Medicare 101 for SNFs

PrimeWest Health
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Cyndy Folie RN
Presenter’s Qualifications:

• RN with 25 years MC experience with different intermediaries
• 14 years as MC Consultant to MN DHS’s Medicare Revenue Enhancement Program
• Former SNF DON with MC experience
• Conducts Medicare records audits & training
Course Description

• This course is designed to assist Skilled Nursing Facility (SNF) staff and case managers understand the Medicare Part A SNF benefit period, coverage guidelines and documentation requirements.
Objectives

- Participant will be able to:
  - Define “skilled” and medically necessary
  - List 2 direct skilled nursing services
  - Explain when a benefit period ends
  - Give an example of “skilled care plan management” and explain the documentation requirements to support the coverage
  - Explain when to issue the Notice of Medicare Non-Coverage (NOMNC)
  - Explain how to document to show integration of therapy programs into nursing care
Course Outline

• Introduction
• Statutory Requirements
• Benefit Periods
• Definitions
• Categories of Medicare Coverage
• Documentation
• Denial Letters
• Case Studies
• Questions & Post Test
Technical Requirements

• Must meet technical and coverage criteria
• Have Medicare card & entitled to benefits
• Days available in benefit period
• MD certifies “skilled care” upon admission, day 14 and every 30 days thereafter
• Traditional MC – must have 3 day qualifying hospital stay (3 nights) - MSHO waives
Skilled Services

- Ordered by MD, requires professional nurse or therapist, or under direct supervision
  - Inherent complexity
  - Nature of service
  - Special medical complications
  - Overall condition
Coverage Criteria

- Daily skilled inpatient care that is reasonable and necessary
  - Consistent with illness, injury
  - Reasonable in duration, frequency, quantity
  - Effective standard of treatment
  - Accepted standards of practice
Benefit Period

• Way of measuring use of MC days
• Maximum of 100 SNF days per period
• Begins with 1st hospital stay—traditionally
• Ends with 60 days of no skilled service
• Begin counting with discharge day
• May not be eligible for new period if still receiving skilled care, i.e. tube feeding
• “Benefit Exhausted”
Traditional Medicare

- 30 day transfer rule - can “pick up” Medicare if less than 30 days since discharge from own SNF, another SNF or hospital
- Be in same benefit period
Exception to 30 day transfer

• Needs are “Medically Predictable”
  – MD ordered prior to discharge
  – Specific time frame

Medicare Benefit Policy Manual Chapter 8, Section 20.2.2
SNF Benefit Structure

- Per Benefit Period
- Hospital Deductible $1068
- First 20 days paid fully
- Days 21-100 co-pay of $133.50 daily
- May have several benefit periods in year
Counting Days

• Count day of admit even if less than 24 hours
• Do not count:
  – day of discharge
  – date of death
  – day for Leave of Absence (LOA)
Leave of absence (traditional)

- Away at midnight – is on LOA
  - SNF day not taken
  - Payment not made
  - Consolidated billing does not apply
  - LOA days skipped for MDS purposes

Claims Processing Manual Chapter 6 Section 40.3.5.2
Categories of Coverage

- Presumption of Coverage
- Daily direct skilled services – 7 days/wk
- Teaching and training
- Daily skilled rehabilitation services – 5 days
- Observation and Assessment (O&A)
- Skilled Management of Care Plan
Presumption of Coverage

- Traditional Medicare
- Direct admit from hospital
- Care reasonable & necessary
- Coverage ends with ARD of 5 day MDS
Daily Direct Services

- IVs, IMs, IV feedings
- Tube Feedings-51% total daily calories or 26% calories & 501 cc’s fluid daily
- Naso-pharyngeal, tracheotomy suctioning
- Insertion, sterile irrigation & replacement S/P caths, initial care of new, infected caths
- Dressings with presc ointments & asepsis
Daily Direct Services, cont’d

• Rx decubs, 2 or more Stage IIIs, Stage III or worse or widespread skin disorder
• MD ordered heat txs as part of active tx plan
• Rehab procedures, incl. related teaching such as bowel & bladder training
• Initial phases of medical gases adminis.
• Early post-op care if complications
Wound Care

• Size, depth, nature of drainage, condition of surrounding skin, any special techniques must be documented.

• If sterile or complex dressings, or applying prescription medications, nurse’s skills usually reasonable and necessary for following wound characteristics:
Wound Care, cont’d

• Open draining wounds with colored exudate or foul odor which require ATBs
• Wounds with drains or T-tube which require shortening
• Wounds requiring irrigation, installation of sterile cleansing or medicated solution into several layers or tissue and/or packing with sterile gauze, such as:
Wound Care, cont’d

- Recently debrided ulcers
- Stage 1-4 pressure ulcers
- Wound with exposed vessels or a mass
- Open wounds or widespread skin complications following radiation or which results from immune deficiencies or vascular insufficiencies
- Post-op wounds with infection, allergic reaction, or delayed healing (diabetes, PVD)
- 2nd or 3rd degree burns with complications
- Other open wounds requiring nurse’s skills
Wound Care, cont’d

- 3 skilled services may be involved
  - Daily direct wound care
  - Teaching wound care
  - Skilled observation & assessment
Non-skilled Wounds

• Wounds or ulcers that show:
  – Redness
  – Edema and induration and at times with
  – Epidermal blistering or desquamation

• DO NOT Ordinarily Require direct hands-on skilled nursing
Wound Care Assessment

- Identify risk factors – diabetes, PVD, etc.
- Describe wound – size, Stage, appearance, amount & color of drainage, odor, surrounding skin, tunneling?
- Granulation vs eschar tissue
- Nutrition, hydration status
- Changes from previous assessment
Wound Care Documentation

- Specify TX regimen used
- Compare findings to previous findings
- Chart resident’s response to TX
- If changed, document MD call, new orders, labs, etc
- Document interventions (turning, hydration, etc)
- Interdisciplinary roles? therapy, dietary
Teaching & Training

- Activities which require the skills of a professional to teach resident how to manage tx regimen
- Administration of injectable meds or gases
- Diabetic instruction, diet, meds, foot care
- Care of, IVs, feeding tubes, colostomies
- Gait training or rehab procedures
- Specialized skin care, dressings
Teaching & Training, cont’d

- Do not have to teach a skilled service
- Per Noridian’s July training, may teach a family member to care for resident
- Assess person’s ability to learn
- Document steps in training and ability to recall prior instructions
- Document resident response
Direct Rehab Services

- Key is whether needs skills of professional—not based on potential for recovery
- Are directly related to written TX plan
- Requires knowledge, skills, judgment of professional
- Expected improvement in predicted time
- Meet accepted clinical standards
- Meet reasonable & necessary guidelines – amount, frequency, duration
- If expected results are insignificant to extent & duration of therapy – then not R&N
Physical Therapy

- On-going assessment
- Therapeutic exercises, activities
- Gait evaluation & training
- ROM exercises
- Maintenance therapy
- Ultrasound, short-wave, etc.
- Hot pack, infrared, paraffin baths, w/ ps when special issues e.g. wounds, circulation
Speech Language Pathology

- Services for diagnosis & treat speech language disorders resulting in communication disabilities & for diagnosis of dysphagia
- Restorative & maintenance tx
- Diagnostic & Evaluation Services
- Therapeutic Services
- Dysphagia Treatment
Occupational Therapy

- Medically prescribed tx concerned with improving, restoring lost functions d/t illness, injury, or

- To improve self ability to perform tasks required for independent functioning
Occupational, cont’d

- Eval, re-eval level of function
- Selection, teaching therapeutic exercises
- Planning, implementing, supervising psych active treatment plan
- Planning, implementing sensory integration tasks
- Compensatory ADLs
- Splinting, orthotics; Vocational rehab
Nursing Charting on Rehab

- Should chart when therapy is MC qualifier
- Suggest at least weekly
- Change in Condition?
- Comparison, past to present?
- Cultural differences, i.e. language barrier?
- Current medical issues?
- Carry-over, therapy to nursing
- Conclusion – therapy impacts daily life?
Observation & Assessment

- Skilled when necessary to identify & evaluate need for medical modification of tx plan, or additional medical procedures until tx stable
- Can be necessary until treatment regimen stabilized
- Evidence of instability, or high probability of such
- Interventions & beneficiary response
- MD involvement
Possible Indicators for O&A

- Condition upon hospital discharge
- Indications of medical instability
- Multiple medical conditions which may interact causing complications, or acute sx
- 2 proxies
  - 2 insulin changes in 14 days – must be unstable
  - MD visits/order changes reflecting instability
Documentation for O&A

• Evidence of instability or change in condition
• Daily or more frequent clinical monitoring of VS, skin, lung or bowel sounds, deficiencies in nutrition, hydration, mobility, mental status
• Documented changes in any of above
• Repeated changes in TX plan – unstable
• No check-off boxes - narratives or flow sheets
Anticoagulation Therapy

- Can be covered if observation is documented
- Watch signs of bleeding, potential drug interactions, changes in VS, falls, etc
- Vitamin K orders
- Daily protimes with coumadin adjustment
- Shorter periods of coverage but coverage available
Non-Skilled O&A (Noridian*)

- Med changes for minimal or no symptoms
  - ATBs for “typical” UTI/URI
  - Coumadin changes
  - Anti-hypertensive changes
  - Insulin changes
- Stable oxygen use
- Routine topical dressing changes

*July 29, 2009 training session
Infections & oral antibiotics

- Can be covered if symptoms
- Deny when stable or minimal symptoms
- No coverage if no symptoms, even if ATB
- Shorter duration-few days
- If lapses into management explain all medical or potential complications
Skilled Management

• Development, management & evaluation of care plan based on MD orders
• Required when sum total of unskilled services are part of medical plan d/t overall condition
• Does not need to be explicitly documented if need is clear in record
• Ends when tx stable, res recovered, etc.
Possible Indicators for Management

- Documented medical problems & concerns related to sx with potential complications
- Documented functional deficits creating medical risk (nutrition, dehydration, etc)
- TX plan with frequent modifications
- HX frequent hosp, ER d/t falls, dehydration, malnutrition
- Interrelated services require professional?
- Type, number, complexity of daily services?
Documentation for Management

- Must reflect condition, medical needs, TX regimen & evidence of serious complication
- Describe medical problems & related concerns
- Multiple entries of risks or delayed recovery if not closely supervised
- Care plan showing complexity
- Evidence professionals assessing or supervising non-skilled care
*Documentation Uses*

- Continuity of care
- Quality management of care
- Payment mechanism
- Satisfy legal requirements
- Resident protection
Types of Documentation

- SOAP-sub, obj, assess, plan
- SOAPIE- add implement, evaluation
- SOAPIER- adds revision to evaluation
- Narrative or By Exception
- PIE- problem, intervene, evaluation
- Focus charting- res centered-concerns
  - Data, Actions, Res Response
*Types of Documentation, cont’d*

- **AIR** - Assess, Intervention, Response
  - **A** - “findings” summary, including trends-worse or improved & writer’s impression
  - **I** - Yours or others actions
  - **R** - Resident response

- Designed to avoid repeat of prior entries
- Promotes concise doc of condition, inter.,
  - Especially with flow sheets
*Flow Sheets*

- Quick easy to use
- Cannot be “check-off” boxes
- Little space for “findings”
- Encourage duplication unless customized
- May need narrative to show intervention
- Customized – allow space for data

*Surefire Documentation*
Notice of MC Non-Coverage

- Give no later than 2 days before the termination of covered services
- Use CMS-10095-A form
- Write in date services end – last MC day
- Add date you give the notice
- PW asks you (SNF rep) to sign notice
Non-Coverage Notice, cont’d.

• Valid delivery
  – Able to understand purpose/contents
  – Understand appeal rights
  – If resident unable to understand, give to authorized representative
  – PW requests date & staff signature of person giving notice
Post Test Questions

1) Teaching a family member how to care for a resident after discharge is a Medicare covered service. T___ F____

2) Coverage for observation and assessment for an asymptomatic UTI is a coverable service. T___ F____

3) Routine skin care to an abrasion with bacitracin is a covered service. T___ F____
4) In fee-for-service Medicare, when counting for a 60 day break in skilled service, a hospital stay will affect the benefit period.  
T___ F___

5) A tube feeding qualifies if the resident receives at least 76% of daily calories and 500 cc’s of fluid per day.  
T___ F___

6) The Notice of Medicare Non-Coverage must be given at least 2 days before the last covered day.  
T___ F___
Resources

- CMS Medicare Home Page
- CMS Transmittals
  - http://www.cms.hhs.gov/Transmittals/01_overview.asp
- CMS Forms
  - http://www.cms.hhs.gov/cmsforms/01_overview.asp
- CMS SNF Medicare Benefit Policy Manual
- CMS Skilled Nursing Facility Center
- Noridian
  - https://www.noridianmedicare.com/
- Beneficiary Notices Initiative (denial notices)
  - http://www.cms.hhs.gov/BNI/
- Surefire Documentation: How, What & When Nurses Need to Document, Mosby 1999