluated in depth, called "Level II" PASRR. The results of this evaluation result in a determination of need, determination of appropriate setting, and a set of recommendations for services to inform the individual's plan of care.

- Regulations governing PASRR are found in the Code of Federal Regulations, primarily at 42 CFR 483.100-138.
  https://www.medicaid.gov/medicaid/ltss/institutional/pasrr/index.html

When Should We Consider SNF vs SB

- Patient was a resident of a NH which has SNF level of care and they can meet the patient's needs
- Medically stable
- Low skill care needs
- Mostly custodial care level
- Long term skill needs and most likely will need long-term care (some literature refer to a need of greater than 40 days but not mandatory)
- Patient/family preference when the physician is comfortable with the plan

Medicare Structure

- Medicare is the federal health insurance program created in 1965 for all people **age 65 and older** regardless of their income or medical history, and now covers 44+ million Americans

- Most people age 65 and older are **entitled to Medicare Part A** if:
  - They or their spouse are eligible for Social Security payments and have made payroll tax contributions for 10 or more years.
  - If the patient is already getting benefits from Social Security or the Railroad Retirement Board (RRB), they will automatically get Part A and Part B starting the first day of the month they turn 65. (If their birthday is on the first day of the month, Part A and Part B will start the first day of the prior month)

- Medicare was expanded in 1972 to include people **under age 65 with permanent disabilities**.
  - People under age 65 who receive **Social Security Disability Insurance (SSDI)** generally become eligible for Medicare after a **two-year waiting period**,
  - While those with **End Stage Renal Disease (ESRD) and Lou Gehrig's disease** become eligible for Medicare **when they begin receiving SSDI payments**

- Acute and SNF Care Managers, Discharge Planners and Financial Advisors should review the **Medicare documents available to all on the CMS website**. (See next slide)

Medicare Structure

❑ Medicare is organized into four parts

- **Part A** pays for inpatient hospital, skilled nursing facility, home health post acute or Skilled care, acute IP rehab, psych hospital and hospice care.

- **Part B** pays for physician, outpatient services, and home health visits when not preceded by an acute IP stay and preventive services.

- **Part D** is the outpatient prescription drug benefit, delivered through private plans that contract with Medicare. The benefit includes additional assistance with plan premiums and cost-sharing amounts for low-income beneficiaries. Part D is funded by general revenues, beneficiary premiums, and state payments

- **Part C** refers to the Medicare Advantage program,
  - Medicare Advantage (MA) is a United States health insurance program of managed health care (preferred provider organization (PPO) or health maintenance organization (HMO)) that serves as a substitute for "Original Medicare" Parts A and B Medicare benefits

  - These plans offer combined coverage of Part A, Part B, and in most cases, Part D (prescription drug) benefits

  - Medicare Advantage must cover at least the same benefits covered under Medicare Part A and Part B. But, they may deny paying “cost” at a CAH or only contract with SNFs They may have extra benefits, like coverage for prescription drugs or extra days in the hospital

Medicare Coverage

- **Medicare & You – 2021**
  - https://www.medicare.gov/Pubs/pdf/10050-Medicare-and-You.pdf
  - What does Part A cover? Part A (Hospital Insurance) helps cover:
    - Inpatient care in a hospital
    - Inpatient care in a skilled nursing facility (not custodial or long-term care)
    - Hospice care
    - Home health care
    - Inpatient care in a religious non-medical health care institution

- Covers Original Medicare and Medicare Advantage

Contents

Medicare Coverage

Your Medicare Coverage

- https://www.medicare.gov/coverage/skilled-nursing-facility-snf-care
- Medicare.gov
- See site below for SB/SNF copayment
- https://www.medicare.gov/your-medicare-costs/medicare-costs-at-a-glance

Skilled nursing facility stay

- Days 1–20: $0 for each benefit period .
- Days 21–100: $176 ($185.50 in 2021) coinsurance per day of each benefit period.
- Days 101 and beyond: all costs.

- Co-payment is paid by secondary insurance or self-pay but mostly not Medicaid (may be some differences in States

Medicare Qualifying Stay

- Basic qualification for SB & SNF
  - **Enrolled** in Medicare Part A (Original & Medicare Advantage)
  - Has **100 days** total for skilled care per spell of illness
  - These **days are accumulative for the same or different condition** in a consecutive stretch of days within the spell of illness
  - **Has days available** to use
  - Three **consecutive** day qualifying stay in acute care hospital (**3 midnights) within the last 30 days** **(except COVID waiver)**
    - **Observation** stay still does not count has part of the 3 days
      - Remember that the **MOON** is a CMS requirement for PPS and CAH hospitals and **for both Medicare and Medicare Advantage**
    - Remember that a patient in Observation who ends up needing **greater than 2 MN** can be changed to IP but 3 MN for SNF/SB only starts from when the IP order is written
    - 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

Medicare Qualifying Stay

- Basic qualification for SB/SNF (cont')

  - **Has skilled needs 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

  - "Applicable to be hospital condition" **need not have been the principal diagnosis that precipitated the beneficiary's admission to the hospital,** but could be any one of the conditions present during the qualifying hospital stay

  - Patient may be admitted to SB/SNF and readmitted to a SB/SNF **within the last 30 days of discharge without a new 3-day acute stay if reason for admission is related to the original acute or SB/SNF stay** (different scenarios to be discussed)

Medicare Qualifying Stay

- Basic qualification for SNF/SB (cont')

  - **In addition, the qualifying hospital stay must have been medically necessary**. Medical necessity will generally be presumed to exist except:

    - When the facts that come to the intermediary's attention during the course of its normal **claims review process indicate that the hospitalization may not have been medically necessary**, it will fully develop the case, checking with the attending physician and the hospital, as appropriate.

    - **The intermediary will rule the stay unnecessary only when hospitalization for 3 days represents a substantial departure from normal medical practice.** However, in accordance with Pub. 100-04, Medicare Claims Processing Manual, chapter 30, section 130.2.A, when a beneficiary qualifies for limitation of liability in connection with the hospital stay (or a portion thereof), this conclusively establishes that the hospital stay (or portion thereof) was not medically necessary.

Medicare Qualifying Stay

- Basic qualification for SB/SB (cont')
  - 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
  - **NOTE**: 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 SB/SNF setting, the term **"non-covered care" refers to any level of care less** intensive than the SB/SNF level of care that is covered under the program
  - **Medicare Advantage and other commercial insurance**
    - Usually do not require the 3-day qualifying stay
    - May have agreements with specific programs only
    - Admission criteria are sometimes stricter (ie: amount of required therapy)
    - Pre-cert is a requirement

Three-Day Prior Hospitalization - Foreign Hospital

- A stay of three or more days in a **hospital outside the United States** may satisfy the prior inpatient stay requirement for post-hospital extended care services within the United States if the foreign hospital is qualified as an "emergency hospital"

- If a stay of three or more days in a hospital outside the United States is being considered to satisfy the prior inpatient stay requirement, the SB/SNF will submit documentation to the intermediary.
  - See Medicare Benefit Policy Manual Chapter 8 – page 9 & 10
  - https://mdsfordummies.com/content/medicare-benefit-policy-manual-chapter-8-coverage-extended-care-snf-services-under-hospital?page=9

- **Physician Hold / Deferred Covered Treatment** allows an exception to the "within 30 days of hospitalization" – see next slides

Physician Hold/Deferred Covered Treatment

❑ 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**
  - Example: need to learn to transfer before he goes home or needs IP IV antibiotic

- 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. (See example 1 below.)

- 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 (see example 2).

- 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 (see example 3).

Physician Hold…

- If a physician hold occurs where 30 days or more has elapsed since a level of care change, the SNF/swing bed provider will start the Medicare assessment schedule on the first day that Part A SNF-level services started

- The physician will write an order to start therapy when the patient is able to do weight bearing within 4 to 6 weeks. Once the patient is able to start the therapy then the Medicare 100-day count will start the first day that the patient is able to start therapy services or will start from where you left off if less than 60 days since last SNF stay if applicable

  - The patient may be discharged to home or LTC during the wait period or at a custodial level of care which will change to SB/SNF when patient is ready to start therapy
  - **When admitted to SB/SNF, the biller must be notified of the situation and use "condition code 56 – medical appropriateness" on the UB-04**

- When a patient's medical needs and the course of treatment are **not predictable** at the time of hospital discharge (such as CHF, COPD, CA..) 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 SB/SNF more than 30 days after discharge from the hospital is not justified under this exception to the 30-day rule

Physician Hold...

- **EXAMPLE 1:**
  - A patient who has had an **open reduction of a fracture of the femoral neck** and has a history of diabetes mellitus and angina pectoris is discharged from the hospital on January 30, 1991 and admitted immediately to a SB/SNF. He requires, among other services, careful skin care, appropriate oral medications, a diabetic diet, a therapeutic exercise program to preserve muscle tone and body condition, and observation to detect signs of deterioration in his condition or complications resulting from his restricted mobility, which necessitates skilled management of his care to ensure his safety and recovery. It is medically predictable that when he is medically allowed to bear weight on the affected limb, skilled rehabilitative services will be required. After he is in the SNF for two days, he becomes unhappy and at his request is released to his home in the care of a full time private duty nurse. Five weeks later, when he reaches weight bearing, he is readmitted to the SNF for the needed rehabilitative care. The patient would be eligible for coverage under the program for the care furnished him during both of these stays.

Physician Hold...

- **EXAMPLE 2:**
  - An individual is admitted to a SNF for daily skilled rehabilitative care that, as a practical matter, can be provided only on an inpatient basis in a SNF. After three weeks, the therapy is discontinued because the patient's condition has stabilized, and daily skilled services are no longer required. Six weeks later, however, as a result of an unexpected change in the patient's condition, daily skilled services are again required. Since the second period of treatment did not constitute care which was predictable at the time of hospital discharge and thus could not be considered as care which was deferred until medically appropriate, it would not represent an exception to the 30-day exception rule. Therefore, since more than 30 days of noncovered care had elapsed between the last period of covered care and the reinstitution of skilled services, payment could not be made under the extended care benefit for the latter services.

Physician Hold…

- **EXAMPLE 3:**
  - A patient whose right leg was amputated was discharged from the hospital and admitted directly to a SNF on January 30, 2016. Although upon admission to the SNF the patient required help with meeting his activities of daily living, he did not require daily skilled care. Subsequently, however, after the stump had healed, daily skilled rehabilitative services designed to enable him to use a prosthesis were required. Since at the time of the patient's discharge from the hospital it was medically predictable that covered SNF care would be required at a predeterminable time interval, and since such care was initiated when appropriate, the patient would be entitled to extended care benefits for the period during which such care was provided.

Spell of Illness

- Must have **60 days (ending with the close of the first period of 60 consecutive days)** with no Medicare Part A services (Acute Care or Acute Rehab, SNF/SB, Psych hospital, LTC Hospital) for a new set of 100 days to apply

  - This still holds **even if the patient has a brand-new condition** such as a stroke on day 1 and a hip fracture on day 35 – this case requires new 3 midnight minimum but does not get a new 100 days because they were less then 60 days out of an IP part A bed.

  - This has **nothing to do with IP lifetime days**

Spell of Illness

- **How do I know to look at 30 days or 60 days:**
  - **30 Days**
    - For patients who were discharged from an acute IP stay or SB/SNF stay and we are trying to figure out if they can be re-admitted directly to a skilled bed or not if they do not meet acute criteria
      - Present need for skilled care is related to the last acute admission = yes
      - 30 days or less since last Part A admission = yes
        - In determining the 30-day transfer period, **the day of discharge from the hospital or SNF is not counted in the 30 days** (e.g., D/C on 8/1 – start counting from 8/2)
          - **But only if** the reason for admission is related to the acute hospitalization, they had within the last 30 days
      - Start counting days where you left off if they had a previous SB/SNF stay
        - IE: patient had a 4-day acute stay with acute pneumonia – followed by SB for 7 days and discharged to home for 5 days and now needs to be readmitted with sequala from the pneumonia = can be readmitted directly to SB but Medicare days will start on day 8

Spell of Illness

- **How do I know to look at 30 days or 60 days:**
  - **60 Days**
    - For patients who have had a skilled (Medicare SNF) stay in the past and we want to know if we start on a new 100 days or from where we left off
      - In determining the 60-day transfer period, **the day of discharge from the hospital or the SNF is not counted in the 60 days**
      - **Less than 60 days but greater than 30 days** = new acute admit for a minimum of 3 midnights and we start the count where we left off
      - **Greater than 60 days** = requires new qualifying stay and start the day count at “1” of a new set of 100 days

Spell of Illness

❑ Determining Options for skilled care

- How many days has the patient been home, LTC, Assisted Living, living with child/friend etc… since the last acute care hospital (Medical, Rehab, Psych), skilled care discharge (SNF/NH Medicare bed, SB, SNF Distinct Part Unit [DPU]) or LTAC?
  - **If within 30 days or less, and for same reason** as the qualifying stay, the patient can be admitted directly to a skilled bed if he does not meet criteria for acute
  - If within 30 days for same reason and meets criteria for acute but only for 1 or 2 days, the patient can be transferred to a SNF/SB w/out the full 3-day qualifying stay after the 1-2 days in acute as long as the previous stay is used for the "qualifying stay" on the bill
  - If within 30 days but new condition, the patient then needs a new 3 day qualifying stay

Lowering level of Care in Acute

- 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.

- In addition, when a hospital inpatient's care needs drop from acute - to SNF-level but **no SNF bed is available**, the regulations at 42 CFR 424.13(c) **permit a physician to certify that the beneficiary's continued inpatient stay in the hospital** is, in fact, medically necessary under this particular set of circumstances (see also Pub. 100-01, Medicare General Information, Eligibility, and Entitlement Manual, chapter 4, section 10.6). Accordingly, such additional, "alternate placement" days spent in the hospital can be included in the 3-day count toward meeting the SNF benefit's qualifying hospital stay requirement.

Medicare Benefit Policy Manual

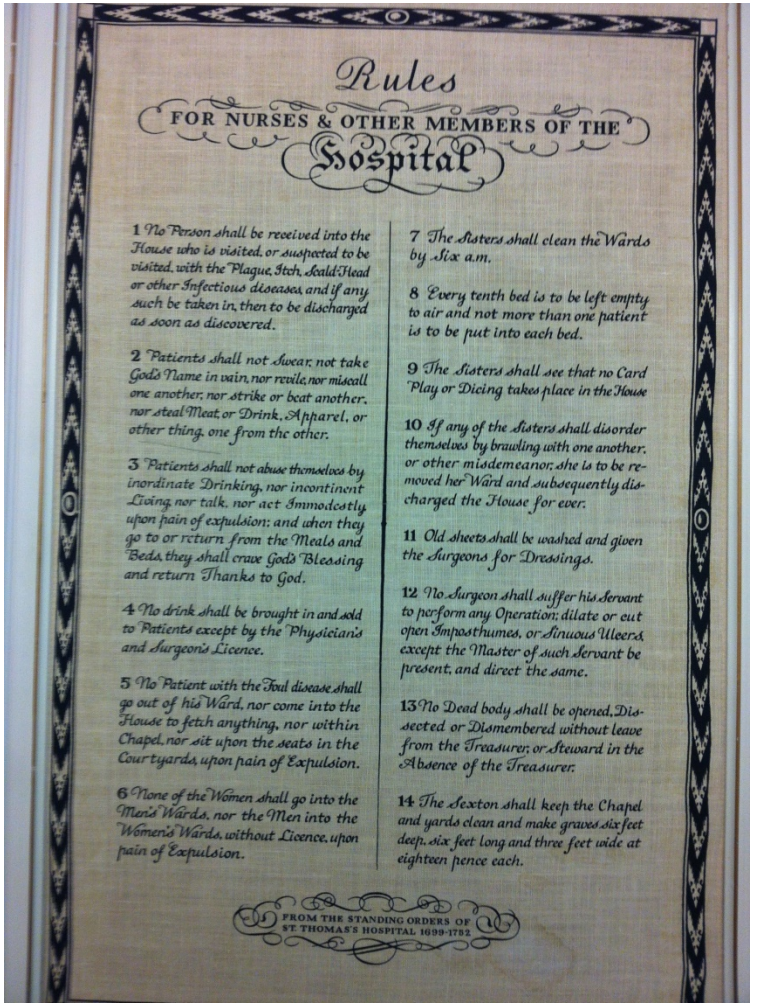
Chapter 8 - Coverage of Extended Care (SNF) Services Under Hospital Insurance

SNF/SB for Other Than Medicare

- Can be cost-based as original Medicare or with contract
- Medicare Advantage – contract are with a pre-approved per diem rate or case-by-case. Very important for the Care Manager to know what $$ amount those are to help determine acceptance of external referrals
- How we get paid from other payers depends on the mutually approved contract for skilled care
- Important to review your contract to see if it covers skilled level of care
- Look for opportunities to go out of contract as needed when cost of care is higher than the payment (e.g., contract per diem + cost of expensive IV med)
- Different payers may have different admission criteria e.g.:
  - 3 midnight acute hospital stay not required for most, if not all commercial payers
  - Therapy 7 days/week
  - Patient requires 2 hrs. of therapy/day
    - Otherwise patient to be admitted in a NH SNF bed
  - Other
- Some payers have different levels of pay depending on services required
- Hospice Care – different contract (skilled and respite)
- Patient on dialysis as mentioned before is billed by the dialysis provider for both Medicare and Medicare Advantage

Admission Requirement

"Hurry Doctor!
This man has Saturday Night Fever!"



Rules
FOR NURSES & OTHER MEMBERS OF THE
Hospital

1 No Person shall be received into the House who is visited, or suspected to be visited, with the Plague, Itch, Scald-Head or other Infectious diseases, and if any such be taken in, then to be discharged as soon as discovered.

2 Patients shall not Swear, not take God's Name in vain, nor revile, nor miscall one another, nor strike or beat another, nor steal Meat, or Drink, Apparel, or other thing, one from the other.

3 Patients shall not abuse themselves by inordinate Drinking, nor incontinent Living, nor talk, nor act Immodestly upon pain of expulsion: and when they go to or return from the Meals and Beds, they shall crave God's Blessing and return Thanks to God.

4 No drink shall be brought in and sold to Patients except by the Physician's and Surgeon's Licence.

5 No Patient with the Foul disease shall go out of his Ward, nor come into the House to fetch anything, nor within Chapel, nor sit upon the seats in the Court yards, upon pain of Expulsion.

6 None of the Women shall go into the Men's Wards, nor the Men into the Women's Wards, without Licence, upon pain of Expulsion.

7 The Sisters shall clean the Wards by Six a.m.

8 Every tenth bed is to be left empty to air and not more than one patient is to be put into each bed.

9 The Sisters shall see that no Card Play or Dicing takes place in the House

10 If any of the Sisters shall disorder themselves by brawling with one another, or other misdemeanor, she is to be removed her Ward and subsequently discharged the House for ever.

11 Old sheets shall be washed and given the Surgeons for Dressings.

12 No Surgeon shall suffer his Servant to perform any Operation; dilate or cut open Imposthumes, or Sinuous Ulcers, except the Master of such Servant be present, and direct the same.

13 No Dead body shall be opened, Dissected or Dismembered without leave from the Treasurer, or Steward in the Absence of the Treasurer.

14 The Sexton shall keep the Chapel and yards clean and make graves six feet deep, six feet long and three feet wide at eighteen pence each.

FROM THE STANDING ORDERS OF ST. THOMAS'S HOSPITAL 1699-1782

Admission Requirement

- https://mdsfordummies.com/content/medicare-benefit-policy-manual-chapter-8-coverage-extended-care-snf-services-under-hospital?page=1

- Medicare Benefit Policy Manual Chapter 8 - **Coverage of Extended Care (SNF) Services** Under Hospital Insurance
  Table of Contents (Rev. 261, 10-04-19)

- Important to know that there are five broad categories of Skilled Care which documentation must support:
  - Observation and assessment
  - Management and evaluation
  - Teaching and training
  - Direct skilled nursing services
  - Direct skilled rehabilitation services (will be discussed during the next webinar)

Admission Requirement

- ***Pre-Admission Requirement - The beneficiary must***:
  - Have been hospitalized in a participating or qualified hospital or participating CAH, for medically necessary **inpatient hospital or inpatient CAH care, for at least 3 consecutive calendar days, not counting the date of discharge**; and
  - **Have been discharged from the hospital or CAH in or after the month he or she attained age 65**, or in a month for which he or she was entitled to hospital or CAH insurance benefits on the basis of disability or end-stage renal disease.

- ***Date of admission requirements***
  - (1) The beneficiary must be in need of posthospital SNF care, be admitted to the facility, and receive the **needed care within 30 calendar days after the date of discharge from a hospital or CAH except with Physician Hold**

- **Level of Care Requirement** : ***skilled nursing and skilled rehabilitation services*** **means services that:**
  - Are ordered by a physician
  - Require the skills of technical or professional personnel such as RNs, LPNs/LVNs, PT, PTA, OT, COTA, SLP or audiologists; and
  - Are furnished directly by, or under the supervision of such personnel

Admission Requirement

- **Skilled care is nursing, or other rehabilitative services provided under the direction of a physician**. To be reimbursed, this care must meet **Medicare standards** and be received in a Medicare-approved facility such as a Medicare-certified Skilled Nursing Facility (SNF). Same applies to swing beds

- Skilled care requires the **involvement of skilled nursing or rehabilitative staff** in order to administer, manage, observe, and evaluate resident/patient care safely and effectively, as well as treat patients.

- Skilled **nursing care** is provided to help improve the patient's condition, or to maintain the patient's current condition and prevent it from getting worse

- Skilled **rehabilitation care** is provided to help improve the patient's condition within a predetermined time period, or to set up a maintenance program that is designed to maintain the patient's current condition and prevent it from getting worse. **Skilled care also helps the patient function more independently and/or helps the patient** learn to take care of personal health needs.

- Generally, skilled care is **necessary only for a short time after a hospitalization**. Care that can be given by non-professional staff is not considered skilled care. **Medicare does not cover custodial care that helps with usual daily activities like walking, eating, or bathing, when that is the only kind of care that a beneficiary needs.** Custodial care may be needed for a much longer period of time.

Admission Requirement

- If the inherent complexity of a service prescribed for a patient is such that it **can be performed safely and/or effectively only by or under the general supervision of skilled nursing or skilled rehabilitation personnel**, the service is a skilled service; e.g., the administration of intravenous feedings and intramuscular injections; the insertion of suprapubic catheters; and ultrasound, shortwave, and microwave therapy treatments.

- The intermediary or MAC **considers the nature of the service and the skills required for safe and effective delivery of that service** in deciding whether a service is a skilled service.

- While a patient's particular medical condition is a valid factor in deciding if skilled services are needed, a **patient's diagnosis or prognosis should never be the sole factor in deciding that a service is not skilled.**

- When rehabilitation services are the primary services, the key issue is whether the skills of a therapist are needed. **The deciding factor is not the patient's potential for recovery, but whether the services needed require the skills of a therapist or whether they can be provided by nonskilled personnel.**

- The daily skilled services must be ones that, as a practical matter, **can only be provided in a SB/SNF on an inpatient basis**

Admission Requirement

- ***Criteria for skilled services and the need for skilled services.***

  To be considered a skilled service, the service must be so inherently complex or because of special medical complications that it **can be safely and effectively performed only by, or under the supervision of professional or technical personnel. In these cases, the complications and special services involved must be documented by physicians' orders and nursing or therapy notes.**

  - For example, a **plaster cast on a leg** does not usually require skilled care. However, if the patient has a preexisting acute skin condition or needs traction, skilled personnel may be needed to adjust traction or watch for complications.

  - **Whirlpool baths** do not ordinarily require the skills of a qualified physical therapist. However, the skills, knowledge, and judgment of a qualified physical therapist might be required where the patient's condition is complicated by circulatory deficiency, areas of desensitization, or open wounds

  - In determining whether services rendered in a SB/SNF constitute covered care, it is necessary to determine whether individual services are skilled, and whether, **in light of the patient's total condition, skilled management of the services provided is needed** even though many or all of the specific services were unskilled.

Admission Requirement

- **Some examples of direct skilled nursing services are:**
  - Intravenous or intramuscular injections and intravenous feeding;
  - Enteral feeding that comprises at least 26 percent of daily calorie requirements and provides at least 501 milliliters of fluid per day;
    - An initial tube feeding can be kept in a SB/SNF for 100 days but they would need 60 days out of an IP program (acute, SB, SNF, IRF, Psych in order to regain skilled days for other reason (to be discussed)
  - Naso-pharyngeal and tracheotomy aspiration;
  - Insertion, sterile irrigation, and replacement of suprapubic catheters;
  - Applications of dressings involving prescription medication and aseptic techniques
  - Treatment of decubitus ulcers (see next slides) or a widespread skin disorder
  - Tracheostomy care, ventilator/respirator, and/or infection isolation.
  - Heat treatments which have been specifically ordered by a physician as part of active treatment and which require observation by skilled nursing personnel to evaluate the patient's progress adequately
  - Rehabilitation nursing procedures, including the related teaching and adaptive aspects of nursing, that are part of active treatment and require the presence skilled nursing personnel; e.g., the institution and supervision of a bowel and bladder program
  - Initial phases of a regimen involving administration of medical gases such as bronchodilator therapy
  - Care of a colostomy during the early post-operative period in the presence of associated complications. The need for skilled nursing care during this period must be justified and documented in the patient's medical record

Admission Requirement

- **Skilled nursing services based on MDS 3.0**

  Some ADL limitation and receiving complex clinical care or have serious medical conditions involving any one of the following:

  - Comatose with more than custodial care needs
  - Septicemia,
  - New diabetes with insulin injections and insulin order changes,
  - COPD with shortness of breath when lying flat,
  - Fever with pneumonia, vomiting, weight loss, or tube feeding meeting intake requirement,
  - Parenteral/IV feeding, IV therapy (medication, hydration..)
  - Transfusions
  - Respiratory therapy 7 days per week (see requirements on later slide)

Admission Requirement

- **Skilled nursing services based on MDS 3.0 (cont')**
  - Multiple sclerosis with some ADL dependency
  - Parkinson's disease with some ADL with dependency
  - Respiratory failure and oxygen therapy while a patient,
  - Enteral feeding that comprises at least 26 percent of daily calorie requirements and provides at least 501 milliliters of fluid per day;
  - Ulcer treatment with two or more ulcers including venous ulcers, arterial ulcers or Stage II pressure ulcers,
  - Ulcer treatment with any Stage III or IV pressure ulcer,
  - Foot infections or wounds with application of dressing,
  - Radiation therapy while needing an inpatient program,
  - Pneumonia with medical/physical issues requiring assessments/tx,
  - Hemiplegia with ADL dependency,
  - Surgical wounds or open lesions with treatment,
  - Burns with treatment,
  - Chemotherapy while needing an inpatient program,
  - Non-chronic oxygen therapy while a patient

Admission Requirement

- **Examples of direct skilled rehab services**
  - The services must be provided with the expectation, based on the assessment made by the physician of the patient's restoration potential, that the condition the patient will improve materially in a reasonable and generally predictable period of time, or the services must be necessary for the establishment of a safe and effective maintenance program.
  - The services must be considered under accepted standards of medical practice to be specific and effective treatment of the patient's condition and,
  - The services must be reasonable and necessary for the treatment of the patient's condition; this includes the requirement of the amount, frequency and duration of the services must be reasonable

Admission Requirement

- **Examples of skilled nursing and rehabilitation services:**

  (a) *Services that could qualify as either skilled nursing or skilled rehabilitation services*

  (1) ***Overall management and evaluation of care plan***

  – (i) When overall management and evaluation of care plan *constitute skilled services.* **The development, management, and evaluation of a patient care plan based on the physician's orders constitute skilled services when**, because of the patient's physical or mental condition, those **activities require the involvement of technical or professional personnel in order to meet the patient's needs, promote recovery, and ensure medical safety**. Those activities include the management of a plan involving a variety of personal care services only when, in light of the patient's condition, the aggregate of those services requires the involvement of technical or professional personnel.

Admission Requirement

- **Examples of skilled nursing and rehabilitation services:**

  Example. An **aged patient with** a history of **diabetes mellitus and angina** pectoris who is **recovering from an open reduction of a fracture of the neck of the femur requires**, among other services, **careful skin care, appropriate oral medications, a diabetic diet, an exercise program to preserve muscle tone and body condition, and observation to detect signs of deterioration in his or her condition or complications resulting from restricted, but increasing, mobility**. Although any of the required services could be performed by a properly instructed person, such a person would not have the ability to understand the relationship between the services and evaluate the ultimate effect of one service on the other. **Since the nature of the patient's condition, age, and immobility create a high potential for serious complications, such an understanding is essential to ensure the patient's recovery and safety**. Under these circumstances, the management of the plan of care would require the skills of a nurse even though the individual services are not skilled. Skilled planning and management activities are not always specifically identified in the patient's clinical record. Therefore, if the patient's overall condition supports a finding that recovery and safety can be ensured

Admission Requirement

❑ Management and Evaluation of a Patient Care Plan

- An aged patient is **recovering from pneumonia, is lethargic, is disoriented, has residual chest congestion, is confined to bed as a result of his debilitated condition, and requires restraints at times**. To decrease the chest congestion, the physician has prescribed frequent changes in position, coughing, and deep breathing. While the residual chest congestion alone would not represent a high-risk factor, **the patient's immobility and confusion represent complicating factors which, when coupled with the chest congestion, could create high probability of a relapse**. In this situation, skilled overseeing of the nonskilled services would be reasonable and necessary, pending the elimination of the chest congestion, to assure the patient's medical safety.

- Skilled planning and management activities are not always specifically identified in the patient's clinical record. Therefore, if the patient's overall condition supports a finding that recovery and safety can be assured only if the total care, skilled or not, is planned and managed by skilled nursing personnel, the intermediary assumes that skilled management is being provided even though it is not readily discernible from the record. **It makes this assumption only if the record as a whole clearly establishes that there was a likely potential for serious complications without skilled management.**

Admission Requirement

- ***Observation and assessment of the patient's changing condition—When observation and assessment constitute skilled services.***

- Observation and assessment constitute skilled services when the skills of a technical or professional person are required to identify and evaluate the patient's need for modification of treatment or for additional medical procedures until his or her condition is stabilized.

- **Example 1***: (GREAT EXAMPLES)*
- *A patient with* **arteriosclerotic heart disease with congestive heart failure** *requires close observation by skilled nursing personnel for signs of decompensation, abnormal fluid balance, or adverse effects resulting from prescribed medication. Skilled observation is needed to determine whether the digitalis dosage should be reviewed or whether other therapeutic measures should be considered, until the patient's treatment regimen is essentially stabilized. The medical documentation must describe the skilled services that require the involvement of nursing personnel to promote the stabilization of the patient's medical condition and safety*

Admission Requirement

❑ *Observation and assessment (cont')*

- **Example 2**:
- A patient has undergone **peripheral vascular disease treatment including revascularization p**rocedures (bypass) with open or necrotic areas of skin on the involved extremity. Skilled observation and monitoring of the vascular supply of the legs is required. The medical documentation must describe the skilled services that require the involvement of nursing personnel to promote the patient's recovery and medical safety in view of the patient's overall condition.

- **Example 3**:
- A patient has undergone **hip surgery and has been transferred to a SNF. Skilled observation and monitoring** of the patient for possible adverse reaction to the operative procedure, development of phlebitis, or skin breakdown, is both reasonable and necessary. The medical documentation must describe the skilled services that require the involvement of nursing personnel to promote the patient's recovery and medical safety in view of the patient's overall condition.

Admission Requirement

❑ *Observation and assessment (cont')*

- **Example 4**:
- A patient has been **hospitalized following a heart attack, and following treatment but before mobilization, is transferred to the SNF.** Because it is unknown whether exertion will exacerbate the heart disease, skilled observation is reasonable and necessary as mobilization is initiated, until the patient's treatment regimen is essentially stabilized. The medical documentation must describe the skilled services that require the involvement of nursing personnel to promote the stabilization of the patient's medical condition and safety.

- **Example 5**:
- A **frail 85-year-old man was hospitalized for pneumonia. The infection was resolved, but the patient, who had previously maintained adequate nutrition, will not eat or eats poorly**. The patient is transferred to a SNF for monitoring of fluid and nutrient intake, assessment of the need for tube feeding and forced feeding if required. Observation and monitoring by skilled nursing personnel of the patient's oral intake is required to prevent dehydration. The medical documentation must describe the skilled services that require the involvement of nursing personnel to promote the patient's recovery and medical safety in view of the patient's overall condition.

Admission Requirement

❑ *Observation and assessment (cont')*

- **Example 6**:
- A patient with **congestive heart failure** may require continuous close observation to detect signs of decompensation, abnormal fluid balance, or adverse effects resulting from prescribed medication(s) that serve as indicators for adjusting therapeutic measures. The medical documentation must describe the skilled services that require the involvement of nursing personnel to promote the patient's recovery and medical safety in view of the patient's overall condition, to maintain the patient's current condition, or to prevent or slow further deterioration in the patient's condition.

- If a patient was admitted for skilled observation **but did not develop a further acute episode or complication, the skilled observation services still are covered so long as** there was a reasonable probability for such a complication or further acute episode. **"Reasonable probability"** means that a potential complication or further acute episode was a likely possibility.

- **Information from the patient's medical record must document that there is a reasonable potential for a future complication or acute episode sufficient to justify the need for continued skilled observation and assessment.**

Admission Requirement

❑ *Observation and assessment (cont')*

- **Such signs and symptoms as abnormal/fluctuating vital signs, weight changes, edema, symptoms of drug toxicity, abnormal/fluctuating lab values, and respiratory changes on auscultation may justify skilled observation and assessment.** Where these signs and symptoms are such that there is a reasonable potential that skilled observation and assessment by a licensed nurse will result in changes to the treatment of the patient, then the services are reasonable and necessary.

- **However, observation and assessment by a nurse is not reasonable and necessary to the treatment of the illness or injury where these characteristics are part of a longstanding pattern of the patient's waxing and waning condition which by themselves do not require skilled services and there is no attempt to change the treatment to resolve them.**

- Skilled observation and assessment may also be required for patients whose primary condition and needs are **psychiatric** in nature or for patients who**, in addition to their physical** problems, have a secondary psychiatric diagnosis.

- These patients may exhibit acute psychological symptoms such as depression, anxiety or agitation, which require skilled observation and assessment such as observing for indications of suicidal or hostile behavior. **However, these conditions often require considerably more specialized, sophisticated nursing techniques and physician attention than is available in most participating SNF/SBs.**

Admission Requirement

- ***Patient education services—When patient education services constitute skilled services.***

- Teaching and training activities, which require skilled nursing or skilled rehabilitation personnel to teach a patient how to manage their treatment regimen, would constitute skilled services. Some examples are:
- Teaching self-administration of injectable medications or a complex range of medications;
- Teaching a newly diagnosed diabetic to administer insulin injections, to prepare and follow a diabetic diet, and to observe foot-care precautions;
- Teaching self-administration of medical gases to a patient;
- Gait training and teaching of prosthesis care for a patient who has had a recent leg amputation;
- Teaching patients how to care for a recent colostomy or ileostomy;
- Teaching patients how to perform self-catheterization and self-administration of gastrostomy feedings;
- Teaching patients how to care for and maintain central venous lines, such as Hickman catheters;
- Teaching patients the use and care of braces, splints and orthotics, and any associated skin care; and
- Teaching patients the proper care of any specialized dressings or skin treatments.
- **The documentation must thoroughly describe all efforts that have been made to educate the patient/caregiver, and their responses to the training. The medical record should also describe the reason for the failure of any educational attempts, if applicable.**

End of Life Benefit

- Although there isn't any direct end-of-life benefit under Medicare Part A in a SNF, there are many times when a person who is at end-of-life receives Medicare benefits in a SNF:
  - The beneficiary can elect their Medicare Hospice benefit, which provides some benefits in the SNF (but not room and board) – hospice pays hospitals based on contract
  - **If a beneficiary, even at the end of life, requires skilled care or services and meets all the requirements** (e.g., 3-day hospital stay, treatment within 30 days of the hospital stay, has a skilled therapy need that would benefit from skilled care, etc), then **that person would be entitled to the skilled care under Medicare. The skilled service is not related to the end of life necessarily, just to the need of the patient**

- **Medical needs or skilled therapy may be needed, and improvement in a patient's condition may occur, even where a chronic or terminal condition exists. The fact that a full or partial recovery is not possible does not necessarily mean that skilled therapy is not needed to improve the patient's condition.**
  - See the Medicare Benefit Policy Manual, Chapter 15 § 220.2 (C)>

- Lastly, the **Medicare HMO may have their own rules** that are specified in the contract between the SNF and the Medicare HMO, so that is a very different issue. (HMO is under Medicare C)

End of Life (cont')

- There are some pretty clear examples of when a beneficiary can receive both hospice and a SNFPPS benefit. A patient that has elected their hospice benefit due to end stage lung CA may also fall and fracture a hip.

  - If the hip fracture has no direct relationship to the end stage diagnosis, the patient may also be entitled to receive therapy even though he is a hospice patient. There is a special condition code that must be on the UB-04 to indicate this situation and documentation should be clear

  - Let's say a patient has been diagnosed with an illness that is in an end-of-life phase and did not elect Medicare Hospice benefit, can he be admitted to SNF/swing bed for pain management. The answer is yes

  - What if a patient is on hospice and decides he can't die at home, meets the qualification for SNF/swing bed (3-day stay etc…) and has skilled needs, must he opt out of hospice?
    - If the end-of-life stay is related to the hospice diagnosis, then the patient would have to opt out or go to an inpatient hospice

Non-Skilled Services

- The following services are considered *non-skilled services* unless rendered under circumstances detailed previously.
  - Administration of routine oral medications, eye drops and ointments (the fact that a patient cannot be relied upon to take such medications himself or herself or that state law requires all medications to be dispensed by a nurse to institutional patients would not change this service to a skilled service)
  - General maintenance care of colostomy and ileostomy
  - Routine services to maintain satisfactory functioning of indwelling bladder catheters (this would include emptying and cleaning containers, and clamping tubing)
  - Dressing changes for non-infected postoperative or chronic conditions
  - Prophylactic and palliative skin care, including bathing, application of creams or treatment of minor skin problems
  - Routine care of the incontinent patient, including use of diapers and protective sheets
  - General maintenance care in connection with a plaster cast (skilled supervision or observation may be required when the patient has a preexisting skin or circulatory condition or needs to have traction adjusted)

Non-Skilled Services

- Routine care in connection with braces and similar devices
- Use of heat as a palliative and comfort measure, such as whirlpool or steam pack
- Routine administration of medical gases after a regimen of therapy has been established, i.e., administration of medical gases after the patient has been taught how to institute therapy
- Assistance in dressing, eating and going to the toilet
- Periodic turning and positioning in bed
- General supervision of exercises that have been taught to the patient and the performance of **repetitious exercises** that do not require skilled rehabilitation personnel. (This includes the actual carrying out of maintenance programs in which the performances of repetitive exercises that may be required to maintain function do not necessitate a need for the involvement and services of skilled rehabilitation personnel. It also **includes the carrying out of repetitive exercises to improve gait, maintain strength or endurance; passive exercises to maintain range of motion in paralyzed extremities, which are not related to a specific loss of function; and assistive walking**.)

"Practical Matter" Criteria

- ***30.7 - Services Provided on an Inpatient Basis as a "Practical Matter" - (Rev. 179, Issued: 01-14-14, Effective: 01-07-14, Implementation: 01-07-14) - A3-3132.6, SNF-214.6***

- *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, the intermediary or MAC considers the individual's physical condition and the availability and feasibility of using more economical alternative facilities or services.*

- *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.*

"Practical Matter" Criteria

- *The availability of capable and willing family or the feasibility of obtaining other assistance for the patient at home should be considered. Even though needed daily skilled services might be available on an outpatient or home care basis, as a practical matter, the care can be furnished only in the SNF if home care would be ineffective because the patient would have insufficient assistance at home to reside there safely.*

- ***EXAMPLE**: A patient undergoing skilled physical therapy can walk only with supervision but has a reasonable potential to learn to walk independently with further training. Further daily skilled therapy is available on an outpatient or home care basis, but the patient would be at risk for further injury from falling, because insufficient supervision and assistance could not be arranged for the patient in his home. In these circumstances, the physical therapy services as a practical matter can be provided effectively only in the inpatient setting.*

"Practical Matter" Criteria

- ***30.7.1 - The Availability of Alternative Facilities or Services - (Rev. 1, 10-01-03) - A3-3132.6.A, SNF-214.6.A***

  Alternative facilities or services may be available to a patient when health care providers such as home health agencies are utilized. These alternatives are not always available in all communities and even where they exist, they may not be available when needed.

- ***EXAMPLE**: Where the residents of a rural community generally utilize the outpatient facilities of a hospital located some distance from the area, the hospital outpatient department constitutes an alternative source of care that is available to the community. Roads in winter, however, may be impassable for some periods of time and in special situations institutionalization might be needed.*

"Practical Matter" Criteria

- *In determining the availability of more economical care alternatives, the coverage or noncoverage of that alternative care is not a factor to be considered. Home health care for a patient who is not homebound, for example, may be an appropriate alternative in some cases. The fact that Medicare cannot cover such care is irrelevant.*

- *The issue is feasibility and not whether coverage is provided in one setting and not provided in another. For instance, an individual in need of daily skilled physical therapy might be able to receive the services needed on a more economical basis from an independently practicing physical therapist. However, the fact that Medicare payment could not be made for the services because the $500 expense limitation applicable to the services of an independent physical therapist had been exceeded or because the patient was not enrolled in Part B, would not be a basis for determining that, as a practical matter, the needed care could only be provided in a SNF.*

"Practical Matter" Criteria

- ***30.7.2 -Whether Available Alternatives Are More Economical in the Individual Case - (Rev. 1, 10-01-03) - A3-3132.6.B, SNF-214.6.B***

- ***EXAMPLE 1:***

  If a patient's condition requires daily transportation to the alternative source of care (e.g., a hospital outpatient department) by ambulance, it might be more economical from a health care delivery viewpoint to provide the needed care in the SNF setting.

- ***EXAMPLE 2:***

  If needed care could be provided in the home, but the patient's residence is so isolated that daily visits would entail inordinate travel costs, care in a SNF might be a more economical alternative.

"Practical Matter" Criteria

- ***30.7.3 -Whether the Patient's Physical Condition Would Permit Utilization of an Available, More Economical Care Alternative - (Rev. 1, 10-01-03) - A3-3132.6.C, SNF-214.6.C***

- *In determining the practicality of using more economical care alternatives, the intermediary considers the patient's medical condition. If the use of those alternatives would adversely affect the patient's medical condition, the intermediary concludes that as a practical matter the daily skilled services can only be provided by a SNF on an inpatient basis.*

- *Determinations on whether a patient's condition would be adversely affected if an available, more economical care alternative were utilized should not be based solely on the fact that the patient is nonambulatory. There are individuals confined to wheelchairs who, though nonambulatory, could be transported daily by automobile from their homes to alternative care sources without any adverse impact. Conversely, there are instances where an individual's condition would be adversely* ***affected by daily transportation*** *to a care facility, even though the individual is able to ambulate to some extent.*

"Practical Matter" Criteria

- *EXAMPLE:*

  *A 75-year-old woman has suffered a **cerebrovascular accident and cannot climb stairs safely.** The patient lives alone in a **second-floor apartment accessible only by climbing a flight of stairs**. She requires physical therapy and occupational therapy on alternate days, and they are available in a CORF one mile away from her apartment. However, **because of her inability to negotiate the stairs, the daily skilled services she requires cannot, as a practical matter, be provided to the patient outside the SB.***

"Practical Matter" Criteria

- *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 intermediary 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. (See the Medicare Benefit Policy Manual, Chapter 3, "Duration of Covered Inpatient Services," §20.1.2, for counting inpatient days during a leave of absence.)*

- Leave of Absence (LOA) and process to be discussed (FI/MAC may question why not home if they can go out so we **recommend mostly therapeutic LOA**

Documentation To Support Skilled Care Needs

- **Therefore the patient's medical record must document as appropriate:**
  - The history and physical exam pertinent to the patient's care, (including the response or changes in behavior to previously administered skilled services);
  - The skilled services provided; including all required observation and assessments
  - The patient's response to the skilled services provided during the current visit;
  - The plan for future care based on the rationale of prior results.
  - A detailed rationale that explains the need for the skilled service in light of the patient's overall medical condition and experiences;
  - The complexity of the service to be performed;
  - Any other pertinent characteristics of the beneficiary.

- The documentation in the patient's medical record must be accurate and avoid vague or subjective descriptions of the patient's care that would not be sufficient to indicate the need for skilled care. For example, the following terminology does not sufficiently describe the reaction of the patient to his/her skilled care:
  - Patient tolerated treatment well
  - Continue with POC
  - Patient remains stable

- Such phraseology does not provide a clear picture of the results of the treatment, nor the "next steps" that are planned. Objective measurements of physical outcomes of treatment should be provided and/or a clear description of the changed behaviors due to education programs should be recorded so that all concerned can follow the results of the provided services.

Documentation to Support Skilled Needs

- CMS Clarification regarding Discharge Summary

  - **Change in Level of Care/Discharge**:
    - 42 CFR 482. 12(c)(4) defines that a physician is responsible for the care of the patient. 482.24(c)(2)(vii) states that all records must document a discharge summary with outcome of hospitalization, disposition of care, and provisions for follow-up care.
    - As the person responsible for the care of the patient it therefore follows the physician must do the discharge summary.
    - Discharge from the acute care hospital bed is required because the patient is changing from one level of care to another pocket of funds. This is a reimbursement requirement for payment. A swing bed is not considered hospital level care. It is defined in the payment regulations as SNF level care and is reimbursed at a lesser amount. It therefore follows that the patient must have a discharge summary following acute care services. When the patient is discharged from the swing bed, they need a discharge summary of SNF level services.

Documentation to Support Skilled Needs

- ***In short, a chart review should be able to identify or presume the following:***
  - Medical Diagnosis including Rehab Diagnosis when applicable
  - The remaining issues secondary to their medical / rehab diagnosis
  - What are the skilled needs
  - Why do they require an IP program
  - Care orders
  - If the skilled need is Management and Evaluation of a Patient Care Plan or Observation and Assessment or Patient Education – that there be specifics of what the staff needs to observe, assess, teach and/or manage…
  - Discharge plan
  - Nursing and therapy treatments, observations, assessment…
  - Discharge Summary to include
    - Status updates
    - Final outcome in relation to admission needs and present status
    - Actual discharge disposition
    - Follow-up plan
- **Please refer to the webinar I presented re: CAH SB Program Documentation Guideline Webinar – April 29, 2020**

Codes for UB-04 to Support Decisions

SNF

Code	Description
20	Beneficiary requested billing. Provider determined services are part of a non-covered level of care or excluded, but beneficiary requests determination by payer. (Limited to home health and inpatient SNF claims.)
55	SNF bed is not available. Patient's SNF admission was delayed more than 30 days after hospital discharge because a SNF bed was not available.
56	Medical appropriateness condition code. Patient's SNF admission was delayed more than the 30 days after hospital discharge as patient's condition made it inappropriate to begin active care within that period.
57	SNF readmission when patient previously received Medicare covered SNF care within 30 days of current SNF admission.
58	SNF patient terminated MA Plan enrollment. Providers report this code to waive 3-day qualifying stay requirement.

Other Resources

- **Subscribe to the Federal Register if not already on their mailing list**

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NOTICES

Webinar # 2

- Rehab Model: Best Practice
- Therapy Involvement
- Rehab Skilled Needs
- Q&A re: Real Life Scenarios


Q&A


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