Bridging the Gap between SNF and Hospice
Pre-Test

https://www.surveymonkey.com/r/DW6RTHS
Introductions and Housekeeping

• Speakers
• Handouts
• Bathrooms
The information provided in this presentation was current as of 7/05/2019.

Any changes or new information superseding the information in this presentation is provided in articles with publication dates after 7/05/2019, posted on our website at: www.PalmettoGBA.com/JJA

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Who is Palmetto GBA?
• Medicare Administrative Contractor (MAC)
• Founded in 1965
• Headquartered in Columbia, South Carolina
• More than 1,500 associates in offices in Alabama, Georgia and South Carolina
• Creates value for government and commercial customers every day
• Finance and accounting
• Claims processing
• Contact center operations
• Enrollment
• Medical review and medical policy
Palmetto GBA Statistics

- 3 billion transactions processed annually
- 7.9 million documents processed via iFlow
- 7.6 million beneficiaries served
65.3 BILLION
dollars in benefits paid

184 MILLION
claims processed

11.5* MILLION
beneficiaries served
(*unduplicated)

2.9 MILLION
customer inquiries answered

2,025
employees working across five operation sites

81
ranking on Information Week’s list of 500 most innovative companies

Calendar year ended December 31, 2018
Leadership

W. JOE JOHNSON
PRESIDENT & COO

NELLA BISHOP
CIO & VICE PRESIDENT
Systems & Support

NEAL BURKHEAD
VICE PRESIDENT
Shared Services

DEBBIE DICKSON
VICE PRESIDENT
Jurisdiction J
A/B MAC Operations

ELAINE GARRICK
VICE PRESIDENT
Support Operations

KEN LEWIS
VICE PRESIDENT & CFO

TIM MASHECK
VICE PRESIDENT
Information Technology Services

ED SANCHEZ
VICE PRESIDENT
Jurisdiction M
A/B MAC Operations
**Mission:** To provide Medicare providers with the timely and accurate information they need to understand the fundamentals of the billing and documentation requirements of the Medicare program and be informed about changes to those regulations in order to reduce the prevalence of billing and documentation errors.

**Vision:** To establish relationships with providers and their associations and societies in order to be recognized as a reliable resource for Medicare education.
• Provide education for providers who are new to the Medicare program
• Provide education tailored to small providers
• Provide education through various channels
• Utilize data analysis in order to identify areas of focus for the education
• Measure the effectiveness of the education provided
Methods:

• **Global Education**: General Medicare billing and documentation requirement education will be offered to providers at large

• **Targeted Education**: Providers will be identified through data analysis and provided education specific to them and their needs
<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
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<tbody>
<tr>
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<td>9,261</td>
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<td>1,708</td>
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<td>406,568</td>
<td>3,027</td>
<td>12,491</td>
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<td>Other</td>
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<td>1,272,851</td>
<td>33,459</td>
<td>10,195</td>
<td>554,250,305</td>
<td>61,783</td>
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<tr>
<td>TOTAL</td>
<td>680,451,129</td>
<td>697</td>
<td>976,257</td>
<td>73,108</td>
<td>9,307</td>
<td>1,233,357,333</td>
<td>137,808</td>
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<tr>
<td>AL</td>
<td>7,531,840</td>
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<td>80,126</td>
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<td>1,676</td>
<td>13,244,575</td>
<td>10,555</td>
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<td>4,975</td>
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<td>11,561</td>
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<td>1,799</td>
<td>33,792,731</td>
<td>20,849</td>
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<td>Other</td>
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<td>28,557</td>
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<tr>
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<td>50,622,733</td>
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<td>75,108</td>
<td>30,229</td>
<td>1,675</td>
<td>101,496,384</td>
<td>71,522</td>
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## 23x SNF (Outpatient Services)

<table>
<thead>
<tr>
<th></th>
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<th></th>
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<td>AL</td>
<td>350,340</td>
<td>21</td>
<td>16,683</td>
<td>422</td>
<td>830</td>
<td>776,816</td>
<td>851</td>
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<tr>
<td>GA</td>
<td>726,490</td>
<td>37</td>
<td>19,635</td>
<td>543</td>
<td>1,338</td>
<td>1,250,839</td>
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<td>TN</td>
<td>3,218,523</td>
<td>122</td>
<td>26,381</td>
<td>2,730</td>
<td>1,179</td>
<td>7,599,782</td>
<td>5,868</td>
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<td>Other</td>
<td>3,022,959</td>
<td>153</td>
<td>19,758</td>
<td>2,617</td>
<td>1,155</td>
<td>5,852,387</td>
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<td>TOTAL</td>
<td>7,318,312</td>
<td>333</td>
<td>21,977</td>
<td>6,312</td>
<td>1,159</td>
<td>15,479,824</td>
<td>13,925</td>
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</tbody>
</table>
Skilled Nursing Facility Program for Evaluating Payment Patterns Electronic Report
The Government Accountability Office has designated Medicare as a program at high risk for fraud, waste and abuse.

Payments to skilled nursing facilities (SNFs) have been identified as vulnerable to abuse.

In 2012 the Office of Inspector General (OIG) found that approximately 25% of SNF claims were billed in error.

The Office of Inspector General encourages SNFs to develop and implement a compliance program to protect their operations from fraud and abuse.
• Beginning in 2013, according to statutory language in section 6102 of the Affordable Care Act, SNFs are required to have a compliance program.

• As part of a compliance program, a SNF should conduct regular audits to ensure services provided are necessary and that charges for Medicare services are correctly documented and billed.
National SNF claims data was analyzed to identify areas within the SNF prospective payment system (PPS), which could be at risk for improper Medicare payment.

These areas are referred to as “target areas.” PEPPER is a data report that contains a single SNF’s Medicare claims data statistics (obtained from the UB-04 claims submitted to the Medicare Administrative Contractor (MAC) for these target areas).
PEPPER is a data report that contains a single SNF’s Medicare claims data statistics (obtained from the UB-04 claims submitted to the Medicare Administrative Contractor (MAC) for these target areas.

All SNFs that have sufficient data to generate a report receive a PEPPER, which contains statistics for these target areas.

The report shows how a SNF’s data compares to aggregate jurisdiction, state and national statistics. Statistics in PEPPER are presented in tabular form as well as in graphs that depict the SNF’s target area percentages over time.
What is PEPPER?

https://pepper.cbrpepper.org/

Updated annually, April 5, 2019
Target Area Percentages are calculated by dividing the number of target discharges/episodes of care by the number of denominator discharges/episodes of care for each provider for each time period, then multiplying by 100.

Example:
- Numerator count = 20, and
- Denominator count = 100
- \( \times 100 = 20 \)

Target Area Percent is 20%
• The Target Area Percent lets the provider know its billing patterns
• The Percentiles give context by helping a provider understand how it compares to other providers
• Definition of a Percentile:
The percentage of providers with a lower target area percent
To calculate Percentiles for all providers in a comparison group (nation, jurisdiction or state) the target area percentages are sorted from largest to smallest for each time period.

Example:

If 40% of the providers' target area percent were lower than provider A, then provider A would be at the 40th percentile.
If a provider’s percent is at or above the 80th percentile, it is considered an outlier:
- 80% of providers had a lower percent.

If a provider’s percent is at or below the 20th percentile, it is considered an outlier (areas at risk for undercoding):
- 20% of providers had a lower percent.
The top two providers’ percentages are at or above the 80th percentile.

The bottom two providers’ percentages are at or below the 20th percentile.
N: count of episodes of care ending in the report period with a length of stay of 20 days.

D: count of all episodes of care ending in the report period.
### JJ 20-day Episodes of Care

#### 759 SNFs

<table>
<thead>
<tr>
<th>Target Area</th>
<th>Q4 FY 2016</th>
<th>Q4 FY 2017</th>
<th>Q4 FY 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of episodes of care with a length of stay of 20 days</td>
<td>7,452</td>
<td>7,407</td>
<td>7,011</td>
</tr>
<tr>
<td>All episodes of care</td>
<td>120,2230</td>
<td>118,454</td>
<td>112,726</td>
</tr>
<tr>
<td>Proportion of Target to Denominator Discharges</td>
<td>6.2%</td>
<td>6.3%</td>
<td>6.2%</td>
</tr>
<tr>
<td>Average Length of Stay for Target</td>
<td>20.0</td>
<td>20.0</td>
<td>20.0</td>
</tr>
<tr>
<td>Average Medicare Payment for Target</td>
<td>$8,959</td>
<td>$9,231</td>
<td>$9,263</td>
</tr>
<tr>
<td>Sum of Medicare Payments for Target</td>
<td>$66,765,867</td>
<td>$68,372,981</td>
<td>$64,942,247</td>
</tr>
</tbody>
</table>
# Alabama 20-day Episodes of Care

## 248 SNFs

<table>
<thead>
<tr>
<th>Target Area</th>
<th>Q4 FY 2016</th>
<th>Q4 FY 2017</th>
<th>Q4 FY 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of episodes of care with a length of stay of 20 days</td>
<td>6,373</td>
<td>5,524</td>
<td>4,978</td>
</tr>
<tr>
<td>All episodes of care</td>
<td>35,820</td>
<td>32,955</td>
<td>30,035</td>
</tr>
<tr>
<td>Proportion of Target to Denominator Discharges</td>
<td>17.8%</td>
<td>16.8%</td>
<td>16.6%</td>
</tr>
<tr>
<td>Average Length of Stay for Target</td>
<td>20.0</td>
<td>20.0</td>
<td>20.0</td>
</tr>
<tr>
<td>Average Medicare Payment for Target</td>
<td>$8,599</td>
<td>$8,703</td>
<td>$8,674</td>
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<tr>
<td>Sum of Medicare Payments for Target</td>
<td>$54,804,084</td>
<td>$48,077,678</td>
<td>$43,178,598</td>
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</table>
# Georgia 20-day Episodes of Care

## 374 SNFs

<table>
<thead>
<tr>
<th>Target Area</th>
<th>Q4 FY 2016</th>
<th>Q4 FY 2017</th>
<th>Q4 FY 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of episodes of care with a length of stay of 20 days</td>
<td>2,908</td>
<td>2,941</td>
<td>2,881</td>
</tr>
<tr>
<td>All episodes of care</td>
<td>40,105</td>
<td>39,214</td>
<td>37,161</td>
</tr>
<tr>
<td>Proportion of Target to Denominator Discharges</td>
<td>7.3%</td>
<td>7.5%</td>
<td>7.8%</td>
</tr>
<tr>
<td>Average Length of Stay for Target</td>
<td>20.0</td>
<td>20.0</td>
<td>20.0</td>
</tr>
<tr>
<td>Average Medicare Payment for Target</td>
<td>$9,100</td>
<td>$9,398</td>
<td>$9,443</td>
</tr>
<tr>
<td>Sum of Medicare Payments for Target</td>
<td>$26,463,109</td>
<td>$27,639,853</td>
<td>$27,206,273</td>
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</table>
### Tennessee 20-day Episodes of Care

#### 323 SNFs

<table>
<thead>
<tr>
<th>Target Area</th>
<th>Q4 FY 2016</th>
<th>Q4 FY 2017</th>
<th>Q4 FY 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of episodes of care with a length of stay of 20 days</td>
<td>2,104</td>
<td>2,146</td>
<td>2,005</td>
</tr>
<tr>
<td>All episodes of care</td>
<td>46,264</td>
<td>44,640</td>
<td>42,163</td>
</tr>
<tr>
<td>Proportion of Target to Denominator Discharges</td>
<td>4.5%</td>
<td>4.8%</td>
<td>4.8%</td>
</tr>
<tr>
<td>Average Length of Stay for Target</td>
<td>20.0</td>
<td>20.0</td>
<td>20.0</td>
</tr>
<tr>
<td>Average Medicare Payment for Target</td>
<td>$8,894</td>
<td>$9,104</td>
<td>$9,059</td>
</tr>
<tr>
<td>Sum of Medicare Payments for Target</td>
<td>$18,712,014</td>
<td>$19,536,336</td>
<td>$18,163,295</td>
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</tbody>
</table>
### 20-day Episodes of Care (new as of the Q4FY17 release)

<table>
<thead>
<tr>
<th>Time Period</th>
<th>Target Area Percent</th>
<th>Target Count (Numerator)</th>
<th>Denominator Count</th>
<th>Target (Numerator) Average Length of Stay</th>
<th>Denominator Average Length of Stay</th>
<th>Target (Numerator) Sum of Payments</th>
</tr>
</thead>
<tbody>
<tr>
<td>10/1/15 – 9/30/16</td>
<td>2.9%</td>
<td>20</td>
<td>700</td>
<td>20.0</td>
<td>32.5</td>
<td>$228,658</td>
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<tr>
<td>10/1/16 – 9/30/17</td>
<td>2.1%</td>
<td>16</td>
<td>773</td>
<td>20.0</td>
<td>39.0</td>
<td>$214,075</td>
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<tr>
<td>10/1/17 – 9/30/18</td>
<td>1.4%</td>
<td>11</td>
<td>777</td>
<td>20.0</td>
<td>43.6</td>
<td>$137,215</td>
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</table>

#### Comparative Data

<table>
<thead>
<tr>
<th>Time Period</th>
<th>National 80th Percentile</th>
<th>Jurisdiction 80th Percentile</th>
<th>State 80th Percentile</th>
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</thead>
<tbody>
<tr>
<td>10/1/15 – 9/30/16</td>
<td>10.3%</td>
<td>10.8%</td>
<td>10.7%</td>
</tr>
<tr>
<td>10/1/16 – 9/30/17</td>
<td>10.8%</td>
<td>10.8%</td>
<td>10.7%</td>
</tr>
<tr>
<td>10/1/17 – 9/30/18</td>
<td>10.7%</td>
<td>10.7%</td>
<td>10.7%</td>
</tr>
</tbody>
</table>

*Data not available when target count less than 11.*

**Suggested Interventions for High Outliers:**

This could indicate that the SNF is continuing treatment beyond the point where services are necessary. The SNF should review documentation for beneficiary episodes of care with a length of stay of 20 days to ensure that beneficiaries’ continued care is appropriate and that they received a skilled level of care. The SNF should review appropriateness of plans of care and discharge planning.

**Note:**
State and/or jurisdiction percentiles are zero if there are fewer than 11 providers with reportable data for the target area in the state and/or jurisdiction.
90+ Day Episodes of Care

N: count of episodes of care ending in the report period with a length of stay of 90+ days.

D: count of all episodes of care ending in the report period.
<table>
<thead>
<tr>
<th>Target Area</th>
<th>Q4 FY 2016</th>
<th>Q4 FY 2017</th>
<th>Q4 FY 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of episodes of care with a length of stay of 20 days</td>
<td>7,671</td>
<td>6,425</td>
<td>5,423</td>
</tr>
<tr>
<td>All episodes of care</td>
<td>120,223</td>
<td>118,454</td>
<td>112,726</td>
</tr>
<tr>
<td>Proportion of Target to Denominator Discharges</td>
<td>6.4%</td>
<td>5.4%</td>
<td>4.8%</td>
</tr>
<tr>
<td>Average Length of Stay for Target</td>
<td>98.5</td>
<td>98.5</td>
<td>98.5</td>
</tr>
<tr>
<td>Average Medicare Payment for Target</td>
<td>$32,902</td>
<td>$33,551</td>
<td>$33,570</td>
</tr>
<tr>
<td>Sum of Medicare Payments for Target</td>
<td>$252,391,870</td>
<td>$215,565,272</td>
<td>$182,051,993</td>
</tr>
<tr>
<td>Target Area</td>
<td>Q4 FY 2016</td>
<td>Q4 FY 2017</td>
<td>Q4 FY 2018</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------</td>
<td>------------</td>
<td>------------</td>
<td>------------</td>
</tr>
<tr>
<td>Number of episodes of care with a length of stay of 90+ days</td>
<td>2,133</td>
<td>1,921</td>
<td>1,523</td>
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<tr>
<td>All episodes of care</td>
<td>35,820</td>
<td>32,955</td>
<td>30,035</td>
</tr>
<tr>
<td>Proportion of Target to Denominator Discharges</td>
<td>6.0%</td>
<td>5.8%</td>
<td>5.1%</td>
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<tr>
<td>Average Length of Stay for Target</td>
<td>98.9</td>
<td>98.9</td>
<td>98.7</td>
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<td>Average Medicare Payment for Target</td>
<td>$27,414</td>
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<td>$27,354</td>
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<tr>
<td>Sum of Medicare Payments for Target</td>
<td>$58,473,276.86</td>
<td>$53,421,405.59</td>
<td>$41,660,514.87</td>
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## Georgia 90+ Day Episodes of Care

<table>
<thead>
<tr>
<th>Target Area</th>
<th>Q4 FY 2016</th>
<th>Q4 FY 2017</th>
<th>Q4 FY 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of episodes of care with a length of stay of 90+ days</td>
<td>2,924</td>
<td>2,541</td>
<td>2,195</td>
</tr>
<tr>
<td>All episodes of care</td>
<td>40,105</td>
<td>39,214</td>
<td>37,161</td>
</tr>
<tr>
<td>Proportion of Target to Denominator Discharges</td>
<td>7.3%</td>
<td>6.5%</td>
<td>5.9%</td>
</tr>
<tr>
<td>Average Length of Stay for Target</td>
<td>98.6</td>
<td>98.5</td>
<td>98.7</td>
</tr>
<tr>
<td>Average Medicare Payment for Target</td>
<td>$31,859</td>
<td>$32,384</td>
<td>$32,892</td>
</tr>
<tr>
<td>Sum of Medicare Payments for Target</td>
<td>$93,155,608.85</td>
<td>$82,287,941.89</td>
<td>$72,197,326.32</td>
</tr>
</tbody>
</table>
## Tennessee 90+ Day Episodes of Care

<table>
<thead>
<tr>
<th>Target Area</th>
<th>Q4 FY 2016</th>
<th>Q4 FY 2017</th>
<th>Q4 FY 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of episodes of care with a length of stay of 90+ days</td>
<td>3,953</td>
<td>3,441</td>
<td>2,858</td>
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<tr>
<td>All episodes of care</td>
<td>46,264</td>
<td>44,640</td>
<td>42,163</td>
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<td>Proportion of Target to Denominator Discharges</td>
<td>8.5%</td>
<td>7.7%</td>
<td>6.8%</td>
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<tr>
<td>Average Length of Stay for Target</td>
<td>98.6</td>
<td>98.6</td>
<td>98.6</td>
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<tr>
<td>Average Medicare Payment for Target</td>
<td>$31,128</td>
<td>$31,745</td>
<td>$32,251</td>
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<tr>
<td>Sum of Medicare Payments for Target</td>
<td>$123,049,553.57</td>
<td>$109,234,106.39</td>
<td>$92,173,672.19</td>
</tr>
</tbody>
</table>
• This could indicate that the SNF is continuing treatment beyond the point where services are necessary

• The SNF should review documentation for beneficiary episodes of care with a length of stay of 20 days/90 days to ensure that beneficiaries’ continued care is appropriate and that they received a skilled level of care

• The SNF should review appropriateness of plans of care and discharge planning
Part I

Vinsetta Montgomery
Senior Provider Relations Representative
Provider Outreach and Education
Agenda

- Medicare Beneficiary Identifier (MBI)
- Claims Payment Issues Log (CPIL)
- Fraud & Abuse
- Medicare Secondary Payer (MSP)
- Skilled Nursing Facility (SNF)
- eServices — Registration
- Resources
Medicare Beneficiary Identifier (MBI)
Why is there a Change?

- The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 mandates removal of the Social Security Number (SSN) based Health Insurance Claim Number (HICN) from Medicare cards to address current risk of beneficiary medical identity theft.

What is the Change?

- CMS will generate MBIs for all Medicare beneficiaries.
- Those affected include active, deceased, and new beneficiaries.
- All active and new beneficiaries will receive Medicare cards with the MBI.

Benefits

- If Medicare card is lost or stolen, a new MBI will be generated.
- Old MBI will be deactivated.
- The new MBI is not associated with Social Security Numbers.
Transition period
April 2018 through December 31, 2019

Starting January 1, 2020, you **MUST** submit claims using MBIs (with a few exceptions), no matter what date you performed the service. We’re now in a transition period that goes through December 31, 2019, where you can use either the HICN or the MBI to exchange data with us.

**Exceptions AFTER the transition Period:**

- **Appeals** — People filing appeals can use either the HICN or the MBI for their appeals and related forms
- **Adjustments** — You can use the HICN indefinitely for some systems (Drug Data Processing, Risk Adjustment Processing, and Encounter Data) and for all records, not just adjustments
Medicare Beneficiary Identifier (MBI)

Can’t Find the MBI?

- Ask your patients. If they don’t know:
  - Refer them to 800-Medicare (800–633–4227)
  - Refer them to www.mymedicare.gov

- Check the remittance advice
  - After October 1, 2018, the MAC will return both the MBI and HICN on the remittance Advice

- Use the MAC's secure MBI Lookup Tool
  - eServices
Claims Payment Issues Log (CPIL)
The CPIL is a list of system-related claims payment and processing issues. They are reported to the Centers for Medicare & Medicaid Services (CMS) and/or the Fiscal Intermediary Standard System (FISS).

- The CPIL link is located on the Palmetto GBA Home page and from Tools.
- Check often for updates before contacting the provider contact center.
- The issues are identified by stand-alone articles and will be updated as needed.

**Options:** Current Issues & Resolved Issues

**Article Update Notifications**

- Receive notification when one of the CPIL articles is updated.
- Sign up in the new Article Update Notification box.
- You can only sign up for notifications on a per-article basis.
Jurisdiction J Part A MAC
Part A Providers in Alabama, Georgia and Tennessee

Top Links
- CERT Error Rate Map
- Claims Payment Issues Log
- Credit Balance Reporting (CMS 838)
- Medical Policies
- Medicare Secondary Payer
- Overpayments and Recoupment

Top Forms/Tools
- Medicare Forms
- Charge Denial Rate Calculator
- eServices Portal
- IVR Conversion Tool

View All Tools
Claims Payment Issues Log -

Here is a list of current system-related claims payment and processing issues. These issues have been reported to the Centers for Medicare & Medicaid Services (CMS) and/or the Fiscal Intermediary Standard System (FISS). Please check often for updates before contacting the provider contact center. The issues are identified by stand alone articles and will be updated as needed.

Need help finding what you are looking for on this page?
Please Select a Topic: Please Select

Article Update Notifications
Would you like to receive a notification when one of the CPIL articles is updated? At the bottom of each article, sign up in the new Article Update Notification box, and we'll send you an email with the new article any time it changes.

Note: You can only sign up for notifications on a per-article basis; if you would like notifications for more than one, please sign up for each article individually.

Latest Articles

Clinical Trial Implantable Defibrillator Claims

06/28/2019
PROTECT the MEDICARE PROGRAM, your PATIENTS and YOURSELF

Medicare FRAUD & ABUSE is a serious problem that needs your attention

Here are ways to avoid fraudulent activities:

- Designate a compliance officer or contact and implement compliance and practice standards
- Conduct appropriate training and education while developing open lines of communication with employees


For more information, visit the Medicare Learning Network at https://go.cms.gov/mln-fraud-abuse


ICN#095363 September 2016
The government's primary civil tool for addressing healthcare fraud is the False Claims Act (FCA).

- Most FCA cases are resolved through settlement agreements

- The Office of the Inspector General (OIG) assesses the future trustworthiness of the settling parties (which can be individuals or entities) for purposes of deciding whether to exclude them from the Federal healthcare programs or take other action
CMS Improperly Paid Millions of Dollars for Skilled Nursing Facility Services When the Medicare 3-Day Inpatient Hospital Stay Requirement Was Not Met

Federal Requirements

• Beneficiary must have been an inpatient of a hospital (one or more) for a medically necessary stay of at least 3 consecutive calendar days, not counting the date of discharge (42 CFR § 409.30(a)(1))

• May not include observation, emergency room, or discharge days

• Must be admitted to the SNF and receive the needed care within 30 calendar days (unless the post-hospital SNF care would not be medically appropriate within 30 days) after the date of discharge from a hospital (42 CFR § 409.30(b))
Why Requirement Was Not Met:

- Absence of a coordinated notification mechanism
- Hospitals did not always provide correct inpatient stay information to SNFs
- SNFs used a combination of inpatient and non-inpatient hospital days to determine whether the 3-day rule was met
- CMS allowed SNF claims to bypass the CWF qualifying stay edit

https://oig.hhs.gov/oas/reports/region5/51600043.asp
FOR GENERAL PUBLIC & PROVIDERS - REPORT ABOUT MEDICARE & MEDICAID:

By Phone
Health & Human Services Office of the Inspector General
1-800-HHS-TIPS
(1-800-447-8477)
TTY: 1-800-377-4950

By Fax
maximum 10 pages
1-800-223-8164

By Mail
Office of Inspector General
ATTN: OIG HOTLINE OPERATIONS
P.O. Box 23489
Washington, DC 20026

Online
Health & Human Services Office of the Inspector General Website
Medicare Secondary Payer (MSP) is the term generally used when the Medicare program does not have primary payment responsibility. That is, when another entity has the responsibility for paying before Medicare.
Common Situations — Primary vs. Secondary Payer Responsibility

• Working Aged (Medicare beneficiaries age 65 or older) and Employer Group Health Plan (GHP)
• Disability and Employer GHP
• End-Stage Renal Disease (ESRD)
• Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)
• Retiree Health Plans
• No-fault Insurance and Liability Insurance
• Workers’ Compensation Insurance
Conditional Payments

• A provider may submit a claim to Medicare for conditional payment for services for which another payer is responsible

• If payment has not been made or cannot be expected to be made promptly from the other payer, Medicare may make a conditional payment, under some circumstances, subject to Medicare payment rules

• Conditional payments are made subject to repayment when the primary plan makes payment
Types of Conditional Payment

Group Health Plan (GHP) Conditional Payment — The physical or mental incapacity of the beneficiary, provider, physician or other supplier, or beneficiary failed to file a proper claim with the GHP.

No-Fault, Workers’ Compensation, and Liability Insurance Conditional Payment — A conditional payment may be made in situations where liability, no-fault or workers’ compensation claims apply when:

• The claim has been submitted to the primary payer; and
  ✓ There is an expectation that payment will be recovered from the primary payer once payer status or liability settlements are resolved; or
  ✓ Payment is not received promptly
Situations When Conditional Payment is Denied

Medicare will deny claims submitted for conditional payment when the provider submits the claim to the liability, no-fault, or workers’ compensation claims and payment is denied if:

• There is an employer GHP that is primary to Medicare
• Provider did not send the claim to the employer GHP first
• Provider submitted the claim to the liability insurer (including the self-insurer), no-fault, insurer or workers’ compensation entity, but the insurer entity did not pay the claim if:
  ✓ There is an employer GHP that is primary to Medicare
  ✓ The employer GHP denied the claim because the GHP asserted that the liability insurer (including the self-insurer), no-fault insurer or WC entity should pay first
Additional Tips

• If the liability, workers’ compensation or no-fault denies payment because the benefits are exhausted, do not submit a MSP claim. Submit the claim to Medicare as primary.

• If the MSP record on the CWF file does not show a termination date, contact the Benefits Contractor & Recovery Center (BCRC), formerly known as the Coordination of Benefits Contractor (COBC), to have the record updated. The claim will be submitted to Medicare as primary after the BCRC updates the record. Remarks should be entered on the claim explaining that the benefits have been exhausted. Providers may refer to MLN Matters Article SE1416 for more information on how to contact the BCRC.
MSP — Conditional Payments

Additional Tips

• If the services are not related to the open liability, workers’ compensation, or no-fault record, follow the instructions on the MSP Interactive Tool to submit the claim as Medicare primary.

• A conditional claim cannot be submitted to Medicare if there is no MSP record on the CWF. If the services are related to the open liability, workers’ compensation, or no-fault plan, contact the BCRC to have the appropriate record added to the patient’s file.

• If the primary insurer denies a claim because the policy has terminated, do not submit a MSP claim. If the MSP record on the CWF file does not show the termination date, contact the BCRC to have the record updated. Medicare cannot process the claim for primary payment until the CWF file has been updated.
Can a provider deny service to a Medicare beneficiary because of an open WC, no-fault, or liability insurance MSP record found on the Common Working File (CWF)? (Providers state they are not admitting or seeing a beneficiary because Medicare will not pay for services due to an open MSP record.)

Answer:
No. Services cannot be refused on this basis AND it is against the law! Medicare makes payment on covered and reimbursable services based on strict processes and procedures.
Does the Questionnaire have to be completed at each encounter?

**Answer:**

**Complete questionnaire if:**
- New patient
- Changed insurance information/uncertainty
- Questionnaire on file is >90 days old

**No questionnaire needed if:**
- Patient MSP question information **has not** changed
- Document that all the questions were **not** asked based on the beneficiary’s statement that their insurance information has not changed

**Exceptions:**
- Reference Lab
- Medicare Advantage (MA) Members
- Provider Based and Non-Provider Based Services, such as Ambulance Services
Skilled Nursing Facility (SNF)

Coverage

Consolidated Billing (CB)
Benefit Period

Begins the day the Medicare beneficiary is admitted to a hospital or SNF as an inpatient and ends after he or she has not been an inpatient of a hospital or received skilled care in a SNF for 60 consecutive days.

- Once the benefit period ends, a new benefit period begins when the beneficiary has an inpatient admission to a hospital or SNF
- New benefit periods do not begin due to a change in diagnosis, condition, or calendar year
- 100 Days of coverage:
  - 20 days paid in full by Medicare
  - 80 days with coinsurance ($170.50 for 2019)
  - Beyond 100 days: 100% of all costs
Benefit Period — Multiple

May be more than one benefit period in a calendar year, or one benefit period may overlap a calendar year.

- Diagnoses do not affect benefit period determination
- Renewed every 60 days if there is no inpatient hospitalization
Benefit Period — Start

Begins with first day patient is furnished inpatient hospital or extended care services by a qualified provider in a month for which patient is entitled to hospital insurance benefits.

- Midnight to midnight method of counting
Benefit Period — End

Ends when patient has not been inpatient in a hospital, SNF or Swing Bed (SB) for 60 consecutive days.

- Count begins with day patient was discharged
- For benefit period purposes, SNF/SB inpatient status ends when patient no longer meets daily skilled care requirements
Part A SNF Coverage Criteria

• Beneficiary is entitled to the Medicare Part A benefit
• Require daily skilled level of care services
• Daily skilled services can only be provided on an inpatient basis in a SNF
• Must be medically reasonable and necessary for treatment of the patient’s illness or injury
Qualifying hospital stay of at least 3 consecutive days of inpatient care for related illness/injury

- Not counting day of discharge or time in observation
- Stay can be in one or more Medicare participating hospitals
  - Or institution that meets at least the conditions of participation for emergency service hospital
- Admitted to SNF within 30 days of hospital discharge
Clarifications

• Psychiatric Hospitals: 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.

• Stays in Religious Nonmedical Health Care are excluded for the purpose of satisfying the 3-day period of hospitalization
Three (3) Day Qualifying Hospital Stay Exception

Disenrollment from a Medicare Advantage hospital stay before SNF admission
- If admitted to SNF prior to effective date of disenrollment
30 Day Transfer Requirement

Must be transferred to a participating SNF within 30 days after discharge from hospital

Unless

• Patient’s condition makes it medically inappropriate to begin active treatment in a SNF immediately after hospital discharge, and;

• It is medically predictable at time of hospital discharge that patient will require covered care within a predetermined time.
SNF Readmissions

- If patient is discharged from skilled level of care (LOC) and subsequently is readmitted at a skilled LOC to same or another facility within 30 days, a new qualifying stay is not required.
- If readmission occurs more than 30 days after discharge, a new qualifying stay is required unless there’s a medically appropriate delay.
- Care must be related to prior hospital or SNF stay.
Consolidated Billing
Background

- BBA 1997 mandated payment for majority of services provided to patients in a Medicare-covered Part A SNF stay be bundled in PPS
  - Excluded services not subject to CB

- Bundled services required to be billed by SNF/SB
  - Entities that provide services for patients in a SNF stay cannot bill separately for those services
Facilities Subject to CB

• Medicare participating SNFs Short term hospitals, long term hospitals, and rehabilitation hospitals certified as SB
  • Except CAH SB

• All Part A and B physical, occupational and speech therapy services must be provided directly or indirectly, and billed by SNF
  • Includes covered and non-covered stays
SNF CB — Requirements

• Requirement makes SNF responsible for billing almost all services during a Medicare stay
  • Services must be furnished directly by SNF resources or obtained under arrangement with an outside entity

• SNF must reimburse entity for services subject to CB whether agreement is in place prior to services or after
SNF CB — Requirements

• Exception to specifically excluded services
• Excluded services are separately furnished and billed to Part B by outside sources

http://www.cms.gov/SNFConsolidatedBilling/
Under Arrangement

Private agreement/contract between SNF and outside entity is recommended

- Both parties should reach common understanding on terms of payment
- Absence of a valid arrangement does not invalidate SNF responsibility to reimburse outside entity

CMS sample agreement forms at:
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/BestPractices.html
SNF CB — Major Categories

- CMS divides services affected by SNF CB into major categories
  - General Explanation of Major Categories for SNF CB
- Must understand these major categories to apply CB principles correctly to billing
<table>
<thead>
<tr>
<th>Major Category I</th>
<th>Major Category II</th>
<th>Major Category III</th>
<th>Major Category IV</th>
<th>Major Category V</th>
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<tbody>
<tr>
<td>Exclusion of Services Beyond the Scope of a SNF</td>
<td>Additional Services Excluded when Rendered to Specific Beneficiaries</td>
<td>Additional Excluded Services Rendered by Certified providers</td>
<td>Additional Excluded Preventive and Screening Services</td>
<td>Part B Services Included in SNF Consolidated Billing</td>
</tr>
</tbody>
</table>

- **Outpatient basis at a hospital/critical access hospital (CAH) only, not by a SNF. Excluded from SNF PPS and CB Part A stays.**

- **Services provided to:** (A) End Stage Renal Disease (ESRD) or (B) hospice elected beneficiaries by specific licensed Medicare providers, and are excluded from SNF PPS and consolidated billing.

- **These services may be provided by any Medicare provider licensed to provide them, except a SNF, and are excluded from SNF PPS and consolidated billing.**

- **These services are covered as Part B benefits and are not included in SNF PPS. Such services must be billed by the SNF for beneficiaries in a Part A stay with Part B eligibility.**

- **Therapy services are included in SNF PPS and consolidated billing for residents in a Part A stay, and must be billed by the SNF alone for its Part B residents.**
Major Category I
Exclusion of Services Beyond the Scope of a SNF

- Computerized Axial Tomography (CT) Scans
- Cardiac Catheterization
- Magnetic Resonance Imaging (MRIs)
- Radiation Therapy
- Angiography, Lymphatic, Venous, related procedures
- Outpatient Surgery and related procedures (inclusion)
- Emergency Services
- Ambulance Transportation
Major Category II
Additional Services Excluded when Rendered to Specific Beneficiaries

- Dialysis — Home dialysis supplies/equipment and self-care home dialysis support services
- Institutional dialysis services and supplies
- Erythropoietin (EPO) and Darbepoetin (DPA)
- Hospice Care for a Beneficiary’s Terminal Illness
Major Category III
Additional Excluded Services Rendered by Certified providers

- Chemotherapy
- Chemotherapy Administration
- Radioisotopes and their Administration
- Customized Prosthetic Devices
Major Category IV
Additional Excluded Preventive and Screening Services

- Mammography
- Vaccines — Pneumococcal, Flu or Hepatitis B
- Vaccine Administration
- Screening — Pap Smear and Pelvic Exams
- Colorectal Screening Services
- Prostate Cancer Screening
- Glaucoma Screening
- Diabetic Screening
- Cardiovascular Screening
- Initial Preventative Physical Exam (IPPE)
- Abdominal Aortic Aneurysms (AAA) Screening
Major Category V
Part B Services Included in SNF Consolidated Billing

Therapy services are included in SNF PPS and consolidated billing for residents in a Part A stay.

- Must be billed by the SNF alone for its Part B residents

Therapies billed with revenue codes:

- 42x (physical therapy)
- 43x (occupational therapy)
- 44x (speech-language pathology)
Billing

SNF claims are billed to Medicare monthly

- Submit claims to Palmetto GBA monthly
  - Submit in sequence for patient
  - Current claim must finalize before next claim is submitted

- Upon discharge of the patient
- When patient’s benefits have exhausted
- Patient no longer needs skilled care
Billing

• SNF must bill for all services provided to Part A residents covered in a Part A stay

• Psychological services furnished by a clinical social worker

• Services “incident to” the professional services of a physician or other health care professional
Exclusions

- Services that are outside the PPS bundle
- They remain separately billable to Part B when furnished to an SNF resident by an outside supplier
Exclusions

Excluded RHC/FQHC Physician Services

- Physician/Non-Physician Practitioner services included within the scope of RHC and FQHC services

Only this subset of RHC/FQHC services may be covered and paid separately during Part A stay.
Exclusions

- Professional services a practitioner performs personally
- Exclusion does not apply to physician "incident to" services furnished by someone else as "incident to" practitioner's professional service
  - These "incident to" services furnished by others to SNF residents are subject to CB
  - HCPCS for services subject to SNF CB editing
<table>
<thead>
<tr>
<th>Excluded Services</th>
<th>Excluded ‘Incident to’</th>
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</thead>
<tbody>
<tr>
<td>Physician services - Physician, PA, NP, certified nurse midwife, CRNA, qualified psychologist</td>
<td>Cardiac catheterizations</td>
</tr>
<tr>
<td></td>
<td>Certain lymphatic and venous procedures</td>
</tr>
<tr>
<td>Home dialysis supplies/equipment, self-care home dialysis support services and Institutional dialysis services/supplies</td>
<td>Ambulatory surgery; involves use of operating room</td>
</tr>
<tr>
<td></td>
<td>Emergency services</td>
</tr>
<tr>
<td>EPO and DPA for certain dialysis patients</td>
<td>CT scans, MRIs, angiography and custom prosthetic devices</td>
</tr>
<tr>
<td>Hospice care</td>
<td>Chemotherapy items and administration</td>
</tr>
<tr>
<td>Ambulance trip</td>
<td>Radiation therapy, radioisotope services</td>
</tr>
</tbody>
</table>
SNF — Consolidated Billing

SNF — Ambulance Exclusions

• Initial trip to SNF admission
• Trip home after discharge not followed by readmission to same or another SNF by midnight
• Trip for inpatient admission to hospital/CAH
• Trip to/from hospital/CAH for ER services or other outpatient exclusions
• Trip home for services under HHA plan of care
• Trip for Part B dialysis services
eServices is a free, provider self-service application.

Palmetto GBA’s goal is to give providers fast and secure access to Medicare information via an Internet-based portal. This portal provides access to the following services:

- Beneficiary Eligibility
- Claim Status
- Claim Submissions and Reopening Requests (Part B)
- Remittance Advices
- Financial Information and Forms
- Submission of Responses
  - Medical Review Requests
  - Appeals
- Electronic Mail
- Complex Medical Review Results
To participate in eServices, you must have an Electronic Data Interchange (EDI) Enrollment Agreement on file with Palmetto GBA.

In addition, you must have received payments in the past.
Jurisdiction J Part A MAC
Part A Providers in Alabama, Georgia and Tennessee

If your cost report is not received by the due date, penalty withholding will be initiated and will remain in effect until a valid cost report has been accepted which can take up to 30 days after the cost report has been received.

Top Links
- CERT Error Rate Map
- Claims Payment Issues Log
- Credit Balance Reporting (CMS 838)
- Medical Policies
- Medicare Secondary Payer
- Overpayments and Recoupment

Top Forms/Tools
- Medicare Forms
- Charge Denial Rate Calculator
- eServices Portal
- IVR Conversion Tool

Time to submit claims with MBIs only
Get It, Use It! The transition period during which the system accepts both HCNs and MBIs ends on December 31, 2019. Begin submitting claims with the MBI now! Learn more.

Have Questions About Using eServices?
See our eServices User Guide for answers about registering, logging into, and administering an eServices account - as well as using portal features.

Two New Options to Unlock Your eServices Account!
eServices has two features which allow you to unlock your account.

You Do Make a Difference
We value your feedback and your suggestions.
Validation Email Link

Please verify your eServices profile by clicking this link:

https://www_palmettogbaapps_com/evecx_improvev2UpdateVerifyProfileFinalStep.do?hash=xzloMzn1nnCsvLVx2zEczGyOe4YjEzdq6&userid=omg8013

If you receive your emails in the plain text format, you will need to copy the URL above and paste it into the address bar of your browser window.

In the event that you are directed to a page asking for a validation code, please copy and paste the following information into the corresponding fields to verify your profile:

Verification Code: xzloMzn1nnCsvLVx2zEczGyOe4YjEzdq6 User ID: omg8011

Thank you for accessing eServices.

Verification emails are sent from ops.no.reply@palmettogba.com

Please ensure your email address is correct on your profile before contacting Palmetto GBA for assistance.
eServices Security Updates

**Account Inactivity**
You must sign into your eServices account at least once every 30 days.
If you fail to log into your account within 30 days, you will be deactivated.
To activate your account, you must re-register for eServices.

**Session Timeout**
If there is no activity for 15 minutes, you will be logged out.
A pop-up message will display at 10 minutes to give you a warning.

**Lock-out**
Three invalid login attempts in a 120 minute period will lock you out of eServices.
To unlock your account, you must contact our Provider Contact Center (select the EDI option) to verify your identity.

**Passwords**
You must change at least six characters when prompted to change your password.
It is acceptable to shift the password characters to different positions to meet this requirement.
Responsibilities:
- Creating the provider user
- Assigning a temporary password to the provider user
- Assigning application permissions to the provider user
- Creating additional provider administrators
- Modifying the provider user profile
- Terminating provider users or additional provider administrators

Any access granted and maintained by the provider administrator is the sole responsibility of that provider administrator. Palmetto GBA has no responsibility for maintaining provider user access and permission to the data assigned to them by the provider administrator.
**Question:** I have multiple NPIs and PTANs. Do I need to register each one?

**Answer:** Yes, you must register for each PTAN/NPI combination. If you have multiple NPIs associated with a PTAN, you must register each PTAN/NPI combination separately. Each combination will have a unique user ID.

**Suggestion:** Link existing eServices user IDs!!!!

- Link previously assigned eServices user IDs under one default ID
- Log into eServices with the users default
- Access the Account Linking sub-tab by first selecting the My Account Tab
- Enter the user ID/password of the eServices account that you wish to link

*Only active IDs that are not already linked to a default user ID are eligible for account linking*
Account Linking

Be sure you are logged in to the account with the User ID you want as your default User ID.

For each account you want to link, enter the User ID and password for that account below.

You will be notified of the status of your link request via inbox messages to your selected default User ID. Link requests may take up to 24 hours to be processed.

Notes:

- You cannot link accounts that are already linked to a default User Id.
- You cannot link accounts that are inactive/have been terminated for any reason. Examples include, but are not limited to:
  - Terminated by provider administrator
  - Terminated by Palmetto GBA support team
  - Terminated for inactivity (no log in for 60 days)
  - Terminated for not completing recertification or profile verification timely
CMS Resources

- Internet Only Manuals (IOM)
- Transmittals
- Medicare Learning Network (MLN)
- Quarterly Provider Updates
# Internet-Only Manuals (IOMs)

The Internet-only Manuals (IOMs) are a replica of the Agency’s official record copy. They are CMS’ program issuances, day-to-day operating instructions, policies, and procedures that are based on statutes, regulations, guidelines, models, and directives. The CMS program components, providers, contractors, Medicare Advantage organizations and state survey agencies use the IOMs to administer CMS programs. They are also a good source of Medicare and Medicaid information for the general public.

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<tr>
<th>Publication #</th>
<th>Title</th>
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<tr>
<td>100</td>
<td>Introduction</td>
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<tr>
<td>100-01</td>
<td>Medicare General Information, Eligibility and Entitlement Manual</td>
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<tr>
<td>100-02</td>
<td>Medicare Benefit Policy Manual</td>
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<td>100-03</td>
<td>Medicare National Coverage Determinations (NCD) Manual</td>
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<td>100-04</td>
<td>Medicare Claims Processing Manual</td>
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<td>Medicare Secondary Payer Manual</td>
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<td>100-06</td>
<td>Medicare Financial Management Manual</td>
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<td>100-07</td>
<td>State Operations Manual</td>
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<tr>
<td>100-08</td>
<td>Medicare Program Integrity Manual</td>
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<td>100-09</td>
<td>Medicare Contractor Beneficiary and Provider Communications Manual</td>
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## 2019 Transmittals

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<tr>
<th>Transmittal</th>
<th>Issue Date</th>
<th>Subject</th>
<th>Implementation Date</th>
<th>CR #</th>
<th>MM Article #</th>
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<td>2019-02-08</td>
<td>Implementation of the Skilled Nursing Facility (SNF) Patient Driven Payment Model (PDPM)</td>
<td>2019-07-01</td>
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</table>
MLN Publications

These educational resources explain topics such as coding, preventive services, and provider compliance. We review and update Publications every 12-18 months. They are free and you can print them.

Search the list below for a topic or title, such as DMEPOS. You can also view the MLN Catalog to browse our educational resources by subject or product type.

The weekly MLN Connects newsletter gives updates on MLN Publications and Medicare program information.

<table>
<thead>
<tr>
<th>Date</th>
<th>Topic</th>
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<tr>
<td>2019-06</td>
<td>Provider Compliance</td>
<td>Medicare DMEPOS Improper Inpatient Payments</td>
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<td>2019-06</td>
<td>Provider Compliance</td>
<td>Provider Compliance Tips for Enteral Nutrition Therapy</td>
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<td>2019-06</td>
<td>Preventive Services</td>
<td>Medicare Preventive Services</td>
<td>Educational Tool</td>
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</table>
QPU April - June 2019

The Quarterly Provider Update provides a listing of Agency regulations and meeting notices. Non-regulatory changes to the Medicare and Medicaid programs, consisting of manual instructions, are also included in this listing.

In an effort to improve the presentation of the Quarterly Provider Update (QPU), we modified the layout of the page and incorporated the links to the documents in a table format. The QPU report is available in Adobe Acrobat file format and is sorted by Provider Type.

Downloads

- Issuances for April - June 2019 [PDF, 40KB]
- Issuances for April - June 2019 [ZIP, 31KB]
- Regulations for April - June 2019 [PDF, 50KB]
- Regulations for April - June 2019 [ZIP, 44KB]
• Topics
• Forms/Tools
• Events
• Top Links
• Listserv Signup
• Provider Contact Center (PCC)
Do You Have Feedback for Us - 2019 MAC Satisfaction Indicator (MSI) Survey Is Available Now!

The 2019 MAC Satisfaction Indicator (MSI), a survey administered by the Centers for Medicare & Medicaid Services (CMS), is available now. The MSI is your opportunity to offer detailed feedback on your interactions with Palmetto GBA over the last year. There are sections of the survey for feedback on Provider Enrollment, EDI and Claims, as well as the Provider Contact Center, eServices online portal and Provider Outreach and Education. The MSI survey is only offered on an annual basis, for a specified window of time, so don't miss your chance to be heard.

Palmetto GBA has made numerous improvements to our services and have more planned in the coming months. Read our “You Do Make A Difference” page to see all the enhancements implemented as a result of your feedback on our surveys.
Listserv: Are you receiving updates from Palmetto GBA?

- Must be registered to receive updates!
- Select “Listserv” from any page on the Palmetto GBA website to go to the registration page.
Provider Contact Center (PCC)

- Hours of operation will be 8 a.m. until 6 p.m. ET
- 877–567–7271
- The Interactive Voice Response (IVR) Hours of Availability — 24 hours a day, 7 days a week
  - Except dark days
  - IVR Job Aids available
Part II

Sandra Booker
Senior Provider Education Consultant
Provider Outreach and Education
• Three Day Qualifying Hospital Stay
• Certifications/Recertifications
• Targeted Probe and Educate (TPE) and Additional Documentation Requests (ADRs)
• Documentation and Medical Review Denials
• Patient Driven Payment Model (PDPM)
Three-Day Hospital Qualifying Stay
Three-Day Qualifying Stay

• The beneficiary must have been an inpatient of a hospital for a medically necessary stay of at least three (3) consecutive calendar days.

• For purposes of the SNF benefit's qualifying hospital stay requirement, inpatient status commences with the calendar day of hospital admission.
The extended care services must have been for the treatment of a condition for which the beneficiary was receiving inpatient hospital services (including services of an emergency hospital) or a condition which arose while in the SNF for treatment of a condition for which the beneficiary was previously hospitalized.

Note: Time spent in observation or in the emergency room prior to (or in lieu of) an inpatient admission to the hospital does not count toward the 3-day qualifying inpatient hospital stay.
Three-Day Qualifying Stay

• If the beneficiary is not immediately admitted to a SNF following a three-day qualifying hospital stay, extended care services must be initiated within 30 days after discharge from a hospital stay that included at least three consecutive days of medically necessary inpatient hospital services.

• The 30-day period begins on the day following actual discharge from the hospital and continues until the individual is admitted to a participating SNF, and requires and receives a covered level of care.
An acceptable certification statement must contain the following information:

• The individual needs skilled nursing care (furnished directly by or requiring the supervision of skilled nursing personnel) or other skilled rehabilitation services;
• Such services are required on a daily basis;
• Such services can only practically be provided in a SNF or swing-bed hospital on an inpatient basis;
• Such services are for an ongoing condition for which the individual received inpatient care in a hospital; and
• A dated signature of the certifying physician or NPP.
An acceptable recertification statement must contain the following information:

- The reasons for the continued need for post hospital SNF care;
- The estimated time the individual will need to remain in the SNF;
- Plans for home care, if any;
- If the reason for continued need for services is a condition that arose after admission to the SNF (and while being treated for an ongoing condition for which the individual received inpatient care in a hospital) this must be indicated; and
- A dated signature of the recertifying physician or NPP
How and When to Document the Certification and Recertification Statements
There is no specific format or procedure for documentation of the certification or recertification statement(s), but they must include the content previously discussed.

For example, (if appropriate) the physician or NPP could sign and date a statement that:

- All of the required information is included in the individual’s medical record; and
- Continued post hospital extended care services are medically necessary.
• The certification must be obtained at the time of admission or as soon thereafter as is reasonable and practicable
• The first recertification is required no later than the 14th day of post hospital SNF care
• Subsequent recertifications are required at least every 30 days after the first recertification

Note: Delayed certifications and recertifications must include an explanation for the delay and any medical or other evidence which the SNF considers relevant for purposes of explaining the delay.
Incorrect Certifications/Recertifications

- A physician order dated the day of admission to the SNF stated “resident certified as skilled (Medicare)”
- There was no indication of the need for daily skilled care, for inpatient services or for services for an ongoing condition for which the individual received inpatient care in a hospital care
- Therefore the certification was not complete
Example #2

Incorrect Certifications/Recertifications

• A record selected by CERT for medical review did not have a certification or recertification statement.

• In response to a request for additional documentation, the facility submitted an initial certification and a recertification dated after the dates of service for the claim.

• There was no explanation of the reason(s) for the delayed certification.

• Therefore, the medical record did not meet Medicare requirements.
Incorrect Certifications/Recertifications

- A SNF medical record contained a 30-day recertification dated prior to the claim’s dates of service
- There was no initial certification
- A request for further documentation resulted in an initial certification and a 14-day recertification, both signed six months after the claim’s dates of service
- In addition, the 30-day recertification was returned with a new date, also well after the claim dates of services
- There was no explanation of the reason(s) for the delayed certification
- Documentation did not meet the requirements for SNF certification and recertification.
Targeted Probe & Educate (TPE) and Additional Documentation Requests (ADRs)
• Targeted Probe and Educate (TPE) began as a pilot program in June of 2016
• Developed from the Inpatient as well as HH Probe and Educate models
• Previous success was demonstrated by:
  • Decreased appeals
  • Increased acceptance of provider education
Previous Medical Review Process

• Service-specific and provider-specific edits
• Probe with progression to Targeted Medical Review with percent of claims sampled
• Quarterly results reviewed for continuation of edit
• No interaction with clinical review staff to understand denials
• Up to three rounds of probe review
• Each round consists of a 20–40 claims for review
• One-on-one education intervention with clinical staff
• Allow 45–56 days between education intervention and next round
• Discontinue review when provider becomes compliant
• Monitor for one year via data analysis with follow-up review if needed
• Palmetto GBA will mail a letter to those providers that have been selected for TPE review
• Letter outlines the reason for selection, and provides an overview of the TPE process and contact information
• It is imperative when responding to the ADR that you include the name and number of your designated contact person
• Our medical reviewer will contact your designated person prior to the conclusion of each TPE round to discuss the review summary
Goal

- Reduce payment errors by identifying and addressing billing errors made by providers concerning coverage and coding

Strategy

- Develops a problem-focused, outcome-based operational plan that identifies risks and describes the planned interventions to address the CERT error rate
- Palmetto GBA utilizes DMAIC (Define, Measure, Analyze, Improve and Control) procedure to organize and prioritize the plan
What is an ADR?

An ADR is when a contractor requests additional documents to be sent in for the record to be reviewed. If it is an easy fix, such as a missing order or note, the reviewer will call and ask you to fax the missing document(s).

How do you know if you have an ADR?

You can view your claim status on the Direct Data Entry (DDE), if you claim status/location is SB6001, the claim has been selected for review and documents must be submitted.
Test Your Knowledge
How does an ADR affect you as a provider?

- You have 45 days from the date of the ADR to respond. If you do not respond, it is counted as an error (56900) for not responding timely. This can delay payment of your claim or claims.

- There is an ADR response calculator on the Palmetto GBA website that allows you to put in your ADR date tell you when you have to have your documents submitted. For example: if your ADR date is January 18 you must have your documents in no later than March 4.
How do I respond to an ADR?

Again, you have 45 days from the ADR date to respond and submit the documentation that has been requested. If not, you will receive error code 56900 for not responding in a timely manner.

Where do I send my ADR?

Where to send your ADR will be on the letter that you receive. If you are responding to more than one ADR, you must separate the medical records for each ADR. They cannot be combined. Number your pages, so that it is easily identifiable if a page is missing. The fastest and most efficient way to send in ADRs is through eServices and it is imperative that you list a point of contact on the front of your ADR sheet so that the reviewer can contact them if needed.
What address do my ADR letters go to?

- All ADR letters go to the correspondence address. On the Palmetto GBA website, you may access the list of where your letters go under the forms/tools tab and select the Provider Address job aid.

- If an address needs to be changed, please be mindful that if anything that is listed in the group that the address will be changed for all. For example, if you change the address for ADRs to go directly to the office, everything that is listed under correspondence will go to that address.

CMS 885A form has to be completed and submitted for this change.
Test Your Knowledge
What is the most frequently occurring documentation problem?
The most frequently observed documentation problem is not meeting medical necessity.
• Progress in bowel and bladder continence or regulation following an injury that impacts such function

• Ongoing assessment of nutritional and hydration status in patients who are no longer able to eat or drink in an adequate manner

• Ongoing safety assessment: Not just physical limitations, but also such cognitive functions as memory, judgment, and problem-solving
Skin integrity, including positioning techniques and weight-shifting to prevent pressure areas in relatively immobile patients, checking for developing problems in body areas with diminished or absent sensation, and care for any wounds or areas of already compromised skin integrity.
Ongoing assessment of the effects of treatment implemented by other members of the interdisciplinary team, including the patient’s ability to carry over techniques and compensatory mechanisms learned in therapy as well as the patient’s functional capability throughout a 24-hour period based upon changes in medical stability, pain, endurance, and cognition.
Educational interventions (how to maintain optimal health despite changes in function).

- Information about the injury/condition
- Training in medical techniques (tracheostomy care, tube feedings, bowel and bladder programs)
- Prevention of complications
- What to do if a complication arises after discharge
- Planning for follow-up medical care
Discharge planning: Assist in identification of the patient’s special medical needs for aftercare.

- What type of assistance will be needed?
- Who can provide the assistance?
- What changes need to be made in the patient’s discharge environment?
- What patient/caregiver education is needed to ensure a safe discharge?
Documentation Example #1

Fred is a 69-year-old male who was transported to a hospital after his wife found him unresponsive on the floor at home when she returned from shopping. A CAT scan of the head showed that Fred had an intracranial hemorrhage. He now presents with severe cognitive deficits, paraplegia of his right (dominant) side, and difficulty swallowing thin liquids. The physician has ordered a complete swallowing evaluation by SLP and thickened liquids until the evaluation can be completed. According to his wife, Fred’s diet at home consisted mostly of fried foods and sweets. While reviewing Fred’s past medical history, the MD found that Fred had been diagnosed with hypertension 2 years ago but was currently not taking any medications because he had not followed up with a physician since this diagnosis was made. Fred’s wife states that Fred refused to take any medications. Fred has a history of at least three TIAs in the past 2 years.
Fred requires 24-hour rehabilitation nursing for the following:

- Monitoring of hypertension and effects of new medication
- Education of patient and spouse re: HTN
- Monitoring of bowel and bladder function
- Monitoring skin integrity (r/t hemiparesis and mobility deficits)
- Follow-through with interdisciplinary plan of care
- Monitor effectiveness and carryover of techniques and compensatory mechanisms learned in therapy
Matthew is an 84-year-old male who came into the hospital for elective bilateral total knee replacements secondary to osteoarthritis per physician recommendation. Matthew lives alone and plans to return home alone with home care services if needed. He is being admitted to the rehabilitation unit to increase his functional independence before returning home. Matthew had a COPD exacerbation and experienced respiratory complications which will be addressed by respiratory therapy while he is on the rehabilitation unit.
Matthew requires 24-hour rehabilitation nursing for:

- Nursing assessment including monitoring of respiratory status, VS, and pulse oximetry readings (COPD)
- Care of surgical incisions (including dressing changes per MD order) and monitoring skin integrity
- Administering medications and treatments as ordered by MD and documenting their effects
- Monitoring of bowel and bladder function
- Pain management
- Follow-through on interdisciplinary POC
- CPM application per MD orders
Screening

• Screening helps determine the individual’s appropriateness for this level of care
• This would include a preliminary review of the patient’s condition and previous medical record to determine if the patient is likely to benefit from this level of service
Medical stability of the patient:
• Manageable in the SNF
• Does the patient require skilled services?

Is the patient having functional problems affecting:
• Self care
• Mobility
• Motor function
• Bowel/bladder management
• Pain management
• Safety
• Cognitive function
• Communication
Admitting Appropriate Patients

• Patient/family goals
• Anticipated social support
• Expected length of stay
• Viable discharge destination
• Rehabilitation goals
• Rehabilitation plans
Screening Questions

- Is the patient medically stable?
- Is physician monitoring needed?
- Is rehabilitation nursing needed?
- Are at least two therapies needed?
- Can the patient participate in 3 hours of therapy a day?
- Can the patient receive rehabilitation at a lower level of care?
- Can the patient be discharged to a community setting?
The history and physical should include:

- Past medical history vs. current conditions
- Factual findings and diagnoses
- List of complications

Comorbid Conditions

- Physicians need to include all current comorbid functional and medical conditions in the admission history and physical
- Newly identified conditions should be identified in the daily note, team meeting and discharge summary
- Should be factored into the plan of care
These examples do not demonstrate the need for 24 hour physician availability or level of care:

- No complaints. VSS. Denies pain. Labs okay. Continue PT/OT.
- Pt is stable. No new problems.
- Pt is doing well. Speech improving. Ambulated some.
Admission note 6/2/07: Pt admitted today for intense level of rehabilitation services in preparation for prosthetic fitting and training with eventual goal of ambulation. Barriers to discharge identified: impaired mobility and transfers due to BKA, impaired ability to perform ADLs (bathing, grooming, dressing, toileting and bladder/bowel management), impaired ability to perform independent living skills (simple meal preparation, driving), four stairs to enter home, labile diabetes and CHF, skin integrity and prevention of complications, pain management and adaptive equipment needs. See admission H&P for complete details of rehabilitation plan and goals. Initial team conference on Tuesday.

Dr John Doe
Medical Review Denials
# Medical Review Denials

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<tr>
<th>Rank</th>
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<th>Denial Description</th>
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<td>5D503/5D504</td>
<td>Not Medically and Reasonable Necessary</td>
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<tr>
<td>2</td>
<td>56900</td>
<td>Auto Denial – Requested Records Not Submitted</td>
</tr>
<tr>
<td>3</td>
<td>5DOWN</td>
<td>Medical Review Downcode</td>
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<tr>
<td>4</td>
<td>5D002/5X002</td>
<td>Agree With Provider (Bene Liable)</td>
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<tr>
<td>5</td>
<td>5D507/5H507</td>
<td>SNF MDS Is Not in the National Repository</td>
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Patient Driven Payment Model (PDPM)
What is PDPM?

• The Patient Driven Payment Model (PDPM) is a new case-mix classification system for classifying SNF patients in a Medicare Part A covered stay into payment groups under the SNF Prospective Payment System.

• Effective beginning October 1, 2019, PDPM will replace the current case-mix classification system, the Resource Utilization Group, Version IV (RUG-IV).
Why the change from RUG-IV to PDPM?

• Eliminates the incentive that SNF providers would receive to furnish therapy regardless of the patient’s unique characteristics, goals or needs

• It will improve the overall accuracy and appropriateness of SNF payments by classifying patients into payment groups based on specific, data-driven patient characteristics

• Will reduce the burden on SNF providers
Five of the components are case-mix adjusted to cover resources that vary according to patient characteristics

- PT
- OT
- SLP
- Nursing
- NTA (non-therapy ancillary services)

- There is also an additional non-case-mix adjusted component to address resources that do not vary by patient
- Different patient characteristics are used to determine a patient’s classification into a case-mix group (CMG) within each of the case-mix adjusted payment components
• The PDPM uses clinically relevant factors, rather than volume-based service for determining Medicare payment.

• Under the PDPM, patient characteristics are used to assign patients into CMGs across the payment components to derive payment.

• Additionally, the PDPM adjusts per diem payments to reflect varying costs throughout the stay.
Similar to the current RUG-IV model, per-diem payment under PDPM would be determined by two primary factors: base rates that correspond to each component of payment and CMIs that correspond to each payment group. Each resident would be classified into a resident group for each of the five case-mix-adjusted components. The base rate for each case-mix-adjusted component would be multiplied by the CMI corresponding to the assigned resident group.
PDPM Patient Classification
• PT and OT: Clinical category, functional score
• SLP: Presence of acute neurologic condition, related comorbidity/cognitive impairment, mechanically-altered diet, swallowing disorder
• Nursing: Same characteristics as RUG-IV
• NTA: NTA Comorbidity Score
PT & OT Components

• PDPM patient characteristics used to predict therapy costs rather than rely on service use

• PT and OT components, two classifications used:
  • Clinical Category
  • Functional Status
SNF patient is first classified into a clinical category based on primary diagnosis for SNF stay

- ICD-10-CM codes, coded on Minimum Data Set (MDS) in Item I0020B, are mapped to a PDPM clinical category:
  - Clinical classification may be adjusted by a surgical procedure that occurred during the prior inpatient stay, as coded in Section J
<table>
<thead>
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<th>PDPM Clinical Categories</th>
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<tr>
<td>Major Joint Replacement or Spinal Surgery</td>
<td>Cancer</td>
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<tr>
<td>Non-Surgical Orthopedic/Musculoskeletal</td>
<td>Pulmonary</td>
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<td>Orthopedic-Surgical Extremities not Major Joint</td>
<td>Cardiovascular and Coagulations</td>
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<td>Acute Infection</td>
<td>Acute Neurologic</td>
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<td>Medical Management</td>
<td>Non-Orthopedic Surgery</td>
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## PT and OT Clinical Categories

<table>
<thead>
<tr>
<th>PDPM Clinical Categories</th>
<th>PT &amp; OT Clinical Categories</th>
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<td>Major Joint Replacement or Spinal Surgery</td>
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<tr>
<td>Cancer</td>
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<td>Pulmonary</td>
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<td>Cardiovascular &amp; Coagulations</td>
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<tr>
<td>Acute Infections</td>
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</table>
Calculated as sum of scores on ten Section GG items:

- Two bed mobility items
- Three transfer items
- One eating item
- One toileting item
- One oral hygiene item
- Two walking items
## PT & OT Components: Payment Group

<table>
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<tr>
<th>Clinical Category</th>
<th>PT &amp; OT Function Score</th>
<th>PT &amp; OT Case Mix</th>
<th>PT CMI</th>
<th>OT CMI</th>
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<td>1.41</td>
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<td>Other Orthopedic</td>
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<td>Other Orthopedic</td>
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<td>24</td>
<td>TP</td>
<td>1.08</td>
<td>1.09</td>
</tr>
</tbody>
</table>
Patient characteristics predictive of increased cost:

- Acute Neurologic clinical classification
- Certain SLP-related comorbidities
- Presence of cognitive impairment
- Use of a mechanically-altered diet
- Presence of swallowing disorder
Twelve SLP comorbidities were identified as predictive of higher SLP costs:

- Conditions and services combined into a single SLP-related comorbidity flag
- Patient qualifies if any of conditions/services is present

<table>
<thead>
<tr>
<th>SLP Comorbidities</th>
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<tbody>
<tr>
<td>Aphasia</td>
</tr>
<tr>
<td>Laryngeal Cancer</td>
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<tr>
<td>CVA, TIA, or Stroke</td>
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<tr>
<td>Apraxia</td>
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<tr>
<td>Hemiplegia or Hemiparesis</td>
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<tr>
<td>Dysphagia</td>
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<tr>
<td>Traumatic Brain Injury</td>
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<td>ALS</td>
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<tr>
<td>Tracheostomy (while Resident)</td>
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<tr>
<td>Oral Cancers</td>
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<tr>
<td>Ventilator (while Resident)</td>
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<td>Speech &amp; Language Deficits</td>
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<tr>
<td>Presence of Acute Neurologic Condition, SLP Related Comorbidity, or Cognitive Impairment</td>
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</tbody>
</table>
Under PDPM, a patient’s cognitive status is assessed in exactly the same way as under RUG-IV:

Scoring the patient’s cognitive status, for purposes of classification, is based on the Cognitive Function Scale (CFS), which is able to provide consistent scoring across the BIMS and staff assessment.

<table>
<thead>
<tr>
<th>Cognitive Level</th>
<th>BIMS Score</th>
<th>CPS Score</th>
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<tbody>
<tr>
<td>Cognitively intact</td>
<td>13–15</td>
<td>0</td>
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<tr>
<td>Mildly Impaired</td>
<td>8–12</td>
<td>1–2</td>
</tr>
<tr>
<td>Moderately Impaired</td>
<td>0–7</td>
<td>3–4</td>
</tr>
<tr>
<td>Severely Impaired</td>
<td>–</td>
<td>5–6</td>
</tr>
</tbody>
</table>
PDPM utilizes the same basic nursing classification structure as RUG-IV, with certain modifications:

- Function score based on Section GG of the MDS 3.0
- Collapsed functional groups, reducing the number of nursing groups from 43 to 25
## Nursing Component: Payment Groups (1)

<table>
<thead>
<tr>
<th>RUG-IV Nursing RUG</th>
<th>Extensive Services</th>
<th>Clinical Conditions</th>
<th>Depression</th>
<th>Restorative Nursing Services</th>
<th>Function Score</th>
<th>CMG</th>
<th>CMI</th>
</tr>
</thead>
<tbody>
<tr>
<td>ES3</td>
<td>Tracheostomy &amp; Ventilator</td>
<td></td>
<td></td>
<td></td>
<td>0–14</td>
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<tr>
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<td>Tracheostomy &amp; Ventilator</td>
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<td></td>
<td></td>
<td>0–14</td>
<td>ES2</td>
<td>3.06</td>
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<tr>
<td>ES1</td>
<td>Infection Isolation</td>
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<td></td>
<td></td>
<td>0–14</td>
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<tr>
<td>HE2/HD2</td>
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<td>Serious medical conditions e.g., comatose, septicemia, respiratory therapy</td>
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<td></td>
<td>0–5</td>
<td>HDE2</td>
<td>2.39</td>
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<td>Serious medical conditions e.g., comatose, septicemia, respiratory therapy</td>
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<td></td>
<td>0–5</td>
<td>HDE1</td>
<td>1.99</td>
</tr>
<tr>
<td>HC2/HB2</td>
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<td>Serious medical conditions e.g., comatose, septicemia, respiratory therapy</td>
<td>Yes</td>
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<td>6–14</td>
<td>HBC2</td>
<td>2.23</td>
</tr>
<tr>
<td>HC1/HB1</td>
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<td>Serious medical conditions e.g., comatose, septicemia, respiratory therapy</td>
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<td>RUG-IV Nursing RUG</td>
<td>Extensive Services</td>
<td>Clinical Conditions</td>
<td>Depression</td>
<td>Restorative Nursing Services</td>
<td>Function Score</td>
<td>CMG</td>
<td>CMI</td>
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<td>------------</td>
<td>-----------------------------</td>
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<td>-----</td>
</tr>
<tr>
<td>LE2/LD2</td>
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<td>Serious medical conditions e.g., radiation therapy or dialysis</td>
<td>Yes</td>
<td></td>
<td>0–5</td>
<td>LDE2</td>
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<tr>
<td>LE1/LD1</td>
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<tr>
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<td>Yes</td>
<td></td>
<td>6–14</td>
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<tr>
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<td>Serious medical conditions e.g., radiation therapy or dialysis</td>
<td>No</td>
<td></td>
<td>6–14</td>
<td>LBC1</td>
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<tr>
<td>CE2/CD2</td>
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<td>Conditions requiring complex medical care e.g., pneumonia, surgical wounds, burns</td>
<td>Yes</td>
<td></td>
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<td>CDE2</td>
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<tr>
<td>CE1/CD1</td>
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<td>Conditions requiring complex medical care e.g., pneumonia, surgical wounds, burns</td>
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<td>CDE1</td>
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<tr>
<td>CC2/CB2</td>
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<td>Conditions requiring complex medical care e.g., pneumonia, surgical wounds, burns</td>
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<td>6–14</td>
<td>CBC2</td>
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<tr>
<td>CA2</td>
<td></td>
<td>Conditions requiring complex medical care e.g., pneumonia, surgical wounds, burns</td>
<td>Yes</td>
<td></td>
<td>15–16</td>
<td>CA2</td>
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<tr>
<td>RUG-IV Nursing RUG</td>
<td>Extensive Services</td>
<td>Clinical Conditions</td>
<td>Depression</td>
<td>Restorative Nursing Services</td>
<td>Function Score</td>
<td>CMG</td>
<td>CMI</td>
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<tr>
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<td>------------</td>
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</tr>
<tr>
<td>CC1/CB1</td>
<td></td>
<td>Conditions requiring complex medical care e.g., pneumonia, surgical wounds, burns</td>
<td>No</td>
<td>6-14</td>
<td>CBC1</td>
<td>1.34</td>
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<td>CA1</td>
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<td>BB2/BA2</td>
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<td>Behavioral or cognitive symptoms</td>
<td>2 or more</td>
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<td>BAB2</td>
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<tr>
<td>BB1/BA1</td>
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<td>Behavioral or cognitive symptoms</td>
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<td>11-16</td>
<td>BAB1</td>
<td>0.99</td>
<td></td>
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<tr>
<td>PE2/PD2</td>
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<td>2 or more</td>
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<td>PDE2</td>
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<tr>
<td>PE1/PD1</td>
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<td>Assistance with daily living and general supervision</td>
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<td>0-5</td>
<td>PDE1</td>
<td>1.47</td>
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<td>PC2/PB2</td>
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<td>Assistance with daily living and general supervision</td>
<td>2 or more</td>
<td>6-14</td>
<td>PBC2</td>
<td>1.21</td>
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<tr>
<td>PA2</td>
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<td>Assistance with daily living and general supervision</td>
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<td>15-16</td>
<td>PA2</td>
<td>0.7</td>
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<tr>
<td>PC1/PB1</td>
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<td>Assistance with daily living and general supervision</td>
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<td>PBC1</td>
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<tr>
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<td>0-1</td>
<td>15-16</td>
<td>PA1</td>
<td>0.66</td>
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</tbody>
</table>
NTA Component

NTA classification is based on presence of certain comorbidities or use of certain extensive services.

Comorbidity score is a weighted count of:

• Comorbidities associated with high increases in NTA costs grouped into various point tiers.
• Points assigned for each additional comorbidity present, with more points awarded for higher-cost tiers.
Comorbidities and extensive services for NTA classification are derived from a variety of MDS sources, with some comorbidities identified by ICD-10-CM codes reported in Item I8000.
One comorbidity Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) is reported on the SNF claim, in the same manner as under RUG-IV:

- NTA classification will be adjusted by the appropriate number of points for this condition by the CMS PRICER for patients with HIV/AIDS
<table>
<thead>
<tr>
<th>Condition/Extensive Service</th>
<th>Source</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV/AIDS</td>
<td>SNF Claim</td>
<td>8</td>
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<tr>
<td>Parenteral Intravenous (IV) Feeding: Level High</td>
<td>MDS Item K0510A2, K0710A2</td>
<td>7</td>
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<tr>
<td>Special Treatments/Programs: Intravenous Medication Post-admit Code</td>
<td>MDS Item O0100H2</td>
<td>5</td>
</tr>
<tr>
<td>Special Treatments/Programs: Ventilator or Respirator Post-admit Code</td>
<td>MDS Item O0100F2</td>
<td>4</td>
</tr>
<tr>
<td>Parenteral IV feeding: Level Low</td>
<td>MDS Item K0510A2, K0710A2, K0710B2</td>
<td>3</td>
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<tr>
<td>Lung Transplant Status</td>
<td>MDS Item I8000</td>
<td>3</td>
</tr>
<tr>
<td>Special Treatments/Programs: Transfusion Post-admit Code</td>
<td>MDS Item O0100I2</td>
<td>2</td>
</tr>
<tr>
<td>Major Organ Transplant Status, Except Lung</td>
<td>MDS Item I8000</td>
<td>2</td>
</tr>
<tr>
<td>Multiple Sclerosis Code</td>
<td>MDS Item I5200</td>
<td>2</td>
</tr>
<tr>
<td>Opportunistic Infections</td>
<td>MDS Item I8000</td>
<td>2</td>
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<tr>
<td>Asthma Chronic obstructive pulmonary disease (COPD) Chronic Lung Disease Code</td>
<td>MDS Item I6200</td>
<td>2</td>
</tr>
<tr>
<td>Bone/Joint/Muscle Infections/Necrosis - Except Aseptic Necrosis of Bone</td>
<td>MDS Item I8000</td>
<td>2</td>
</tr>
<tr>
<td>Chronic Myeloid Leukemia</td>
<td>MDS Item I8000</td>
<td>2</td>
</tr>
<tr>
<td>Wound Infection Code</td>
<td>MDS Item I2500</td>
<td>2</td>
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<tr>
<td>Diabetes Mellitus (DM) Code</td>
<td>MDS Item I2900</td>
<td>2</td>
</tr>
<tr>
<td>Condition/Extensive Service</td>
<td>Source</td>
<td>Points</td>
</tr>
<tr>
<td>-----------------------------------------------------------------</td>
<td>----------------</td>
<td>--------</td>
</tr>
<tr>
<td>Endocarditis</td>
<td>MDS Item I8000</td>
<td>1</td>
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<tr>
<td>Immune Disorders</td>
<td>MDS Item I8000</td>
<td>1</td>
</tr>
<tr>
<td>End-Stage Liver Disease</td>
<td>MDS Item I8000</td>
<td>1</td>
</tr>
<tr>
<td>Other Foot Skin Problems: Diabetic Foot Ulcer Code</td>
<td>MDS Item M1040B</td>
<td>1</td>
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<tr>
<td>Narcolepsy and Cataplexy</td>
<td>MDS Item I8000</td>
<td>1</td>
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<tr>
<td>Cystic Fibrosis</td>
<td>MDS Item I8000</td>
<td>1</td>
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<tr>
<td>Special Treatments/Programs: Tracheostomy Care Post-admit Code</td>
<td>MDS Item O0100E2</td>
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<tr>
<td>Multi-Drug Resistant Organism (MDRO) Code</td>
<td>MDS Item I1700</td>
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<tr>
<td>Special Treatments/Programs: Isolation Post-admit Code</td>
<td>MDS Item O0100M2</td>
<td>1</td>
</tr>
<tr>
<td>Specified Hereditary Metabolic/Immune Disorders</td>
<td>MDS Item I8000</td>
<td>1</td>
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<tr>
<td>Morbid Obesity</td>
<td>MDS Item I8000</td>
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<tr>
<td>Special Treatments/Programs: Radiation Post-admit Code</td>
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<tr>
<td>Highest Stage of Unhealed Pressure Ulcer - Stage 4</td>
<td>MDS Item M0300D1</td>
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<tr>
<td>Psoriatic Arthropathy and Systemic Sclerosis</td>
<td>MDS Item I8000</td>
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<tr>
<td>Chronic Pancreatitis</td>
<td>MDS Item I8000</td>
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</tr>
<tr>
<td>Proliferative Diabetic Retinopathy and Vitreous Hemorrhage</td>
<td>MDS Item I8000</td>
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</tr>
<tr>
<td>Condition/Extensive Service</td>
<td>Source</td>
<td>Points</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------------------------</td>
<td>-------------------------------</td>
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</tr>
<tr>
<td>Other Foot Skin Problems: Foot Infection Code, Other Open Lesion on Foot Code, Except Diabetic Foot Ulcer Code</td>
<td>MDS Item M1040A, M1040B, M1040C</td>
<td>1</td>
</tr>
<tr>
<td>Complications of Specified Implanted Device or Graft</td>
<td>MDS Item I8000</td>
<td>1</td>
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<tr>
<td>Bladder and Bowel Appliances: Intermittent Catheterization</td>
<td>MDS Item H0100D</td>
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<tr>
<td>Inflammatory Bowel Disease</td>
<td>MDS Item I1300</td>
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<tr>
<td>Aseptic Necrosis of Bone</td>
<td>MDS Item I8000</td>
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<tr>
<td>Special Treatments/Programs: Suctioning Post-admit Code</td>
<td>MDS Item O0100D2</td>
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<tr>
<td>Cardio-Respiratory Failure and Shock</td>
<td>MDS Item I8000</td>
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<tr>
<td>Myelodysplastic Syndromes and Myelofibrosis</td>
<td>MDS Item I8000</td>
<td>1</td>
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<tr>
<td>Systemic Lupus Erythematosus, Other Connective Tissue Disorders, and Inflammatory Spondylopathies</td>
<td>MDS Item I8000</td>
<td>1</td>
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<tr>
<td>Diabetic Retinopathy - Except Proliferative Diabetic Retinopathy and Vitreous Hemorrhage</td>
<td>MDS Item I8000</td>
<td>1</td>
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<tr>
<td>Nutritional Approaches While a Resident: Feeding Tube</td>
<td>MDS Item K0510B2</td>
<td>1</td>
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<td>Severe Skin Burn or Condition</td>
<td>MDS Item I8000</td>
<td>1</td>
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<tr>
<td>Intractable Epilepsy</td>
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<td>Malnutrition Code</td>
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<td>Condition/Extensive Service</td>
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<td>Points</td>
</tr>
<tr>
<td>---------------------------------------------------------------</td>
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<tr>
<td>Disorders of Immunity — Except: RxCC97: Immune Disorders</td>
<td>MDS Item I8000</td>
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<tr>
<td>Cirrhosis of Liver</td>
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<td>Bladder and Bowel Appliances: Ostomy</td>
<td>MDS Item H0100C</td>
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<tr>
<td>Respiratory Arrest</td>
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<tr>
<td>Pulmonary Fibrosis and Other Chronic Lung Disorders</td>
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## NTA Component: Payment Groups

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<th>NTA Score Range</th>
<th>NTA Case Mix Group</th>
<th>NTA Case Mix Index</th>
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<td>12+</td>
<td>NA</td>
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<tr>
<td>9–11</td>
<td>NB</td>
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<td>6–8</td>
<td>NC</td>
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<tr>
<td>3–5</td>
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<td>1.34</td>
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<td>1–2</td>
<td>NE</td>
<td>0.96</td>
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<td>NF</td>
<td>0.72</td>
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## Determinants of Payment in PDPM

<table>
<thead>
<tr>
<th>PT de</th>
<th>OT</th>
<th>SLP</th>
<th>Nursing</th>
<th>NTA</th>
</tr>
</thead>
</table>
| • Primary reason for SNF care  
• Functional status | • Primary reason for SNF care  
• Functional status | • Primary reason for SNF care  
• Cognitive status  
• Presence of swallowing disorder or mechanically altered diet  
• Other SLP-related comorbidities | • Clinical information from SNF stay  
• Functional status  
• Extensive services received  
• Presence of depression  
• Restorative nursing services received | • Comorbidities present  
• Extensive services received |

Point in the stay (variable per diem adjustment)

Point in the stay (variable per diem adjustment)

Point in the stay (variable per diem adjustment)
Advantages of PDPM
Advantages of PDPM

- Removes therapy minutes as the basis for therapy payment
- Establishes separate case-mix-adjusted component for NTA services, thereby improving targeting of resources to medically complex beneficiaries and increasing payment accuracy for these services
- Enhances payment accuracy for nursing services by making nursing payment dependent on a wide range of clinical characteristics (as originally considered for RUG-IV) rather than being primarily a function of therapy minutes and functional status
- Improves targeting of resources to beneficiaries with diverse therapy needs by dividing single therapy component into three separate case-mix-adjusted components: PT, OT, and SLP
Advantages of PDPM

• Provides additional resources to facilities for treating potentially vulnerable populations, including beneficiaries with the following characteristics: high NTA utilization, extensive services (ventilator, respirator, or infection isolation), dual enrollment in Medicare and Medicaid, end-stage renal disease (ESRD), longer prior inpatient stays, diabetes, wound infections, IV medication, bleeding disorders, behavioral issues, chronic neurological conditions, and bariatric care

• Enhances payment accuracy for all SNF services by: (1) basing payment for each component on predicted resource utilization associated with clinically-relevant resident characteristics and (2) introducing variable per-diem payment adjustments to track changes in resource use over a stay

• Promotes consistency with other Medicare and post-acute payment settings by basing resident classification on objective clinical information while minimizing the role of service provision in determination of payment
Helpful Links/References

- MLN Catalog

- CMS website
  - https://www.cms.gov

- Palmetto GBA website
  - https://www.PalmettoGBA.com
• The Physician Certification and Recertification for Extended Care Services in the “Medicare Benefit Policy Manual”, Chapter 8, Section 40

• The SNF Inpatient Part A Billing and SNF Consolidated Billing in the “Medicare Claims Processing Manual”, Chapter 6
Helpful Links/References

• The Skilled Nursing Facility (SNF) Spell of Illness Quick Reference Chart

• The Skilled Nursing Facility Prospective Payment System Fact Sheet

• CMS Medicare Benefit Policy Manual (Pub. 100-02), chapter 8: “Coverage of Extended Care (SNF) Services Under Hospital Insurance”
Part III

Charles Canaan
Senior Provider Education Consultant
Provider Outreach and Education
Hospice in the Nursing Home
Inefficiencies

• Need for ongoing coordination of care between the hospice and nursing home staff
• Communication with family members
• Roles are distinct
• Hospice tends to the end of life needs of the patient
• Nursing homes provide custodial services just as a family would in a home setting
Why can’t the nursing home instead of the hospice just provide the end of life services?

Nursing homes are already heavily burdened by staffing shortages and intense regulation.

Their staff, while highly trained, isn’t well equipped to offer the formalized and specific end of life services that hospice caregivers deliver.

It is sort of like asking an ophthalmologist to deliver babies.

http://hospiceactionnetwork.org/linked_documents/get_informed/issues/nursing_home/HAN_NH_QA.pdf
SNF and Hospice

Two independent regulations:

- COPs for Hospice: 42 C.F.R. Part 418 – “Palliative care is patient and family centered care that optimizes quality of life by anticipating, preventing, and treating suffering...[by] addressing physical, intellectual, emotional, social, and spiritual needs and to facilitate patient autonomy, access to information and choice.”
- COPs for NH: 42 C.F.R. Part 483 – “highest practicable physical, mental and psychosocial well-being”
SNF vs Hospice

• SNF Resident or Legal Representative Must Elect Hospice Care.

• Election of hospice care for in lieu of skilled services, nursing home care for terminal illness, complicated by elderly patient’s multiple chronic conditions that make it difficult to identify if treatments are, in fact curative.

• When Medicare beneficiary who resides in NH elects hospice, there is no reimbursement for room and board unless the beneficiary is also Medicaid recipient.
To be covered, hospice services must meet all of the following requirements:

• Must be reasonable and necessary for the palliation and management of the terminal illness as well as related conditions

• Individual must elect hospice care

• Plan of care must be established and periodically reviewed by the attending physician, the medical director, and the interdisciplinary group of the hospice program

• Plan of care must be established before hospice care is provided

• Services provided must be consistent with the plan of care

• Certification that the individual is terminally ill must be completed
Medicare Hospice Care

- Care is palliative, rather than curative
- It includes, among other things, nursing care, medical social services, hospice aide services, medical supplies (including drugs and biologicals), and physician services
- The beneficiary waives all rights to Medicare payment for services related to the curative treatment of the terminal condition or related conditions but retains rights to Medicare payment for services to treat conditions unrelated to the terminal illness
- Beneficiaries may revoke their election of hospice care and return to standard Medicare coverage at any time
Hospice Levels of Care

- Routine Home Care
- Continuous Home Care
- General Inpatient Care
- Respite Care
The 2014 Hospice Wage Index reiterates the December 1983 final rule: “…we believe that the unique physical condition of each terminally ill patient makes it necessary for these decisions to be made on a case by case basis. It is our general view that hospices are required to provide virtually all care that is needed by terminally ill patients.”
Related or Unrelated

The 2014 Wage Index states that, in light of previous statements, it is CMS’ view that “unless there is clear evidence that a condition is unrelated to the terminal prognosis, all services would be considered related. …it is the responsibility of the hospice physician to document why a patient’s medical needs would be unrelated to the terminal prognosis.”
CMS states that “it is often not a single diagnosis that represents the terminal prognosis, but the combined effects of several conditions that make the patient’s conditional terminal.”
• Given to a patient who would be expected to die within 6 months
• This is the patient’s principal diagnosis
All body systems are interrelated; all conditions, active or not, have the potential to affect the total individual.

The presence of comorbidities is recognized as potentially contributing to the overall status of the individual and should be considered when determining the terminal prognosis.
Common End of Life Symptoms

- Pain
- Nausea / Vomiting
- Anxiety and Depression
- Constipation and Diarrhea
- Insomnia
- Agitation, Psychosis, Delirium
- Fluid Retention

- Appetite Loss
- Infections
- Oral / Pharyngeal Secretions
- Fatigue
- Dyspnea
- Wounds & Decubitus Ulcers
- Dyspepsia

To Cover or Not To Cover (PART 2): Guidelines for Covered Medications in Hospice Patients
Julia Harder, PharmD, CGP
Determining Relatedness to the Terminal Prognosis Process Flow

Physician uses all available information to evaluate:
- Terminal prognosis of 6 months or less
- Terminal and related diagnoses that contribute to the terminal prognosis
- Symptoms caused or exacerbated by terminal diagnosis, related diagnosis or treatment of terminal and related diagnoses

Note: Determining relatedness is a continuous process by the hospice physician which takes into account the changes in the patient's condition.

Identify the PRINCIPAL (TERMINAL) HOSPICE DIAGNOSIS

Are there other diagnoses caused by or exacerbated by the PRINCIPAL HOSPICE DIAGNOSIS?
- YES
- NO

Are there additional symptoms that contribute to the 6 month or less prognosis?
- YES
- NO

Are there additional diagnoses, conditions, or symptoms caused or exacerbated by treatment of the RELATED CONDITIONS?
- YES
- NO

NOTE:
- The decision about relatedness is determined by the hospice physician and is individualized based on the patient's clinical status. (patient-by-patient, case-by-case)
- Decisions about relatedness change as the patient's condition changes.
- Clinical examples related to this process flow are included in the "Determining Relatedness in Hospice" resource.

*The following are used as equivalent terms:
terminal hospice diagnosis = principal hospice diagnosis = primary terminal diagnosis = primary hospice condition"
Examples of Unrelatedness

• “Glaucoma is pathophysiologically unrelated to the patient’s lung cancer, and does not contribute to the terminal prognosis.”
• “Hypothyroidism is physiologically unrelated to the patient’s COPD, and since it is well managed, it does not contribute to a worsened prognosis.”
• Hospice patient with a terminal diagnosis of lung cancer might receive inhalants for the treatment of SOB related to the terminal diagnosis.

• The patient may also have bone pain associated with metastasis for which the patient receives opioids and other medications for pain relief.

• The opioids result in constipation that requires a laxative for symptom relief.
Condition Code 07

• Treatment of a non-terminal condition for a hospice patient.

• Report this code when the patient has elected hospice care, but the provider is not treating the patient for the terminal condition.
• Beneficiary has elected the Medicare hospice benefit and services billed as being related to the terminal diagnosis.
• Verify what health care services the beneficiary is receiving at the time of admission.
• Review the beneficiary's Medicare eligibility information in the Common Working File (CWF), the HIPAA Eligibility Transaction System (HETS) or the MAC portal at the time of admission and prior to submitting a claim.
• Consult with the hospice to ensure that the services being provided are not related to the hospice terminal diagnosis.

• When submitting a claim to Medicare for services that are determined as unrelated to the terminal illness, verify that the diagnosis on the claim are not an exact match or related to the terminal diagnosis and ensure condition code 07 is entered in FL 18-28 of the CMS-1450 claim form.

• Condition code 07 can only be used when the services are unrelated to the terminal diagnosis; any other use of condition code 07 may be considered abusive.
Nursing Home/Hospice Contracts

• Routine Hospice Care
• Inpatient Hospice Care
  • Pain control and symptom management that cannot be managed elsewhere
  • Respite purposes for caregiver breakdown (for hospice patients admitted from the community)
    • 24-hour RN not required for respite § 418.108(b)
  • Patient access and family-like areas
  • Hospice also provides care
Contract Services

• Hospice can contract and purchase hospice non-core services from the SNF:
  • PT, OT, ST, hospice aide, meds and supplies related to terminal illness

• Cannot contract for Hospice core services:
  • RN, SW, Physician, Counseling – dietary, bereavement and spiritual.

• Cannot provide continuous care services to patients in a skilled nursing facility
• Contracts should delineate what the respective staffs are responsible for
• Hospice has professional responsibility for management of hospice care
• The hospice and SNF/NF must have a written agreement that specifies the provision of hospice services in the facility.
• The agreement must be signed by authorized representatives of the hospice and the SNF/NF before the provision of hospice services.
• The written agreement must include at least the following:
1) The manner in which the SNF/NF or ICF/IID and the hospice are to communicate with each other and document such communications to ensure that the needs of patients are addressed and met 24 hours a day.

(2) A provision that the SNF/NF or ICF/IID immediately notifies the hospice if—
   (i) A significant change in a patient’s physical, mental, social, or emotional status occurs
   (ii) Clinical complications appear that suggest a need to alter the plan of care
   (iii) A need to transfer a patient from the SNF/NF and the hospice makes arrangements for, and remains responsible for, any necessary continuous care or inpatient care necessary related to the terminal illness and related conditions
   iv) A patient dies
(3) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided.

(4) An agreement that it is the SNF/NF’s responsibility to continue to furnish 24 hour room and board care, meeting the personal care and nursing needs that would have been provided by the primary caregiver at home at the same level of care provided before hospice care was elected.

(5) An agreement that it is the hospice’s responsibility to provide services at the same level and to the same extent as those services would be provided if the SNF/NF resident were in his or her own home.
(6) A delineation of the hospice’s responsibilities, which include, but are not limited to the following:

• Providing medical direction and management of the patient
• Nursing
• counseling (including spiritual, dietary and bereavement)
• social work
• provision of medical supplies, durable medical equipment and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions
• All other hospice services that are necessary for the care of the resident’s terminal illness and related conditions.
(7) A provision that the hospice may use the SNF/NF nursing personnel where permitted by State law and as specified by the SNF/NF to assist in the administration of prescribed therapies included in the plan of care only to the extent that the hospice would routinely use the services of a hospice patient’s family in implementing the plan of care.
(8) A provision stating that the hospice must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by anyone unrelated to the hospice to the SNF/NF or administrator within 24 hours of the hospice becoming aware of the alleged violation.

(9) A delineation of the responsibilities of the hospice and the SNF/NF or to provide bereavement services to SNF/NF or staff.
The hospice must provide the SNF/NF with the following information:

(i) The most recent hospice plan of care specific to each patient
(ii) Hospice election form and any advance directives specific to each patient
(iii) Physician certification and recertification of the terminal illness specific to each patient
(iv) Names and contact information for hospice personnel involved in hospice care of each patient
(v) Instructions on how to access the hospice’s 24-hour on-call system
(vi) Hospice medication information specific to each patient
(vii) Hospice physician and attending physician (if any) orders specific to each patient.
(f) Standard: Orientation and training of staff. Hospice staff must assure orientation of SNF/NF staff furnishing care to hospice patients in the hospice philosophy, including hospice policies and procedures regarding methods of comfort, pain control, symptom management, as well as principles about death and dying, individual responses to death, patient rights, appropriate forms, and record keeping requirements.
• Provided when families or caregivers need respite or relief

• Provided in a participating hospice inpatient unit, participating hospital, Skilled Nursing Facility (SNF) or Nursing Facility (NF) or Intermediate Care Facility

• Services provided in the facility must conform to the Hospice’s POC
Inpatient Respite Care

- Maximum of 5 days at a time
- Hospice agency remains the professional manager of the patient’s care
- Payment for the sixth consecutive day is made at the routine home care rate
- The patient can receive more than one respite episode per billing period
• Indicate the facility that is providing inpatient respite care
• Reflect why respite care is necessary
• Give Dates of Service
• Indicate why multiple admissions were necessary
• Units are reported in days
Patients (in general) may be admitted for short-term general inpatient care when the physician and hospice interdisciplinary team believes the patient needs pain control or symptom management that cannot feasibly be provided in other settings.
Upon transfer to GIP, documentation should include:

- Precipitating event (onset of out of control symptoms)
- Interventions tried in the home that have failed
Sudden deterioration requiring intensive nursing intervention
Uncontrolled nausea and vomiting
Pathological fractures
Respiratory distress which becomes unmanageable
Transfusions for relief of symptoms
Traction and frequent repositioning requiring more than one staff member
Wound care requiring complex and/or frequent dressing changes that can not be managed in the patient’s residence
Severe agitated delirium or acute anxiety or depression secondary to the end-stage disease process requiring intensive intervention and not manageable in the home setting
Document the GIP Needs

- Pain, despite numerous changes to medication
- Bleeding that won’t stop
- Nausea and vomiting, despite changes to medication
- Terminal agitation, unresponsive to medication
- Medication adjustment that must be monitored 24/7
- Stabilizing treatment that cannot take place at home
- Note: Document the patient GIP needs on a daily basis
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<th>Total Charge</th>
<th>Percent GIP Charge to Total Charge</th>
<th>Percent GIP Claims to Total Claims</th>
<th>Percent SNF GIP Charge to Total Charge</th>
<th>Percent SNF GIP Medicare IDs to Total Medicare IDs</th>
<th>Average GIP LOS</th>
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GIP is the second most expensive level of hospice care
• OIG found that 82 percent of hospice claims for beneficiaries in nursing facilities did not meet Medicare coverage requirements.

• In addition, OIG identified a number of cases in which the use of inpatient respite care for beneficiaries in nursing facilities may have been inappropriate.
Hospices Billed inappropriately in SNFs

Hospices billed inappropriately for about half of GIP stays in SNFs

- Other Settings: 30
- SNF: 48
A 101-year-old beneficiary with dementia was cared for by a for-profit hospice in Alabama. His pain was never under control despite spending 16 days in GIP in a SNF. The beneficiary suffered significant pain during personal care and wound care. The hospice did not change the pain medication until the last day, when the dosage was slightly increased. In addition, the beneficiary needed an alternating pressure mattress at the start of the GIP stay, but the hospice did not order it for more than a week. Medicare paid the hospice more than $9,500 for this stay.
An 89-year-old beneficiary was under the care of a nonprofit hospice that billed for 16 days of GIP in a SNF. The beneficiary’s symptoms were uncontrolled for 14 days during which the hospice rarely changed his medication dosage. The patient continued to experience respiratory distress and anxiety. The hospice did not order any medical social services although the beneficiary and his family could have benefited from increased hospice services and emotional support. The hospice received just over $11,600 for this GIP stay.
A 66-year-old beneficiary with cancer was in pain throughout his GIP stay in a SNF. The beneficiary’s severe pain was not managed, and he did not have frequent assessments and adjustments of his care plan to bring the pain under control. Also, more involvement from the interdisciplinary team members was needed during the stay. The hospice was paid more than $2,000 for this patient’s stay.
• Regardless of care setting, the hospice IDG is responsible for the professional management of the patient’s care in accordance with the hospice plan of care as set by the IDG
• Contracts with appropriate facilities for GIP services should be clear regarding the IDG oversight role, scope of services, communication, and all the other federal and state regulatory requirements regarding services by arrangement
• The written agreements may also clarify payment rates and procedures
While the frequency of IDG visits to a patient receiving GIP level of care is not specified in the regulations, a good standard of care is daily visits from an IDG member to assure professional management, coordination of the plan of care, communication with the patient and family, continuity of care and evaluation of continued eligibility for this level of care.
Visits from the Hospice Team

• Coordination through communication with the physician overseeing inpatient care is also essential for professional care management purposes and moving the patient toward discharge from GIP

• The IDG should also continue services provided by Social Workers and Chaplains as needed and continue support and communication to the family and caregivers during a GIP stay
Consideration of the discharge planning needs of the patient should occur the moment the patient transfers to the GIP level of care.

The hospice (not the facility discharge planners when the facility is a hospital) is responsible for managing the discharge.

Documentation should show that the IDG is assessing the situation on a daily basis and planning for the transfer to another setting or level of care.

SNF Responsibilities

- Communicating and coordinating patient’s care with the hospice
- Monitoring the patient’s condition and reporting any changes to the hospice

SNF Responsibilities

• The routine daily care for patients at the nursing home
• Normally scheduled medical care and examinations by the attending physician and medical director
• Providing medications and supplies for care not related to the patient’s terminal illness

Interdisciplinary Team

Volunteers
Nurses
Physicians
Therapists
Spiritual Counselors
Home Health Aides
Social Workers
Bereavement Counselors
Patient & Family
PIG

Problems
Interventions
Goals

PIG-OUT

PIG and outcomes
D – Deaths (include all discharges, transfers and revocations)
A – Admits
R – Recertifications
E – Existing patients (grouped per diagnosis / LCD category)
Questions
Event Survey

https://www.surveymonkey.com/r HH7Q6HD

Post-Test

https://www.surveymonkey.com/r DSFQ2V2