



# The Medicare Basics Course

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PRESENTATION TITLE

## Agenda

### Technical Eligibility

- Enrolled in Medicare
- Qualifying 3-day hospital stay
- Days available in a benefit period
- Physician certification/recertification of skilled need

### Skilled Level of Care Coverage Requirements

- Direct skilled services
- Indirect skilled services



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# Introduction

Understanding Medicare coverage criteria is critical for all members of the interdisciplinary team to ensure the center's success.

This session will cover technical eligibility and skilled coverage requirements.

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# Medicare Basics

## Medicare 101

- Health insurance for U.S. citizens or legal permanent residents:
  - Age 65 or older,
  - Under age 65 with certain disabilities, and
  - Any age with end-stage renal disease (ESRD) or amyotrophic lateral sclerosis (ALS)
- Part A: Hospital, inpatient SNF, home health care, hospice care
- Part B: Physician and other health care services, outpatient care, DME, home health care, many preventive services
- Part C: Medicare Advantage (MA) plan; Covers Part A, Part B, and often Part D drugs
- Part D: Prescription drug benefit

## Medicare Part A - SNF

- Medicare covers up to 100 days in each eligible benefit period
- Medicare pays 100% for the first 20 days
- Starting on day 21, beneficiary is responsible for a co-pay
  - 2023: \$217 per day



## **Technical Eligibility**

## **Technical Eligibility Requirements**

- Enrolled in Medicare
- 3 day Qualifying Hospital Stay
- Benefit Days Available
- Physician Certification of Skilled Need

## Medicare Coverage – Admissions

- Verify Medicare Coverage
- Determine if it is traditional Medicare Part A or Medicare Managed Care
- Medicare as a Secondary payor Screening (MSP)

## 3-Day Qualifying Hospital Stay

- Three consecutive midnights *as an inpatient* in a medically necessary hospital stay
  - Be careful about ER time and observation stays which are not inpatient status
  - MOON: Medicare Outpatient Observation Notice must be provided to any beneficiary receiving observation services in excess of 24 hours notifying of observation status
- Three midnights do not have to be at the same hospital, but do have to be consecutive

## Benefit Period

- A beneficiary may qualify for up to 100 days of Medicare Part A coverage in a benefit period if technical and daily skilled coverage criteria are met
- The benefit period begins when admitted to the hospital
- The benefit period ends when there are 60 consecutive days or more in which the resident does not receive SNF or higher level of care (60-day wellness period)
- There is no limit to the number of 100-day benefit periods as long as the resident experiences a 60-day wellness period, at some point, followed by a 3-day qualifying hospital stay
  - The wellness period does not have to immediately precede the hospitalization

## Benefit Period

- Once a beneficiary exhausts their benefit period, they will not be eligible for another benefit period until they achieve a 60 day wellness period, even if they are hospitalized for 3 or more days for a completely unrelated event
- Facilities need to validate prior to admission that the beneficiary has days remaining in a benefit period
- The HIPAA Eligibility Transaction Systems (HETS) allows providers to check Medicare beneficiary eligibility status in real time
  - Previously named the Common Working File
  - Is only a starting point for researching benefit periods as is only as current/accurate as other provider billing

## Benefit Period – 30 Day Transfer

- Medicare coverage in the SNF must begin within 30 days of discharge from the qualifying hospital stay
  - Day of hospital discharge does not count in the thirty day transfer requirement
- Medicare coverage can resume within 30 days of the last covered day when there are days remaining in the benefit period
- When skilled care is needed and initiated in a SNF, but another payment source which is primary to Medicare has covered the initial portion of the SNF stay:
  - The timely transfer requirement is considered to be met even if actual Medicare payment does not commence until later (after 30 days)
  - For example, if private health insurance pays 45 days and the beneficiary still needs and receives skilled care: Medicare day 1 would be day 46 of this stay. Days 1-45 in SNF (when Medicare was secondary) are not deducted from the SNF benefit period

## Benefit Period – Medical Appropriateness Exception

- May begin Part A stay more than 30 days after hospital discharge when patient's condition makes it medically inappropriate to begin SNF stay immediately after hospital discharge
- Must be medically predictable at the time of the hospital discharge that covered care will be required within a pre-determinable time period
- If beneficiary enters a SNF immediately upon discharge from hospital, for either covered or noncovered care, does not necessarily negate coverage at a later date, assuming the subsequent covered care was medically predictable
- Using the medical Appropriateness Exceptions – three options:
  - 1. Go home or to another setting and return to SNF after 30 days
  - 2. Go to a SNF utilizing another payor source until eligible for skilled care
  - Go to SNF in a Part A stay for a covered service that is needed now, then come off until the medically predicted time frame is over and go back on

## Physician Certification

- Physician must certify that SNF services are required to be given on an inpatient basis because of the resident's need for skilled nursing or rehabilitation care
- Physician certifies that care is needed on a continuing basis for the condition(s) for which he/she was receiving inpatient hospital services prior to his/her transfer to the SNF
- Initial physician certification is required on admission, or as soon thereafter as is reasonable and practical
- Physician, physician assistant (PA), nurse practitioner (NP), or clinical nurse specialist (CNS) may sign certifications
  - May be attending physician or physician on SNF staff with knowledge of the case –
  - The NP, CNS, or PA cannot have a direct or indirect employment relationship with the SNF

## Physician Recertification

- The first recertification must be obtained by day 14 of the stay, can be obtained with the initial certification
- Additional recertifications are required within 30 days of the date of the previous recertification
- The recertification statement must contain:
  - The continued need for extended care services
  - The estimated period of time required for the resident to remain in the facility
  - Any plans for home care, if appropriate
  - Need for SNF care is for a condition related to hospital stay or which arose during the SNF stay

## Delayed Certifications

- Delayed certifications and recertifications will be honored where there has been an isolated oversight or lapse
- Must include an explanation and relevant evidence for the delay.
- SNF may choose format, but delayed certifications must comply with the content requirements of the certification or recertification.



## Skilled Level of Care Criteria

## Skilled Care

- Must be for the treatment of a condition for which the beneficiary was:
  - Receiving inpatient hospital services or
  - A condition that arose while in the SNF for treatment of a condition for which the beneficiary was previously hospitalized
- Skilled services must be required on a daily basis as an inpatient in a SNF as a practical matter
- Skilled services must be ordered by a physician and must be reasonable and necessary when considering the frequency and duration

## Practical Matter Criteria

- As a practical matter, daily services can only be provided in a SNF if they are not available on an outpatient basis where individual resides, or transportation to the closest facility would be:
  - Excessive physical hardship
  - Less economical
  - Less efficient or effective than an inpatient institutional setting, or
  - If home care would be ineffective because patient has insufficient assistance to reside at home safely

## 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.

## Practical Matter Criteria

- Practical matter criterion should never be interpreted so strictly that it results in automatic denial of coverage for those who meet SNF level-of-care requirements, but are away from the SNF for a brief period of time (e.g., car ride, holiday meals)
- Day LOA began is treated as a day of discharge and is not counted as an inpatient day unless the patient returns to the facility by midnight of the same day. The day the patient returns to the hospital or SNF from an LOA is treated as a day of admission and is counted as an inpatient day if the patient is present at midnight on that day

## More About Skilled Care

- Skilled nursing and/or skilled rehabilitation services are those services, furnished pursuant to physician orders, that:
  - Require the skills of qualified technical or professional health personnel such as registered nurses, licensed practical (vocational) nurses, physical therapists, occupational therapists, and speech-language pathologists or audiologists; and
  - Must be provided directly by or under the general supervision of these skilled nursing or skilled rehabilitation personnel to assure the safety of the patient and to achieve the medically desired result.
- Diagnosis or prognosis should never be the sole factor in deciding that a service is or is not skilled

## Skilled Services

- Daily Skilled Rehabilitation Services
- Daily Skilled Nursing Services
- Indirect Skilled Services
  - Management and Evaluation of a Care Plan
  - Observation and Assessment
  - Teaching and Training

## Direct Skilled Rehabilitation Services

- Therapy services must be of an inherent level of complexity and sophistication, or the condition of the resident must be of a nature that requires the judgment, knowledge, and skills of a qualified therapist.
- Therapy services meet accepted standard of medical practice and
  - Be provided with the expectation that the patient's condition will improve measurably in a generally predictable time frame, or
  - Must be necessary for the establishment of a safe and effective maintenance program, or
  - Requires the skills of a qualified therapist for the performance of a safe and effective maintenance program
- The deciding factors are always whether the services are considered reasonable, effective treatments for the patient's condition and require the skills of a therapist, or whether they can be safely and effectively carried out by non-skilled personnel without the supervision of qualified professionals

## Direct Skilled Nursing Services

- 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;
  - Naso-pharyngeal and tracheotomy aspiration;
  - Insertion, sterile irrigation, and replacement of suprapubic catheters;

## Direct Skilled Nursing Services

- Examples, continued:
  - Heat treatments which have been specifically ordered by a physician as part of active treatment and which require observation by nurses to adequately evaluate progress.
  - Rehabilitation nursing procedures, including the related teaching and adaptive aspects of nursing, that are part of active treatment.
  - Oxygen therapy only in the initial phases of treatment.
    - Routine administration after a regimen of therapy has been established is not covered.
  - 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

## Direct Skilled Nursing Services

- Examples, continued:
  - Treatment of pressure or stasis ulcers at a Stage3 or higher
    - application of dressings involving prescription medications and aseptic techniques and treatment of extensive decubitus ulcers or other widespread skin disorder.
    - Changes of dressings for noninfected postoperative or chronic conditions and prophylactic and palliative skin care, including bathing and application of creams, or treatment of minor skin problems, do not meet the definition of skilled level of care.

## Indirect Skilled Nursing Services

- ***A service that is ordinarily considered nonskilled could be considered a skilled service in cases in which, because of special medical complications, skilled nursing or skilled rehabilitation personnel are required to perform or supervise it or to observe the patient.*** In these cases, the complications and special services involved must be documented by physicians' orders and nursing or therapy notes.
- **EXAMPLE:** 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.

## Indirect Skilled Nursing Services

- In determining whether services rendered in a 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.***
- **EXAMPLE:** An 81-year-old woman who is aphasic and confused, suffers from hemiplegia, congestive heart failure, and atrial fibrillation, has suffered a cerebrovascular accident, is incontinent, has a Stage 1 decubitus ulcer, and is unable to communicate and make her needs known. Even though no specific service provided is skilled, the patient's condition requires daily skilled nursing involvement to manage a plan for the total care needed, to observe the patient's progress, and to evaluate the need for changes in the treatment plan.

## Indirect Skilled Nursing Services

- The possibility of adverse effects from the improper performance of an otherwise unskilled service does not make it a skilled service **unless there is documentation to support the need for skilled nursing or skilled rehabilitation personnel.**
- *Although the act of turning a patient normally is not a skilled service, for some patients the skills of a nurse may be necessary to assure proper body alignment in order to avoid contractures and deformities.*
- *In all such cases, the reasons why skilled nursing or skilled rehabilitation personnel are essential must be documented in the patient's record.*

## Management and Evaluation of a Care Plan

- The development, management, and evaluation of a patient care plan, constitute skilled nursing services when, *in terms of the patient's physical or mental condition, these services require the involvement of skilled nursing personnel to meet the patient's medical needs, promote recovery, and ensure medical safety.*
- However, the planning and management of a treatment plan that does not involve the furnishing of skilled services may not require skilled nursing personnel; e.g., a care plan for a patient with organic brain syndrome who requires only oral medication and a protective environment.
- *The sum total of nonskilled services would only add up to the need for skilled management and evaluation when the condition of the beneficiary is such that there is an expectation that a change in condition is likely without that skilled nursing intervention.*

## Management and Evaluation of a Care Plan

- **EXAMPLE 1:** An aged patient with a history of diabetes mellitus and angina pectoris is recovering from an open reduction of the neck of the femur. 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 notice signs of deterioration in his condition or complications resulting from his restricted (but increasing) mobility.
- Although any of the required services could be performed by a properly instructed person, that person would not have the capability to understand the relationship among the services and their effect on each other. Since the nature of the patient's condition, his age and his immobility create a high potential for serious complications, such an understanding is essential to assure the patient's recovery and safety.
- The management of this plan of care requires skilled nursing personnel until the patient's treatment regimen is essentially stabilized, even though the individual services involved are supportive in nature and do not require skilled nursing personnel.

## Management and Evaluation of a Care Plan

- **EXAMPLE 2:** 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.

## Management and evaluation of a Care Plan

- 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.*

## Observation and Assessment

- Observation and assessment are skilled services when the likelihood of change in a patient's condition requires skilled nursing or skilled rehabilitation personnel to identify and evaluate the patient's need for possible modification of treatment or initiation of additional medical procedures, until the patient's treatment regimen is essentially stabilized.

## Observation and Assessment

- **EXAMPLE 1:** 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.

## Observation and Assessment

- **EXAMPLE 2:** A patient has undergone peripheral vascular disease treatment including revascularization procedures (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.
- **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, skin breakdown, or need for the administration of subcutaneous Heparin, is both reasonable and necessary.

## Observation and Assessment

- **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.
- **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.

## Observation and Assessment

- 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.
- 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.

## Teaching and Training Activities

- 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 and Training Activities

- Examples, continued:
  - 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.

## Questionable Situations

- There must be specific evidence that daily skilled nursing or skilled rehabilitation services are required and received if:
  - The primary service needed is oral medication; or
  - The patient is capable of independent ambulation, dressing, feeding, and hygiene.



## Summary

It is critical for all members of the interdisciplinary team to understand the basics of Medicare regulations and their role in the beneficiary's and facility's success. Ongoing education and staff development is critical.

# Thank you

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