LONG-TERM CARE
SKILLED SERVICES

How to Document for
Proper Medicare Reimbursement

ELIZABETH MALZAHN-MCLAREN

To reduce your facility’s risk of unwanted outcomes and ensure proper Medicare reimbursement for the type and number of skilled services provided, it’s essential to submit claims appropriately and in accordance with the Centers for Medicare & Medicaid Services’ (CMS) skilled services regulations. Don’t miss out on Medicare reimbursement or put your facility at risk for fraudulent penalty charges and monetary recoupment!

Long-Term Care Skilled Services: How to Document for Proper Medicare Reimbursement breaks down CMS’ skilled services requirements and explains how facilities can best manage the daily operations that affect skilled coverage and necessary documentation. This book provides information for all staff members who play a role in determining and documenting skilled services and includes:

- Easy-to-understand explanations of complex CMS rules and regulations regarding skilled services
- A topic-driven format enabling readers to research specific questions and conveniently and efficiently obtain complete and descriptive answers
- Examples of documentation for skilled services
- Guidance to help facilities receive the benefits and reimbursement they deserve
- Downloadable forms

THIS BOOK WILL HELP YOU:

- Identify common problems and challenges associated with skilled services and gain a better understanding of how to handle the major pain points
- Properly assess skilled services under the MDS 3.0
- Increase skilled census and improve their facility’s reputation with the support of the entire staff
- Avoid under- and overpayments from Medicare with easy-to-understand explanations of complex rules and regulations
- Provide necessary skilled services to each resident through a complete understanding of eligibility requirements
- Accurately document skilled services using proven, time-saving solutions for proper Medicare reimbursement

ELIZABETH MALZAHN-MCLAREN
Long-Term Care Skilled Services

How to Document for Proper Medicare Reimbursement

Elizabeth Malzahn-McLaren
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Elizabeth Malzahn-McLaren

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As the skilled nursing and assisted living resource for Covenant Retirement Communities since 2009, Malzahn-McLaren oversees the skilled nursing and assisted living operations at the senior services provider’s 13 campuses nationwide.

An authority on healthcare regulation and compliance, Malzahn-McLaren conducts training programs for Covenant Retirement Communities as well as for HCPro, and for national and state nonprofit healthcare organizations.
Foreword

Industry Scope

As the skilled nursing industry transforms to meet the changing needs of beneficiaries, we are seeing an increase in utilization of skilled nursing facility (SNF) Medicare days. Although the number of skilled nursing facility (SNF) providers remains relatively stable, total Medicare payments to SNFs in 2014 were in excess of $31 billion dollars. According to MedPAC, 20% of all Medicare beneficiaries discharged from the hospital go to SNFs to recover before they return to the community. As cost of care continues to increase, the relationship between cost of care and reimbursement has diminished, triggering an increase in medical reviews, stringent documentation requirements for skilled care and services, and an increase in the number of denials of payment.

Reimbursement drives healthcare today and forces Medicare to ensure that SNFs adhere to the multitude of rules and regulations to prevent unnecessary expenditures in entitlement plans. Scrutiny by multiple regulators is increasing along with the growing expenditure of dollars. Medicare in a SNF can be broken down into three distinct components: eligibility, coverage, and payment. This book deals with the ins and outs of skilled coverage and supporting documentation.

Frequent Obstacles Encountered

Too often, we hear, “Mrs. A’s therapy is done, so we’re going to cut her from skilled service.” We get caught up in the notion that in order to be skilled, a resident must be receiving therapy or intensive nursing care. Failure to recognize other skills or skilled services prompts discontinuing or “cutting” the patient from skilled care too soon, depriving him or her of his or her skilled benefit and depriving the facility of needed revenue.
Sometimes, only because the patient classifies into a payment or resource utilization group (RUG) category, skilled coverage is continued, even though there is not a daily skilled need! Although the two aspects—coverage and payment—are related and interdependent, a patient must still meet all the skilled coverage guidelines as well as classify into a RUG category in order to receive a benefit. Sometimes, the CMS Common Working File has not been properly notified or updated. Therefore, it will not calculate the required 60-day break in skilled service that is necessary to generate a new benefit period. It could be the result of not submitting the correct claim information from your billing department or the billing department of another institution.

Experiment in your own facility. Determine the actual criteria and process staff use in your facility to determine who is “skilled” and who is not. Ask staff members on various shifts which patients under their care are “skilled” and why. Ask them to identify the daily skilled needs. Now check the documentation. Does the documentation truly support “skilled need and skilled care”? Does it support the benefit period? Does the patient also classify for a RUG payment category? If responses vary among staff, as I suspect they will, documentation of those patients will probably not be accurate or complete and will not withstand scrutiny from medical review.

*It all needs to work together: Coverage, payment, and supporting documentation*

Frequently, the staff wants a magic list or check-off sheet of what defines a skilled resident. Unfortunately, because the combinations of treatments, needs, diagnosis, care, and physician’s orders are infinite, no such list exists. So let’s try to simplify the process, while adhering to the Medicare rules. Facility practice may innocently deviate from the regulations, placing Medicare dollars at risk, and limiting optimal revenue.

The goal in this volume is to return to basics. Review the rules and regulations for skilled coverage and learn to apply them consistently, adjusting facility practices as necessary. This will ensure coverage for those that meet the requirements, allow the facility to manage the daily operations that affect skilled coverage, and direct necessary documentation.

The information presented in this manual is not hard to follow. With a complete understanding of how to handle the major pain points associated with skilled services—which this book will provide—a SNF will put itself in the best possible position to receive proper Medicare reimbursement. We hope you find this text useful in navigating the tedious world of Medicare coverage in a SNF.

—Diane Brown, Director, Postacute Care, HCPro
Chapter 1

Breaking Down the Regulations

Rules and Regulations

The Social Security Act (42. USC, Chapter 7)

Once a law is passed, it is codified in the United States Code (USC) and published on the Government Printing Office website (GPO Access). The original Social Security Act was signed on August 14, 1935, by Franklin D. Roosevelt's administration as part of the New Deal. This act was the first legislation that identified and addressed the need to protect the elderly in our country, and it was funded through employee and employer contributions through a new payroll tax called the Federal Insurance Contributions Act (FICA). After amending it to include the Medicare program in 1965, Congress has since enacted many new provisions, considered to be amendments to the act. The following subchapters outline the areas and the individuals impacted by the original act and its subsequent amendments:

- Subchapter I—Grants to states for old-age assistance
- Subchapter II—Federal old-age, survivors, and disability insurance benefits
- Subchapter III—Grants to states for unemployment compensation administration
- Subchapter IV—Grants to states for aid and services to needy families with children and for child-welfare services
- Subchapter V—Maternal and child health services block grant
- Subchapter VI—Temporary state fiscal relief
- Subchapter VII—Administration
- Subchapter VIII—Special benefits for certain World War II veterans
- Subchapter IX—Employment security administrative financing
- Subchapter X—Grants to states for aid to the blind
- Subchapter XI—General provisions, peer review, and administrative simplification
- Subchapter XII—Advances to state unemployment funds
- Subchapter XIII—Reconversion unemployment benefits for seamen
- Subchapter XIV—Grants to states for aid to permanently and totally disabled
- Subchapter XV—Unemployment compensation for federal employees
- Subchapter XVI—Supplemental security income for aged, blind, and disabled
- Subchapter XVII—Grants for planning comprehensive action to combat mental retardation
- Subchapter XVIII—Health insurance for aged and disabled
- Subchapter XIX—Grants to states for medical assistance programs
- Subchapter XX—Block grants to states for social services
- Subchapter XXI—State Children’s Health Insurance Program (SCHIP)

The Medicare program regulations reside in Subchapter XVII, and the Medicaid program regulations reside in Subchapter XIX. Thus, Medicare is often referred to as Title 18 and Medicaid as Title 19.

**Amendments to the act**

Amendments to the Social Security Act include the following:

- Social Security Amendments of 1965: These amendments, signed into law in 1965 by President Lyndon B. Johnson, created both the Medicare and Medicaid programs.

- The Omnibus Reconciliation Act (1987): Passed by President Ronald Reagan, this legislation was the most significant of its kind since the Medicare and Medicaid programs were created in 1965. It demanded that nursing homes provide an environment that allows its residents to “attain and maintain their highest practicable physical, mental and psychosocial well-being” (Omnibus Reconciliation Act).

- Balanced Budget Act (BBA; 1997): This act was introduced to help balance the Medicare budget within 5 years, by 2002. It included significant payment revisions to skilled nursing facilities (SNF), and it introduced the prospective payment system (PPS) and consolidated billing. In addition to modifying reimbursement under traditional Medicare, this act also introduced
the Medicare + Choice Program options, as well as additional preventative care benefits for Medicare beneficiaries.

- Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act (1999): This revision to the BBA impacted SNFs as follows:
  - Increased payment for higher-cost residents
  - Increased federal rates for all residents
  - Increased the facility-specific rates for all SNFs

- Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (2000): This act included additional reimbursement modifications related to the market basket reduction previously made, removed some ineffective legislation related to consolidated billing requirements for non-Part A stays, and made some additional revisions to the Medicare + Choice Program requirements. There were also several other areas that affected skilled services in a long-term care setting:
  - Waived the 24-month waiting period for individuals with amyotrophic lateral sclerosis to qualify for Medicare benefits
  - Provided additional clarification and coverage for certain drugs and biologicals
  - Substantially revised the Medicare appeals process for both providers and beneficiaries and introduced the qualified independent contractors (QIC) who were contracted for an initial three-year agreement to conduct appeal reconsideration requests

- Medicare Prescription Drug, Improvement and Modernization Act (2003): This act provided what is commonly referred to in the industry as the “largest overhaul of Medicare in the program’s 38-year history.” The following are the highlights of how this act affects SNFs:
  - Introduced a prescription drug benefit and entitlement to Medicare beneficiaries, commonly called Medicare Part D
  - Introduced significant legislation impacting the Medicare + Choice Program, which also changed the name of this program to Medicare Advantage
  - Completely restructured how Medicare Part A and Part B claims are processed, with the gradual replacement of fiscal intermediaries (FI) and carriers with Medicare Administrative Contractors (MAC)

Regulations Developed by CMS

*Medicare regulation (e.g., 42 CFR § 409.33)*

Once laws are passed, the Centers for Medicare & Medicaid Services (CMS) then codifies them into regulation. They are recorded in the *Code of Federal Regulations (CFR)*, which is accessible on the
Government Printing Office website, and must be published in the Federal Register before enactment. Likewise, any changes to regulations must be published in the Federal Register. Note that modifications and updates to the payment portion of the CFR are made at least once each year.

**CMS manuals**


This CMS resource also links to the Future Updates for the IOM to allow users access to the most up-to-date information related to the IOMs.

The following IOMs should be of particular relevance for questions relating to Medicare coverage, coding, billing, and payment for physician services:

- Pub. 100-01: *Medicare General Information, Eligibility, and Entitlement*
- Pub. 100-02: *Medicare Benefit Policy Manual* (basic coverage rules)
- Pub. 100-03: *Medicare National Coverage Determinations Manual* (national coverage decisions)
- Pub. 100-04: *Medicare Claims Processing Manual*
- Pub. 100-05: *Medicare Secondary Payer Manual*
- Pub. 100-16: *Medicare Managed Care Manual*

**CMS program transmittals**

CMS constantly issues new interpretations, mandates, and rules through program transmittals, which can create anxiety for someone who is trying to understand the world of skilled nursing. A transmittal may, for instance, clarify a rule related to Medicare, such as consolidated billing or how to bill for a particular item. According to CMS’ definition:

*The Centers for Medicare & Medicaid Services uses transmittals to communicate new or changed policies or procedures that we will incorporate into the CMS Online Manual System. The cover or transmittal page summarizes and specifies the changes. The transmittals for 2000 through 2003 have been archived.*
In general, there are three types of transmittals:

- Transmittals announcing changes to the substantive manuals: These typically include a “red-lined” copy of revised manual sections.
- One-time notification (OTN) transmittals: These communicate information but do not change the manuals.
  - Some OTN transmittals are “tied” to particular manuals and include the manual name in the transmittal number.
  - Other OTN transmittals are more global in nature and are not tied to any particular substantive manual. Rather, they are tied to the OTN Manual (Pub. 100-20), which is really more of a filing system than a substantive manual. These transmittals include “OTN” in the transmittal number.
- Recurring update notification transmittals: These communicate information that changes on a regular schedule (e.g., code lists, edit specifications), but, like OTN transmittals, they do not make changes to the substantive manuals. They are typically tied to a particular substantive manual and are also tied to the Recurring Update Notification Manual (Pub. 100-21), which is more of a filing system than a true manual.

**Medicare Learning Network articles**

In addition to the manuals and transmittals, CMS publishes a series of articles called Medicare Learning Network (MLN) articles. These articles are intended to provide practical operational information about the Medicare program. Many of the articles are designed to accompany and/or explain recent CMS transmittals. CMS describes the articles as follows:

*The Medicare Learning Network® (MLN) is the home for education, information, and resources for the health care professional community. The MLN provides access to CMS Program information you need, when you need it, so you can focus more on providing care to your patients.*

The articles are grouped by year, and each year has an index available to make searching for specific topics easier.

**Coverage Determinations**

Coverage of items or services under the Medicare benefit is limited to items that are reasonable and necessary and for the treatment of an illness or injury in the most appropriate care setting. Coverage decisions fall into two main categories:

- National coverage determination (NCD)
- Local coverage determination (LCD)
**NCDs**

By CMS’ definition, NCDs “are made through an evidence-based process, with opportunities for public participation. In some cases, CMS’ own research is supplemented by an outside technology assessment and/or consultation with the Medicare Evidence Development & Coverage Advisory Committee (MEDCAC).”

The problem, however, is that not all FIs, carriers, or MACs are completely alike. Each can interpret CMS’ transmittals, CMS’ mandates, and the federal government’s laws differently than the others do. As a result, the government has to provide the “final word” when a definitive clarification of a coverage situation is missing. These clarifications are accomplished through the National Coverage Decision Committee, which issues NCDs.

There is also some guidance offered as to when to use the Medicare Coverage Determination page and when to use the Medicare.gov page:

> The MCD is intended for use by Medicare contractors, providers, and other healthcare industry professionals. People with Medicare, family members, and caregivers should visit Medicare.gov, the official U.S. Government site for people with Medicare, for the latest information on Medicare enrollment, benefits, and other helpful tools.

**LCDs**

To complicate matters further, each FI, carrier, or MAC typically interprets the rules and then issues its policy based on that interpretation. Note that each organization’s policy offers a vast array of interpretations of specific rules and regulations, and it can serve as a great educational tool.

According to Section 1869(f)(2)(B) of the Social Security Act, “For purposes of this section, the term ‘local coverage determination’ means a determination by a fiscal intermediary or carrier under part A or part B, as applicable, respecting whether or not a particular item or service is covered on an intermediary- or carrier-wide basis under such parts.” LCDs contain conditions of coverage as reasonable and necessary and do not contain any information or guidance related to coding or payment.

The CMS website offers a searchable database of LCDs by contractor (FI, carrier, and MAC) and contractor number. Once the specific contractor LCDs are accessed, the LCDs can be sorted by LCD ID, LCD Title, Effective Date, Revision Effective Date, LCD End Date, and Last Updated (Date). This information can all be accessed at www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx

**The Resident Assessment Instrument User’s Manual**

Within all the administrative and clinical rules and regulations, there are more specific manuals, such as the *Resident Assessment Instrument (RAI) User’s Manual*. This manual tells us in detail how
to assess a resident, in ways that none of the aforementioned resources do. October 1, 2010, brought about a significant change in the way residents in a SNF are assessed and introduced the MDS, Version 3.0. As a result of this change, the RAI User’s Manual was completely rewritten. It now offers guidance to SNFs on how to correctly and effectively assess a resident by gathering and inputting resident information into the minimum data set (MDS), a clinical assessment tool required under federal mandate for all residents in either a Medicare- or Medicaid-covered stay in a nursing home. According to CMS:

*MDS 3.0 has been designed to improve the reliability, accuracy, and usefulness of the MDS, to include the resident in the assessment process, and to use standard protocols used in other settings. These improvements have profound implications for NH and SB care and public policy. Enhanced accuracy supports the primary legislative intent that MDS be a tool to improve clinical assessment and supports the credibility of programs that rely on MDS.*

As of the date of this publication, RAI Manual v1.12, updated on November 19, 2014, is the most recent.

**Court cases**

Finally, court cases serve as precedents for various issues, generally related to reimbursement. However, not all court precedents make it into the manuals, transmittals, and so forth.

The most notable recent court case that impacted Medicare beneficiaries and providers was Jimmo v. Sebelius, which was focused on the “Improvement Standard” and how it was applied to a specific beneficiary (Jimmo). Under this standard, claims would be denied if the beneficiary lacked restoration potential, even if they did require a skilled level of care. On January 24, 2013, the US District Court for the District of Vermont approved a settlement agreement in this case. As a part of the settlement, the manual was required to clarify that coverage of therapy “…does not turn on the presence of absence of a beneficiary’s potential for improvement from therapy but rather on the beneficiary’s need for skilled care.”

As required by the settlement, CMS made the manual revisions and published them in Transmittal 179, dated January 14, 2014. CMS notes in several of their fact sheets surrounding this issue that “Nothing in this Settlement Agreement modifies, contracts, or expands the existing eligibility requirements for receiving Medicare coverage.”

**Summary**

The Social Security Act, the Federal Register, Title 42 CFR, manuals, program transmittals, LCDs, NCDs, the RAI User’s Manual, and court precedents can all be valuable resources when determining skilled services.
We discuss each of these resources to show that not all issues related to skilled services can be addressed by a single resource. Sometimes you must use several resources in order to address some of the more complex issues.

**The Online CMS Manual: IOM**

Now that we have identified the sources of Medicare authority, it is time to focus on sections that will serve as valuable resources when making the determination of skilled services in a long-term care setting. When you are through with this section, you will be able to apply critical thinking to the situations you encounter in your own facility. The streamlined CMS manuals allow “one-stop shopping” to find the correct guidance for skilling a resident. Figure 1.1 outlines the *Medicare Manual’s* table of contents, with which you should be somewhat familiar already.

<table>
<thead>
<tr>
<th>Figure 1.1</th>
<th>Medicare Manual Table of Contents</th>
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<tr>
<td>100</td>
<td>Introduction</td>
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<td>100-01</td>
<td>Medicare General Information, Eligibility and Entitlement Manual</td>
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<td>100-02</td>
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<td>100-08</td>
<td>Medicare Program Integrity Manual</td>
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<tr>
<td>100-09</td>
<td>Medicare Contractor Beneficiary and Provider Communications Manual</td>
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<td>100-10</td>
<td>Quality Improvement Organization Manual</td>
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<tr>
<td>100-11</td>
<td>Programs of All-Inclusive Care for the Elderly (PACE) Manual</td>
</tr>
<tr>
<td>100-12</td>
<td>State Medicaid Manual (The new manual is under development. Please continue to use the Paper-Based Manual to make your selection.)</td>
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<tr>
<td>100-13</td>
<td>Medicaid State Childrens Health Insurance Program (Under Development)</td>
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<td>100-14</td>
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We will focus on the main topics of each section to which you will often refer to support making skilled coverage decisions. All of these topics will be discussed in greater detail as you move through *Long-Term Care Skilled Services: Applying Medicare’s Rules to Clinical Practice*, but this will provide you with some of the background information you need to make decisions for skilled services in long-term care.

Although a majority of focus will be on Publication 100-02 (Figure 1.2) because it contains the rules for skilling residents under Medicare, we will touch on other publications in the IOM that will provide valuable information throughout the skilled care decision-making process. In particular, within Publication 100-02, there are several chapters that address the relationship between skilled service, eligibility, benefit periods, and payment.

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<th>Figure 1.2</th>
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<td>CHAPTER</td>
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Note that Chapter 8 of Pub. 100-2 will be our primary avenue for determining whether a resident is skilled. As you read Chapter 8, you will see the various subsections that address specific issues (Figure 1.3). Think of the sections of Chapter 8 as providing the “answers to the test.”
### Figure 1.3

**Medicare Benefit Policy Manual**

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

#### 10 - Requirements - General

- 10.1 - Medicare SNF PPS Overview
- 10.2 - Medicare SNF Coverage Guidelines Under PPS
- 10.3 - Hospital Providers of Extended Care Services

#### 20 - Prior Hospitalization and Transfer Requirements

- 20.1 - Three-Day Prior Hospitalization
- 20.1.1 - Three-Day Prior Hospitalization - Foreign Hospital
- 20.2 - Thirty-Day Transfer
  - 20.2.1 - General
  - 20.2.2 - Medical Appropriateness Exception
    - 20.2.2.1 - Medical Needs Are Predictable
    - 20.2.2.2 - Medical Needs Are Not Predictable
    - 20.2.2.3 - SNF Stay Prior to Beginning of Deferred Covered Treatment
  - 20.2.4 - Effect of Delay in Initiation of Deferred Care
  - 20.2.5 - Effect on Spell of Illness
  - 20.3 - Payment Bans
    - 20.3.1 - Payment Bans on New Admissions
      - 20.3.1.1 - Beneficiary Notification
      - 20.3.1.2 - Readmissions and Transfers
      - 20.3.1.3 - Sanctions Lifted: Procedures for Beneficiaries Admitted During the Sanction Period
      - 20.3.1.4 - Payment Under Part B During a Payment Ban on New Admissions
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      - 20.3.1.6 - Impact on Spell of Illness

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- 30.1 - Administrative Level of Care Presumption
- 30.2 - Skilled Nursing and Skilled Rehabilitation Services
  - 30.2.1 - Skilled Services Defined
  - 30.2.2 - Principles for Determining Whether a Service Is Skilled
  - 30.2.2.1 - Documentation to Support Skilled Care Determinations
  - 30.2.2.3 - Specific Examples of Some Skilled Nursing or Skilled Rehabilitation Services
  - 30.2.3 - Management and Evaluation of a Patient Care Plan
  - 30.2.3.1 - Management and Evaluation of a Patient Care Plan
  - 30.2.3.2 - Observation and Assessment of Patient’s Condition
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  - 30.2.4 - Questionable Situations
| 30.3 - Direct Skilled Nursing Services to Patients |
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| 30.4.1 - Skilled Physical Therapy |
| 30.4.1.1 - General |
| 30.4.1.2 - Application of Guidelines |
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| 30.5 - Nonskilled Supportive or Personal Care Services |
| 30.6 - Daily Skilled Services Defined |
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| 30.7.1 - The Availability of Alternative Facilities or Services |
| 30.7.2 - Whether Available Alternatives Are More Economical in the Individual Case |
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### 40 - Physician Certification and Recertification for Extended Care Services

| 40.1 - Who May Sign the Certification or Recertification for Extended Care Services |

### 50 - Covered Extended Care Services

| 50.1 - Nursing Care Provided by or Under the Supervision of a Registered Professional Nurse |
| 50.2 - Bed and Board in Semi-Private Accommodations Furnished in Connection With Nursing Care |
| 50.3 - Physical, Therapy, Speech-Language Pathology and Occupational Therapy Furnished by the Skilled Nursing Facility or by Others Under Arrangements with the Facility and Under Its Supervision |
| 50.4 - Medical Social Services to Meet the Patient's Medically Related Social Needs |
| 50.5 - Drugs and Biologicals |
| 50.6 - Supplies, Appliances, and Equipment |
| 50.7 - Medical Service of an Intern or Resident-in-Training |
| 50.8 - Other Services |
| 50.8.1 - General |
| 50.8.2 - Respiratory Therapy |

### 60 - Covered Extended Care Days

### 70 - Medical and Other Health Services Furnished to SNF Patients

| 70.1 - Diagnostic Services and Radiological Therapy |
| 70.2 - Ambulance Service |
| 70.3 - Inpatient Physical Therapy, Occupational Therapy, and Speech-Language Pathology Services |
| 70.4 - Services Furnished Under Arrangements with Providers |
Figure 1.4 gives you a bird’s-eye view of the rules, regulations, and resources available to you.

<table>
<thead>
<tr>
<th><strong>Figure 1.4</strong></th>
<th><strong>Rules, Regulations, and Resources Tip Sheet</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Social Security Act</strong></td>
<td>Enacted during the mid-1930s and amended to include the Medicare program during the mid-1960s. Several amendments and statutes have been introduced since. Updated in 1965 to include Medicare and Medicaid programs, commonly referred to as Title 18 and Title 19, respectively.</td>
</tr>
<tr>
<td><strong>Omnibus Reconciliation Act of 1987</strong></td>
<td>Demanded completion of the MDS to encourage skilled nursing facilities to assist residents in attaining and maintaining their highest level of function.</td>
</tr>
<tr>
<td><strong>Balanced Budget Act of 1997</strong></td>
<td>Initiated the prospective payment system (PPS) and consolidated billing for skilled nursing facilities. Also introduced Medicare+Choice options for coverage.</td>
</tr>
<tr>
<td><strong>Medicare, Medicaid and SCHIP Balanced Budget Refinement Act of 1999</strong></td>
<td>Significant reimbursement impact to skilled nursing facility payments.</td>
</tr>
<tr>
<td><strong>Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000</strong></td>
<td>Removal of market basket adjustment to skilled nursing facility payments, updates to Medicare+Choice regulations, consolidated billing refinements and the Medicare Appeals Process.</td>
</tr>
<tr>
<td><strong>Medicare Prescription Drug, Improvement and Modernization Act</strong></td>
<td>Introduced the prescription drug benefit and entitlement referred to as Medicare Part D; changed name of Medicare+Choice to Medicare Advantage; and introduced the Medicare Administrative Contractor (MAC).</td>
</tr>
<tr>
<td><strong>Federal Register</strong></td>
<td>Updated continuously, related to new laws, proposed and changed rules, and regulations.</td>
</tr>
<tr>
<td><strong>Code of Federal Regulations 42 (42 CFR)</strong></td>
<td>One source for anything related to public health.</td>
</tr>
<tr>
<td><strong>Internet-Only Manuals</strong></td>
<td>Streamlined, updated, and consolidated versions of CMS’ various program instructions into an electronic Web-based manual system for all users.</td>
</tr>
<tr>
<td><strong>Program transmittals</strong></td>
<td>CMS mandates, which are issued to intermediaries, carriers, and providers.</td>
</tr>
<tr>
<td><strong>Medicare Learning Network (MLN) Articles</strong></td>
<td>CMS published articles intended to provide practical operational information about the Medicare program.</td>
</tr>
</tbody>
</table>
### Figure 1.4

<table>
<thead>
<tr>
<th>Rules, Regulations, and Resources Tip Sheet (cont.)</th>
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<tbody>
<tr>
<td><strong>National coverage determinations (NCDs)</strong></td>
</tr>
<tr>
<td><strong>Local coverage determinations (LCDs)</strong></td>
</tr>
<tr>
<td><strong>Resident Assessment Instrument (RAI) Manual</strong></td>
</tr>
<tr>
<td><strong>Publication 100-2, Chapter 8</strong></td>
</tr>
</tbody>
</table>

Figure 1.5 is a flowchart that gives you a sense of how Chapter 8 evolved.

### Figure 1.5

<table>
<thead>
<tr>
<th>Road Map to Chapter 8</th>
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Internet-Only Manuals (IOMs)

↓

Publications

100 through 100-24

↓

Publication 100-2

Medicare Benefits Policy

↓

CHAPTER 8

Coverage of Extended Care (SNF) Services Under Hospital Insurance (Part A)

*Sections 10 through 70.4*

The layout of this book will mirror Chapter 8 of Publication 100-02, with added tip sheets, quick reference guides, case studies, and enhanced sections reviewing the MDS 3.0 in detail, focusing on both clinical and therapy needs.
As outlined in Figure 1.4, Chapter 8 of Publication 100-02 is broken out as follows:

- Section 10—Requirements—General
- Section 20—Prior Hospitalization and Transfer Requirements
- Section 30—Skilled Nursing Facility Level of Care—General
- Section 40—Physician Certification and Recertification for Extended Care Services
- Section 50—Covered Extended Care Services
- Section 60—Covered Extended Care Days
- Section 70—Medical and Other Health Services Furnished to SNF Patients

Once we get into Chapter 8, we will begin with Section 10, which reviews the requirements of being classified as a SNF. Section 20 will highlight the technical eligibility requirements of coverage in a SNF; the transfer rules, windows, and exceptions; benefit periods; and how enrollment in other programs can impact coverage under traditional Medicare.

Then, Section 30 will allow us to start dissecting the world of skilled units. This section covers the following issues:

- Admission criteria
- The MDS and how it triggers a resource utilization group (RUG) score
- Definitions of skilled services
- Examples of skilled services
- Management and evaluation of the care plan
- Observation and assessment of the resident
- Questionable situations
- Direct nursing services to residents
- Direct rehabilitation services to skilled residents
- Nonskilled supportive services
- Defining daily skilled services
- Inpatient services versus alternative services

Section 40 covers the requirements for a physician to certify and recertify skilled services in a SNF.
Section 50 identifies the actual services that must be provided in a SNF under Medicare Part A and Part B. Finally, Sections 60 and 70 outline what is considered a covered day and what other services are included in the SNF benefit.

Simple as that! You now know where to locate the resources and guidance for making decisions related to admitting and covering residents under Medicare in a SNF. The next several chapters will provide details, case studies, and additional information to streamline the process of skilling residents under Medicare in a SNF.

**Hierarchy of Oversight**

**CMS**

CMS is a branch of the U.S. Department of Health and Human Services (HHS). This federal agency administers the Medicare program and monitors the Medicaid programs offered by each state.

The following statements outline the mission, vision, and strategic action plan objectives of CMS:

- **CMS’ mission:**
  - To ensure effective, up-to-date healthcare coverage and to promote quality care for beneficiaries

- **CMS’ vision:**
  - To achieve a transformed and modernized healthcare system
  - CMS will accomplish this mission by continuing to transform and modernize America’s healthcare system

- **CMS’ strategic action plan goals include the following:**
  - Skilled, committed, and highly motivated workforce
  - Accurate and predictable payments
  - High-value healthcare
  - Confident, informed consumers
  - Collaborative partnerships

**Fiscal intermediary-carrier model**

A fiscal intermediary, or an FI, is a mediator of financial matters. From a Medicare perspective, an FI is a private company with a Medicare contract to accept, process, pay, and review Medicare Part A claims and some Medicare Part B claims (depending on the provider type). Like an FI, Medicare carriers accept, process, pay, and review Medicare claims, but unlike FIs, they work with only
Medicare Part B claims (depending on the provider type), not Medicare Part A claims.

CMS is in the process of changing the structure of the FI-carrier and is converting all providers to a MAC. Each individual MAC will absorb the duties and roles of the FIs and carriers and be assigned other duties and responsibilities as well.

**MAC**

The Medicare Modernization Act of 2003 required CMS to convert to the current provider oversight model of FIs and carriers that process claims for different providers and for either Medicare Part A or Part B. The new MAC model, however, will allow one entity to process all Medicare Part A and Medicare Part B claims for fee-for-service claims (see Figure 1.7).

According to CMS,

> [They] designed the new MAC jurisdictions to balance the allocation of workloads, promote competition, account for integration of claims processing activities, and mitigate the risk to the Medicare program during the transition to the new contractors. The new jurisdictions reasonably balance the number of fee-for-service beneficiaries and providers. These jurisdictions will be substantially more alike in size than the existing fiscal intermediary and carrier jurisdictions, and they will promote much greater efficiency in processing Medicare’s billion claims a year.

The initial implementation to phase out fiscal intermediaries and carriers began in 2005 and continued through 2011. CMS highlighted the following expected outcomes from the transition to the MAC model:

- **Improved beneficiary services:**
  - Most beneficiaries will have their claims processed by only one contractor, reducing the number of separate explanation of benefits statements a beneficiary will receive and need to organize
  - A/B MACs will be required to develop an integrated and consistent approach to medical coverage across its service area, which benefits both beneficiaries and providers
  - Beneficiaries will be able to have their questions on claims answered by calling 1-800-MEDICARE, their single point of contact

- **Improved provider services:**
  - A simplified interface with a single MAC for Part A and Part B processing and other services will benefit providers
  - Competition will encourage MACs to deliver better service to providers
Requiring MACs to focus on financial management will result in more accurate claims payments and greater consistency in payment decisions.

Office of Inspector General
The mission of the Office of Inspector General (OIG) is:

[T]o protect the integrity of Department of Health and Human Services (HHS) programs, as well as the health and welfare of the beneficiaries of those programs. The OIG has a responsibility to report both to the Secretary and to the Congress program and management problems and recommendations to correct them. The OIG’s duties are carried out through a nationwide network of audits, investigations, inspections and other mission-related functions performed by OIG components.

In late 1998, the OIG published a public notice to solicit information and recommendations for developing compliance programs and guidance for skilled nursing facilities. The information submitted along with that request was carefully reviewed, along with other information previously published by the OIG. Then, in March 2000, the OIG published the Compliance Program Guidance for Nursing Facilities, which explained that, “The creation of compliance program guidance is a major initiative of the OIG in its effort to engage the private healthcare community in combating fraud and abuse.” Also based on the information submitted, the OIG published Supplemental Compliance Program Guidance for Nursing Facilities in September 2008. The following elements of an effective compliance program were published in 65 FR 14289, on March 16, 2000:

- Implementing written policies, procedures, and standards of conduct
- Designating a compliance officer and compliance committee
- Conducting effective training and education
- Developing effective lines of communication
- Enforcing standards through well-publicized disciplinary guidelines
- Conducting internal monitoring and auditing
- Responding promptly to detected offenses and developing corrective action

Each year, in addition to the Compliance Program Guidance information, the OIG provides their annual Work Plan for Skilled Nursing Facilities. For example, the FY15 Work Plan for Skilled Nursing Facilities has the following five areas of focus:

1. Medicare Part A billing by skilled nursing facilities
   a. OIG found during their previous audits that SNFs billed 25% of all 2009 claims in error
   b. This erroneous billing resulted in $1.5 billion in inappropriate Medicare payments
2. Questionable billing patterns for Part B services during nursing home stays
3. State agency verification of deficiency corrections
4. Program for national background checks for long-term-care employees
5. Hospitalizations of nursing home residents for manageable and preventable conditions

In addition to monitoring compliance, the OIG is also responsible for the following:

- Safe harbor regulations and anti-kickback statues
- Medicare and Medicaid fraud control
- Provider-specific work plans that identify target areas of review on an annual basis

**Government Accounting Office**

The Government Accounting Office (GAO) investigates how the federal government, including CMS, spends taxpayer dollars. This independent agency is engaged for special reviews, reports, and projects as directed by Congress. The duties of the GAO include the following, among others:

- Auditing agency operations to determine whether federal funds are being spent efficiently and effectively
- Investigating allegations of illegal and improper activities
- Reporting on how well government programs and policies are meeting their objectives
- Performing policy analyses and outlining options for congressional consideration
- Issuing legal decisions and opinions, such as bid protest rulings and reports on agency rules
To reduce your facility’s risk of unwanted outcomes and ensure proper Medicare reimbursement for the type and number of skilled services provided, it’s essential to submit claims appropriately and in accordance with the Centers for Medicare & Medicaid Services’ (CMS) skilled services regulations. Don’t miss out on Medicare reimbursement or put your facility at risk for fraudulent penalty charges and monetary recoupment!

Long-Term Care Skilled Services: How to Document for Proper Medicare Reimbursement breaks down CMS’ skilled services requirements and explains how facilities can best manage the daily operations that affect skilled coverage and necessary documentation. This book provides information for all staff members who play a role in determining and documenting skilled services and includes:

- Easy-to-understand explanations of complex CMS rules and regulations regarding skilled services
- A topic-driven format enabling readers to research specific questions and conveniently and efficiently obtain complete and descriptive answers
- Examples of documentation for skilled services
- Guidance to help facilities receive the benefits and reimbursement they deserve
- Downloadable forms

This book will help you:

- Identify common problems and challenges associated with skilled services and gain a better understanding of how to handle the major pain points
- Properly assess skilled services under the MDS 3.0
- Increase skilled census and improve their facility’s reputation with the support of the entire staff
- Avoid under- and overpayments from Medicare with easy-to-understand explanations of complex rules and regulations
- Provide necessary skilled services to each resident through a complete understanding of eligibility requirements
- Accurately document skilled services using proven, time-saving solutions for proper Medicare reimbursement