Medicare Entitlement, Eligibility and Coverage Criteria, COVID-19 Isolation and Quarantine, Medicare Skilled Nursing Coverage, and Medicare Part A Skilled Nursing Documentation

3 Hours

Harmony Healthcare INTERNATIONAL

Medicare Entitlement, Eligibility and Coverage Criteria, COVID-19 Isolation and Quarantine, Medicare Skilled Nursing Coverage, and Medicare Part A Skilled Nursing Documentation

3 Hours

Harmony Healthcare International, Inc. (HHI)

"HHI **C.A.R.E.S. a**bout Care"

C.A.R.E.S.™

HHI C.A.R.E.S. About Care

Compliance | Analysis | Audit | Regulatory | Rehabilitation

Reimbursement | Education | Efficiency | Survey

Harmony Healthcare INTERNATIONAL

About Kris

Kris Mastrangelo OTR/L, LNHA, MBA

President and CEO

Owns and operates

Harmony Healthcare International, Inc. (HHI) a nationally recognized, premier Healthcare Consulting firm specializing in C.A.R.E.S.

There are no nonfinancial disclosures to share.

"HHI C.A.R.E.S. About Care."

Educational Activity Completion

Requirements for Successful Completion

3 contact hours will be awarded for this continuing nursing education activity. **Criteria for successful completion includes:**

Attendance for 100% of the entire course (2- and 3-day trainings requires at last 80% attendance). Contact hours will be awarded for time.

Must complete post course exam within 2 weeks of the course and course/teacher evaluation.

Clearly demonstrate the learning outcome of the program.

Participants will receive a certificate of completion immediately following completing the above requirements.

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CEU Disclosure

Harmony Healthcare International (HHI) is accredited as a provider of nursing continuing professional development by the American Nurses Credentialing Center's Commission on Accreditation.

Approval of this continuing education activity does not imply endorsement by AOTA and NAB of any commercial products or services.

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Speaker and Planning Committee Disclosure

- **Disclosures**: The planners and presenters of this educational activity have no relationship with commercial entities or conflicts of interest to disclose.
- **Planners:**
  - Kris Mastrangelo, OTR/L, LNHA, MBA
  - Joyce Sadewicz, PT, RAC-CT
  - Pamela Duchene, PhD, APRN-BC, NEA, FACHE
- **Presenters:**
  - Kris Mastrangelo, OTR/L, LNHA, MBA

Learning Outcomes

1. The learner will be able to identify 2 factors that impact **Medicare Entitlement**.
2. The learner will be able to identify 2 factors that impact **Medicare Eligibility**.
3. The learner will be able to identify how a beneficiary **Breaks a Spell of Illness**.
4. The learner will be able to identify 3 **Skilled Qualifiers** for **Medicare Part A Coverage** for the COVID-19 Isolated patient.
5. The learner will be able to identify the **Four Pillars** of skilled nursing.
6. The learner will be able to apply the elements of skilled coverage in the nursing documentation using **Core Components**.

Learning Outcomes

7. The learner will be able to apply the **elements of skilled coverage** in the nursing documentation using **Four Pillars**.
8. The learner will be able to apply the elements of **skilled coverage** in the nursing documentation using Assessments.
9. The learner will be able to identify documentation requirements to support the delivery of **medically necessary skilled care and services**.
10. The learner will be able to describe the importance of coding the correct, active **ICD-10 diagnoses**.
11. The learner will be able to assign **ICD-10-CM codes** to the highest level of specificity.

Qualifiers for COVID-19

The discussion will advance into the emergent and time-sensitive qualifiers for:

- COVID-19 Skilling Isolation.
- COVID-19 Skilling Quarantine.
- COVID-19 Skilling Infection Control.

Medicare Entitlement, Eligibility and Coverage Criteria

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Medicare Entitlement

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Medicare Entitlement

Medicare Enrollment Original Vs. Medicare Advantage

As of January 2022:

- **34.9M are enrolled in Original Medicare.**
- **29.3M are enrolled in Medicare Advantage or other health plans.** This includes enrollment in Medicare Advantage plans with and without prescription drug coverage.
- 49.8M are enrolled in Medicare Part D. This includes enrollment in stand-alone prescription drug plans as well as Medicare Advantage plans that offer prescription drug coverage.

Medicare Entitlement

Medicare Enrollment Original Vs. Medicare Advantage

- Nearly 11.9 million individuals are dually eligible for Medicare and Medicaid, so are counted in the enrollment figures for both programs.
- Detailed enrollment data can be reviewed here:

https://data.cms.gov/summary-statistics-on-beneficiary-enrollment/medicare-and-medicaid-reports/medicare-monthly-enrollment

Medicare Entitlement

- 65-years or older.
- Paid into Medicare taxes for 10 years or 40 quarters.
- Under 65-years and disabled.
- Open enrollment .
- Medicare Part A inpatient.
- Medicare Part B outpatient.

Medicare Entitlement

- Medicare covers particular, defined items and services. Medicare also only covers items services that **are "reasonable and necessary for the diagnosis or treatment of illness or injury …"** 42 U.S.C. sec. 1395y(a)(1)(A).
- Being "reasonable and necessary" is a **fundamental requirement for Medicare to cover anything.**
- So, when a **doctor is ordering an item or service**, it must be both a:
  - ***covered* item** or service (for example, not purely cosmetic), and it must be
  - **reasonable and necessary for the individual patient.**

Medicare Entitlement

- The **doctor's clinical judgment** will generally come into play **in deciding whether the service is reasonable and necessary for the individual patient**.
- For example, a doctor may order skilled observation and assessment for a patient in a SNF (which is a covered service provided the patient meets all eligibility requirements) **based on the decision that skilled observation and assessment is reasonable and necessary for that patient.**
- Medicare may later disagree and deny coverage if it thinks that the service was not reasonable and necessary. The patient and provider then have the right to appeal to Medicare for Coverage.

Medicare Entitlement

- Part of what the *Jimmo* settlement was about, was that **skilled care can be reasonable and necessary for patients who require such care to maintain or to prevent deterioration.**

Medicare Eligibility

3 Night Qualifying Stay
Certified Bed
Benefit Period (Days Available)
30 Day Transfer Rule
“Practical Matter” Criteria

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Medicare Eligibility in an SNF

1. 3 Night Qualifying Stay
2. Certified Bed
3. Benefit Period (Days Available)
4. 30 Day Transfer Rule
5. Practical Matter

Medicare Eligibility

1. 3 Night Qualifying Stay

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Medicare Eligibility
1. 3 Night Qualifying Stay

The beneficiary must have 3 day

(3 overnights)

in an **acute care hospital.**

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Medicare Eligibility
1. 3 Night Qualifying Stay

- Medicare eligibility for a skilled nursing stay begins with a 3-day qualifying stay in the hospital.
  - Must be an actual admission.
  - Observation stays do not qualify.
  - Behavioral health stays are included.
  - Some areas may have special programs for elective joint replacement where a 3-day stay is not needed.

Medicare Eligibility
1. 3 Night Qualifying Stay

Treated for a condition which was **treated** during a qualified stay…or… which **arose** while in a SNF for a treatment of condition for which the beneficiary **previously was treated in a hospital**.

For Example

Fractured hip **develops pneumonia** secondary to **immobility**.

Medicare Eligibility

2. Certified Bed

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Medicare Eligibility
2. Certified Bed

Beneficiary must reside in **Medicare Certified Bed** in order to receive payments for services rendered.

Medicare Eligibility

3. Benefit Period (Days Available)

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Medicare Eligibility
3. Benefit Period

- **Up to 100 days** of SNF coverage if patient meets level of care criteria.
- **Ends after 60 consecutive days** of non-skilled level of care.
- If level of care remains skilled, resident does not break **spell of illness.**
- **No limit** to number of benefit periods.

Medicare Eligibility
3. Benefit Period

- Under the Final Rule criteria, an **insulin dependent diabetic.**
- **G-tube feeder** can potentially receive a new spell of illness without going home or cessation of disease.

Medicare Eligibility
3. Benefit Period

- A benefit period ends with the conclusion of **60 consecutive days** in which the resident does **not** receive **skilled services.**

Medicare Eligibility

3. Benefit Period

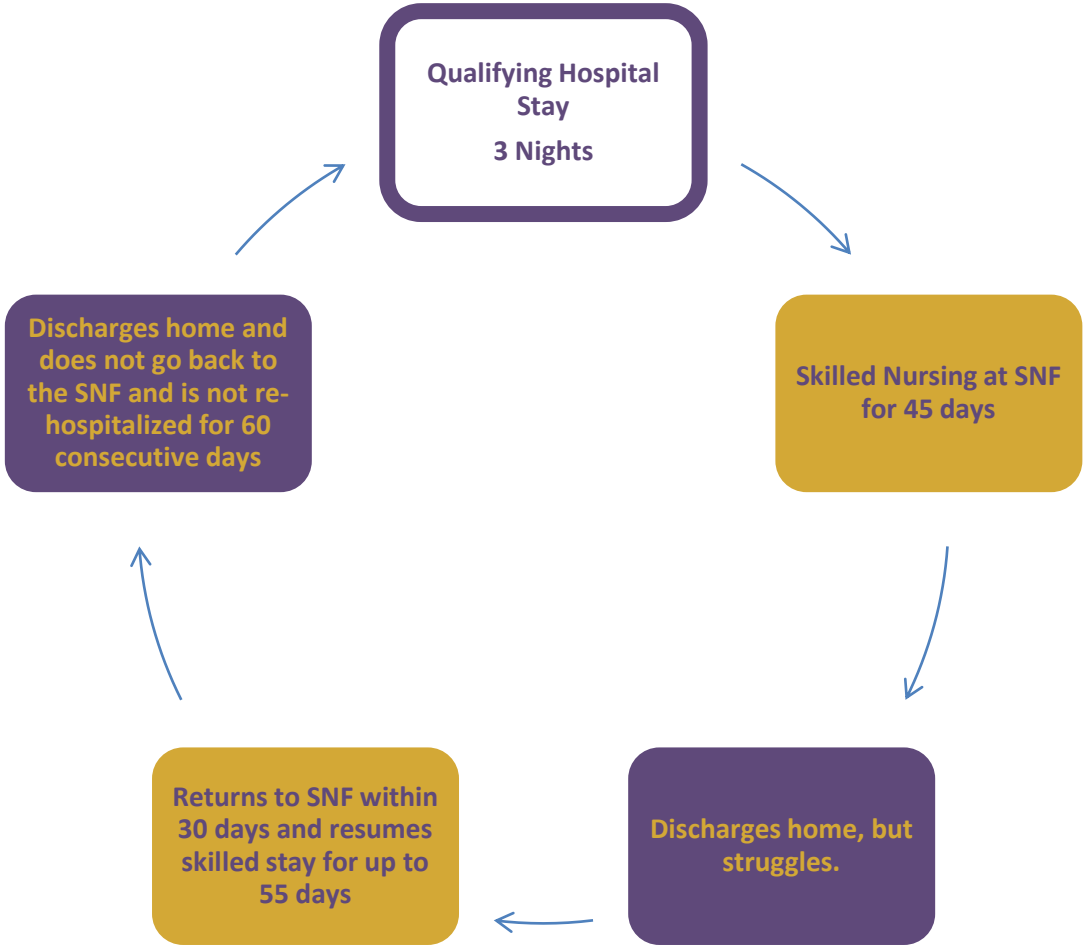
USED	NON-CERT	HOSP	DAY ON
55	65 no skill	4	
44	50 no skill	4	
48	25 no skill	0	
100	G-tube 62 no skill	25	
100	G-tube 62 skill	25	

Medicare Eligibility

3. Benefit Period

USED	NON-CERT	HOSP	DAY ON
55	65 no skill	4	1
44	50 no skill	4	45
48	25 no skill	0	49
100	G-tube 62 no skill	25	1
100	G-Tube 62 skill	25	0

Medicare Eligibility
3. Benefit Period



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Medicare Eligibility
3. Benefit Period

- Once the person discharges from the hospital after a qualifying stay, they are entitled to skilled nursing care for up to 100 days, if they have a skilled need.
- They do not have to go directly to a SNF:
  - Some patients step down from the acute care hospital to an LTACH or Rehab hospital.
  - Some people try to go home and fail.
  - Regardless, they can admit to the SNF for their skilled stay within 30 days of their discharge from the hospital.

Medicare Eligibility
3. Benefit Period

- Once the skilled patient discharges from the skilled stay, they can return to the SNF and resume their skilled nursing stay **within 30 days** without having to return to the hospital, if they have some of their 100 days remaining.
- They must go 60 days after discharging from skilled services without requiring skilled care to reset a new Benefit Period.

Medicare Eligibility

4. 30 Day Transfer Rule

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Medicare Eligibility
4. 30 Day Transfer Rule

- Applies to some patients admitted from home.
- Applies to some patients admitted from a non-acute care setting.
- Applies to patients discharged from Medicare Part A benefits prior to utilizing all available 100 benefit days.
- Do not count day of discharge from hospital.

Medicare Eligibility

5. “Practical Matter” Criteria

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Medicare Eligibility
5. “Practical Matter” Criteria

“As a practical matter, considering economy and efficiency, the daily skilled services can **only be provided** in a skilled nursing facility.”

Medicare Eligibility
5. “Practical Matter” Criteria

1. **Outpatient services are not available** in the area where the individual lives.
2. Outpatient services are available in the area where the individual lives, but **transportation** to the closest facility could cause an **excessive physical hardship**, be less economical, or less effective than placement in the skilled nursing facility.

Medicare Eligibility
5. “Practical Matter” Criteria

3. The availability at home of a capable and willing **caregiver** should be considered, but the care can be furnished only in the skilled nursing facility if home care would be ineffective because there would be **insufficient assistance** at home for the patient/resident to reside there safely.
4. If the use of **alternative services would adversely affect** the patient/resident’s **medical condition**, then as a practical matter the daily skilled service(s) can only be provided on an inpatient basis.

Medicare Eligibility
5. "Practical Matter" Criteria
Leave of Absence

- **Medicare Benefit Policy Manual, Chapter 8, Section 30.7.3:**
  - The regulations "should never be interpreted so **strictly** that it results in the automatic denial of coverage for patients who have been meeting all of the SNF level of care requirements, but who have **occasion to be away from the SNF** for a brief period of time."

Medicare Eligibility
5. “Practical Matter” Criteria
Leave of Absence

- **Frequent or prolonged periods away from the SNF** may leave the MAC to question whether the patient’s care can, as a practical matter, only be furnished on an inpatient basis in a SNF.

Medicare
Coverage and Skilled Care

General

Presumptive Coverage

Skilled Nursing Services

Management and Evaluation of a Care Plan

Observation and Assessment

Teaching and Training

Skilled Rehabilitation

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Medicare Coverage and Skilled Care

1. General
2. Presumptive Coverage
3. Skilled Nursing Services “Inherent Complexity”
4. Management and Evaluation of a Care Plan
5. Observation and Assessment
6. Teaching and Training
7. Skilled Rehabilitation
8. Jimmo Sebelius

Medicare Coverage and Skilled Care
Four Pillars of Skilled Nursing

1. **General**
2. **Presumptive Coverage**
3. Skilled Nursing Services
4. Management and Evaluation of a Care Plan
5. Observation and Assessment
6. Teaching and Training
7. **Skilled Rehabilitation**
8. **Jimmo Sebelius**

Medicare
Coverage and Skilled Care

1. General

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Medicare Coverage and Skilled Care
1. General

- **Skilled Nursing** or **Skilled Rehabilitation Services.**
- On a **Daily Basis.**
- Services rendered are **Reasonable and Necessary.**
- **Physician Ordered.**

Medicare Coverage and Skilled Care
1. General

- Nature of service requires the **skills of RN, LPN.**
- Care **rendered by a licensed person**. Federal regulations define licensed person as physician, nurse and/or therapist.
- Provided directly by or under general **supervision** of a licensed nurse to assure the safety of the patient and to achieve the medically desired result.
- **"General" = initial direction and periodic** inspection of the activity.

Medicare Coverage and Skilled Care
1. General

- Additionally, the requirements for participation at section 1819 (b)(4)(A) of the act require an SNF to furnish the full range of nursing and specialized rehabilitation services needed to attain or maintain each resident's **highest practical state of well-being**, in accordance with Care Plan.

Medicare Coverage and Skilled Care
1. General

- This requires the **clinical judgment of a nurse.**
- Do not confuse **“baseline”** with non-skilled care. A fundamental understanding of skilled care allows discernment of difference.
- Skilled care includes **“treatments or conditions that arose”** secondary to the primary issue.

Medicare Coverage and Skilled Care

1. General

Universal Documentation Guidelines

- Create a complete picture of resident.
- Guides MD.
- Record physical, mental and emotional status.
- Tell a story.
- Paint the picture.

Medicare Coverage and Skilled Care

1. General

Universal Documentation Guidelines – Multiple Standards

- Federal (Regulatory).
- State.
- Professional (Nurse, OT, PT, ST, etc.).
- Federal (Reimbursement).
- Insurance.
- Facility Policy.
- Organization Policy.

Medicare
Coverage and Skilled Care

2. Presumptive Coverage

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Medicare Coverage and Skilled Care
2. Presumptive Coverage

- When the initial Medicare 5-Day Assessment results in a beneficiary being **correctly coded** to one of the top **Nursing CMGs**, creates a "presumptive coverage" from admission up to and including **ARD (Assessment Reference Date).**
- **Lower 8** at risk for denial and audit.

Medicare Coverage and Skilled Care

2. Presumptive Coverage

The coverage that arises from this presumption requires documentation to support skilled care.

Medicare Coverage and Skilled Care

2. Presumptive Coverage

Nursing CMG Intimacy

- Do you know the **Nursing CMG?**
- Do the **nursing notes** support the CMG level?

Skilled Nursing Services

Four Pillars

#3, #4, #5 and #6

Documentation

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Medicare Coverage and Skilled Care
Four Pillars of Skilled Nursing

1. General
2. Presumptive Coverage
3. Skilled Nursing Services
4. Management and Evaluation of a Care Plan
5. Observation and Assessment
6. Teaching and Training
7. Skilled Rehabilitation
8. Jimmo Sebelius

Medicare Coverage and Skilled Care

1. Skilled Nursing Services
2. Management and Evaluation of a Care Plan
3. Observation and Assessment
4. Teaching and Training

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Skilled Nursing
Four Pillars
Documentation

Skilled Nursing Inherent Complexity

The person's care is so **complex** that a licensed nurse is necessary to perform and coordinate their care.

Managing the Care Plan

The ongoing management and development of a person-centered care plan is a skilled need.

Planning for a safe discharge, including reducing the risk of re-hospitalization, is part of **Managing the Care Plan.**

Observation and Assessment

The person's condition/s require/s the observation and assessment of a licensed nurse.

The **need** for assessment is the skilled need.

Education

The person or their caregiver needs education about managing their medical conditions **to attain or maintain the highest practicable level physical, mental, and psychosocial well-being.**

Skilled Nursing

Four Pillars

Documentation

Core Components

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Core Components
COPD

- Patient Name: _____
- Daily Nursing Skills: High risk for respiratory failure related to ventilation-perfusion imbalance, ineffective breathing pattern related to emotional stimulation, fatigue or blunting of respiratory drive, nutritional deficit and activity intolerance related to SOB and adverse effects of medications, inactivity-resultant risk for loss of function exercise related hypoxemia, fatigue from sleep disturbance secondary to bronchodilator's stimulant effect, SOB, anxiety, depression. High risk for S&S indicating impending exacerbation. High risk of infection related to stasis of secretions, reduced activity and decreased motility in lungs.

Core Components
COPD

- Patient Name: _____ (continued)
- Following nursing admission assessment, identify which of the list areas are pertinent for each patient. DAILY NURSES NOTES should address one or more of these areas of skilled nursing. A comprehensive Weekly Note should include all of the identified nursing skills, plus any periodic episodes which have occurred. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care.

Core Components
COPD

- Vital signs.
- Assess for need for (or response to) use of oxygen. Titration of oxygen in response to pulse oximetry readings.
- Administer pharmacologic agents (bronchodilator, antibiotics, corticosteroids, and expectorants).
- Monitor therapeutic levels of medications as ordered.
- Perform bronchial hygiene measures as ordered.
- Pulmonary assessment.
- Report effectiveness of pulmonary treatment.

Core Components
COPD

- Maintain adequate fluid intake, monitor I&O.
- Monitor for signs of infection or further deterioration in respiratory status.
- Reduce or eliminate environmental irritants.
- Monitor the patient's reduction of work of breathing, to lessen depletion of oxygen reserves.
- Monitor nutritional intake and weight.
- Monitor the use of breathing techniques during ADL.
- Monitor response to increased activity and recovery breathing after activity.

Core Components
COPD

- Consult with MD to adjust medications for sleep to optimize bronchodilation and minimize stimulant effects. Monitor the patient's use of bronchial hygiene before sleep, as needed during nocturnal dyspnea.
- Monitor periods of sleeplessness, including the degree of shortness of breath, pulse rate and rhythm, respiratory rate and breathing sounds.
- Assess use of relaxation techniques.
- Review of laboratory studies for abnormal values (review is skilled, even for negative results).

Core Components
COPD

- Assessment for therapeutic response to medication or discontinuance of medication.
- Teaching and training activities: S&S's if impending exacerbation, avoid over medication, practical energy conservation and breathing techniques, S&S's infection. Medication purpose, dose, schedule, adverse effects requiring medical attention. Bronchial hygiene measures. Prevention dehydration, cleaning of respiratory equipment, dietary restrictions, weight monitoring, exercise prescriptions.
- Describe current rehabilitation services and progress.
- Discharge planning.

Skilled Nursing Documentation
Cue Sheets

- **Cue sheets/pinned notes in the EHR** can be used to provide guidance to the staff nurses:
  - Weekly notes.
- This may help staff nurses **focus their attention** on topics that best support the patient's skilled need.
- May **increase efficiency** of the documenting nurse.
- **However, you decide to provide direct care staff with the guidelines for charting, they must be kept updated.**

Core Components
Skilled Nursing Documentation
Cue Sheets

- Starting Nursing notes with:
  - **"Continued need for daily skilled nursing assessment/observation for"** will cue the nursing staff for the reason the patient needs skilled care in the nursing facility for reason of hospitalization.
  - "Skilled teaching and training"- discharge education should happen with each patient who will transition to a lower level of care.

Skilled Nursing Documentation
What to Consider Including

- Patient is at high risk for…
- Skilled assessment of…
- Potential for recurrence of…
- Potential for the following complications…
- There is a likelihood of change related to…
- The medical regimen is not essentially stabilized as evidenced by…

Core Components
Skilled Nursing Documentation
What to Consider Including

- Patient continues to require daily skilled rehab for…
- Observation and assessment for potential complications related to…
- Potential for medical complications related to the diagnosis of…
- Plan of care is being monitored to promote recovery and ensure medical safety related to…
- The patient requires daily skilled management and evaluation of the plan of care related to…

Core Components

Assessments Skilled Nursing Documentation
What to Consider Including

- Skilled neurological assessment resulted in…
- Patient is high risk for _____ secondary to _____.
- Medications adjusted to _____, ongoing skilled assessment of regimen to promote recovery and ensure medical safety.
- Patient continues to require daily skilled nursing as his treatment regimen is not essentially stabilized and there is a potential for recurrence of _____.

Skilled Nursing

Four Pillars

Documentation

“Inherent Complexity”

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Medicare
Coverage and Skilled Care

3. “Inherent Complexity”

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Medicare Coverage and Skilled Care
3. Skilled Care Inherent Complexity

- The patient's condition or treatments are so inherently complex that they require a licensed nurse.
- This doesn't necessarily mean that a lay person cannot be trained to perform the mechanics of the dressing change or to weigh themselves daily and follow PRN diuresis orders.
- The skills of a licensed nurse may be necessary to oversee the process and assess for complications.
- Assessment and Observation are intertwined with inherent complexity. It is not always one or the other. Inherent Complexity inherently requires assessment and observation because of its complexity.

3. Skilled Care Inherent Complexity
Direct Skilled Nursing

- **Enteral Feeding:**
  - Skilled coverage (Medicare Benefits Policy Manual 100-02, Ch 8, §30.3): Enteral feeding that comprises at least 26 percent of daily calorie requirements and provides at least 501 milliliters of fluid per day.
  - Skilled payment (RAI User's Manual, Chapter 6): 51% or more of total calories go through the tube or at least 26% and 501 cc of fluid per day fluid intake.

3. Skilled Care Inherent Complexity
Direct Skilled Nursing

- **Suprapubic Catheters** - This procedure is a major vector for infection that can be fatal if improperly performed (insertion, sterile irrigation and replacement).

Medicare Coverage and Skilled Criteria

3. Skilled Care Inherent Complexity

Direct Skilled Nursing

- **IV** medications.
- N/G, **gastrostomy tubes**, jejunostomy tubes.
- Application of **dressing with prescription medications** and aseptic technique.
- Treatment of **multiple Stage 2 pressure injuries** or **1 pressure injury Stage III** or worse.
- **Initial phases** of a regimen involving **medical gases** such as bronchodilators and oxygen therapy.

3. Skilled Care Inherent Complexity
Direct Skilled Nursing

- **Let's come back to that person with brittle diabetes:**
  - People manage diabetes at home every day.
  - Insulin injections every day and 2 or more order changes for insulin in one week indicate an unstable or "brittle" diabetic.

3. Skilled Care Inherent Complexity
Direct Skilled Nursing

- **And what about the person with CHF?**
  - It doesn't take a licensed nurse to weigh daily and take an extra dose of furosemide.
  - But when potential complications of hypokalemia from too much furosemide, or decompensation, or cellulitis from skin impairments due to swollen legs are factored into the equation, the condition becomes inherently complex.

Medicare Coverage and Skilled Criteria

3. Skilled Care Inherent Complexity

Direct Skilled Nursing

- **Enteral Feeding** - 26% daily calorie requirements and at least 501 milliliters fluid per day.
- **Suprapubic Catheters** - This procedure is a major vector for infection that can be fatal if improperly performed (insertion, sterile irrigation, and replacement).
- **Hypodermoclysis** and subcutaneous injections **no longer skilled.**
- **Daily insulin injections** with 2 order changes over last 14 days.

Medicare Coverage and Skilled Criteria

3. Skilled Care Inherent Complexity

Direct Skilled Nursing

- **IV (parental)** medications.
- N/G, **gastrostomy tubes**, jejunostomy tubes.
- Application of **dressing with prescription medications** and aseptic technique.
- Treatment of **pressure ulcer grade 3** or worse.
- **Initial phases** of a regimen involving **medical gases** such as bronchodilators and oxygen therapy.
- **Colostomy Care.**
- **Bowel and Bladder Training.**

Skilled Nursing

Four Pillars

Documentation

4. Management and Evaluation of a Care Plan

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Medicare Coverage and Skilled Criteria
4. Management of Evaluation of a Care Plan

"Constitute skilled services when, because of the patient's physical or mental condition, those activities require the involvement of technical or professional personnel in order to **meet the patient's needs, promote recovery and ensure medical safety**." (Final Rule 7/31/99)

Medicare Coverage and Skilled Criteria
4. Management of Evaluation of a Care Plan

Example #1:

"An aged patient with a history of diabetes mellitus and angina pectoris who is recovering from an **open reduction** of a fracture of the neck of the femur requires, among other services, careful skin care, appropriate oral medications, a diabetic diet, an exercise program to preserve muscle tone and body condition, and observation to detect signs of deterioration in his or her condition or complications resulting from restricted but increasing mobility." (Final Rule 7/31/99)

Medicare Coverage and Skilled Criteria
4. Management of Evaluation of a Care Plan

Example #1 (continued):

"Although any of the required services could be performed by a **properly instructed person**, such a person would not have the ability to understand the **relationship between the services and evaluate the ultimate effect of one service on the other.** Since the nature of the patient's condition, age, and immobility create a **high potential for serious complications**, such an understanding is essential to ensure the patient's recovery and safety." (Final Rule 7/31/99)

Medicare Coverage and Skilled Criteria
4. Management of Evaluation of a Care Plan

Example #1 (continued):

"Under these circumstances, the management of the plan of care would require the **skills of a nurse** even though the individual services are not skilled. Skilled planning and management activities are not always specifically identified in the patient's clinical record. Therefore, if the patient's overall condition supports a finding that **recovery and safety** can be ensured only if **the total care is planned, managed, and evaluated by technical or professional personnel,** it is appropriate to infer that skilled services are being provided." (Final Rule 7/31/99)

Medicare Coverage and Skilled Criteria
4. Management of Evaluation of a Care Plan

- Management of the Care Plan requires the nursing process.
- The nursing process is a skilled process:
  - **ASSESS** the person.
  - DIAGNOSE (or Determine) existing or potential problems, conditions, and strengths.
  - **PLAN** for care. Set an achievable, measurable goal, and develop interventions to reach the goal.
  - **IMPLEMENT** the interventions.
  - **EVALUATE** the results.

Medicare Coverage and Skilled Criteria
4. Management of Evaluation of a Care Plan

- All aspects of managing the care plan are essentially skilled services.
- If the management of the care plan is not documented, was it done?
  - Managing the Care Plan cannot be considered a skilled service if it is not documented.
  - Direct care staff are IMPLEMENTING the Care Plan:
    - Does that affect the way you think about filling out those flow sheets?

Medicare Coverage and Skilled Criteria
4. Management of Evaluation of a Care Plan

- The person with frequent behaviors due to dementia goes out to geri-psych for 6 days inpatient to try to titrate medications that will help stabilize the person's escalating behaviors.
- When they return to the facility, Social Services, using the recommendations in the person's geri-psych discharge plans, writes a detailed plan of care for de-escalating behaviors.
  - One of the interventions is that nursing will document all behaviors, interventions attempted, and record the effect of the intervention.

Medicare Coverage and Skilled Criteria
4. Management of Evaluation of a Care Plan

- Another intervention is that the nurse and CNA will document any potential triggers or precursors before behaviors.
- The direct care nurse and CNA completely and accurately fills out all flowsheets for behaviors. They **implement** the interventions. They note the presence or absence of potential triggers.
- The Interdisciplinary Team (IDT) uses the flowsheets to **evaluate** the care plan and improve outcomes.

Skilled Nursing
Four Pillars
Documentation

5. Observation and Assessment

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Medicare Coverage and Skilled Criteria

5. Observation and Assessment

- Reasonable probability for **complications** or potential for further acute episodes of the patient's changing condition.
- Needed to **identify and evaluate** the patient's need for modification of treatment, or
- Additional **medical procedures** until his or her condition is stabilized.

Medicare Coverage and Skilled Criteria
5. Observation and Assessment

Example #1:

"A patient with **congestive heart failure** may require continuous close **observation to detect** signs of decompensation, abnormal fluid balance, or adverse effects resulting from prescribed medication(s) that serve as indicators for adjusting therapeutic measures." (Final Rule 7/31/99)

Medicare Coverage and Skilled Criteria
5. Observation and Assessment

Example #2:

"Similarly, surgical patients transferred from a hospital to an SNF while in the **complicated, un-stabilized** postoperative period, for example, after **hip prosthesis or cataract surgery**, may need continued close skilled monitoring for postoperative complications and adverse reaction." (Final Rule 7/31/99)

Medicare Coverage and Skilled Criteria
5. Observation and Assessment

Example #3:

"Patients who, in addition to their **physical problems**, exhibit acute **psychological** symptoms such as **depression, anxiety, or agitation**, may also require skilled observation and assessment by technical or professional personnel to ensure their **safety or the safety of others**, that is, to observe for indications of suicidal or hostile behavior. The need for services of this type must be documented by physicians' orders or nursing or therapy notes." (Final Rule 7/31/99)

5. Observation and Assessment
MONITOR is not a bad word

- Planning to monitor, once the care plan has been established, does not support an ongoing skilled need to monitor.
- **Let that sink in.**
  - Writing about all that monitoring we are going to do without documenting the actual monitoring is not only pointless, saying “will monitor” may prompt deficiencies when the surveyor asks where all this monitoring is recorded.
- It’s the **NEED** for monitoring that requires the skilled services of a licensed nurse.

Skilled Nursing Documentation

5. Observation and Assessment
MONITOR is not a bad word

- The need cannot be supported if there is no evidence that it is actually being done.
- Telling the auditor we are going to monitor does not support the skilled need. We are telling a story. We are painting a picture. We have already done that part.
- Write what your observation or monitoring showed – not just that you are monitoring.

Medicare Coverage and Skilled Criteria

5. Observation and Assessment

- The person's condition requires the Observation and Assessment of a licensed nurse.
- Reasonable probability for **complications** or potential for further acute episodes of the patient's changing condition.
- Needed to **identify and evaluate** the patient's need for modification of treatment, or
- Additional **medical procedures** until his or her condition is stabilized.

Medicare Coverage and Skilled Criteria

5. Observation and Assessment

- CHF patient with daily weights and PRN diuretics.
- Brittle diabetic who has frequent swings in blood sugar.
- Recent Sepsis and at risk for recurrent sepsis.
- Cancer patient on new chemotherapy regime.

5. Observation and Assessment
COVID-19 Skilling Isolation and Quarantine

- According to the CDC, **isolation is for people who are ill, while quarantine** applies to people who have been **in the presence of a disease** but have not necessarily become sick themselves. Per the CDC,

"Isolation separates sick people with a contagious disease from people who are not sick."

- **Isolation** is for patients with **symptoms** and or **positive tests.**
- **Quarantine** is for patients **exposed** but exhibits **no symptoms.**

5. Observation and Assessment
COVID-19 Skilling Isolation

- **Isolation** (Z29.0) and **COVID-19** (UO7.1).
- **Coding isolation** for a patient with an active infectious disease places them into an ES1 Nursing category under both Medicare Part A and certain Medicaid Case Mix states.

5. Observation and Assessment
COVID-19 Skilling Isolation

To **properly code isolation** on the **MDS**, the patient requires:

- **Isolation** for a minimum of **one day.**
- **MD Orders** for isolation.
- **Active Infectious** disease **ICD-10 coded**:
  - On the UB-04, and
  - On the MDS (Section O. and I.).

5. Observation and Assessment
COVID-19 Skilling Isolation

- All **treatments rendered in the patient's room** with documentation to support said services are provided at bedside:
  - Isolation **cannot be coded if the patient is being "cohorted"**, meaning rooming with another patient.

Medicare Coverage and Skilled Criteria
5. Observation and Assessment
COVID-19 Daily Skilled Documentation

- **Skilled (Medicare Part A) Observation and Assessment** is Indicated when there is a reasonable probability or possibility for complications or the potential for further acute episodes.
- This references conditions where there is a **"reasonable probability or possibility"** for:
  - Complications.
  - Potential for further acute episodes.
  - Need to identify and evaluate the need for modification of treatment.
  - Evaluation of initiation of additional medical procedures.

5. Observation and Assessment
COVID-19 Daily Skilled Documentation

- Daily observations and assessments include but are not limited to, fever, dehydration, septicemia, pneumonia, nutritional risk, weight loss, blood sugar control, impaired cognition, mood, and behavior conditions.
- **Example of Daily Skilled Documentation:**
  - "This patient requires daily skilled nursing observation and assessment of signs and symptoms related to exacerbation of COVID-19, pneumonia, and related medical conditions."
- Skilled observation is required until the **treatment regimen is essentially stabilized, and the patient is no longer at risk for medical complications.**

Medicare Coverage and Skilled Criteria

5. Observation and Assessment
COVID-19 Quarantine and Skilled Care

- Although a quarantined patient may not have symptoms, the mere fact the patient was **potentially exposed to COVID-19** warrants daily skilled nursing to observe and assess for signs and symptoms of COVID-19.
- **Observation and Assessment** references conditions where there is a "reasonable probability or possibility" for the nurse to:
  - Evaluate the patient's condition i.e., observe and assess for fever, body aches, loss of appetite,
  - Identify acute episodes, and
  - Identify the need for treatment (modifications).
  - Initiate treatment changes.

5. Observation and Assessment
COVID-19 Quarantine and Skilled Care

- In addition, the nurse may provide **observation and assessment** of signs and symptoms related to:
  - Dehydration.
  - Septicemia.
  - Pneumonia.
  - Nutritional risk.
  - Weight loss.
  - Blood sugar control.
  - Impaired cognition, and
  - Mood and behavior conditions.

5. Observation and Assessment
COVID-19 Quarantine and Skilled Care

- Nurses need to document the defined assessment **on a daily basis.**
- This may include neurological, respiratory, cardiac, circulatory, pain/sensation, nutritional, gastrointestinal, genitourinary, musculoskeletal, and skin assessments.
- In these situations, the Nurse may write:
  - **"This patient requires daily skilled nursing observation and assessment of signs and symptoms related to COVID-19."**
- Skilled observation is required until the **treatment regimen is essentially stabilized.**

Medicare Coverage and Skilled Criteria

5. Observation and Assessment

COVID-19 Reimbursement Medicare Part A Skilled Care

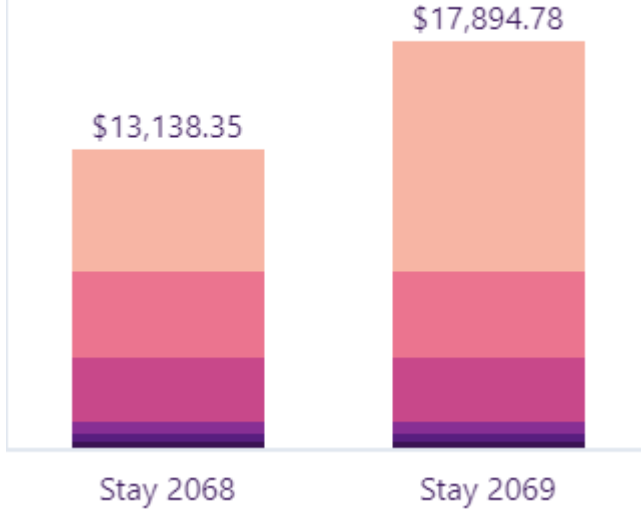
- The difference in reimbursement for accurately coding **isolation** for a patient with **active infectious disease** in urban Massachusetts.

Stay 2068	
Avg Daily Rate	$453.05
	29 Days
PT/OT	TK
SLP	SA
Nursing	CBC2
NTA	ND
HIPPS	KAND1
	Essex County Massachusetts
Duplicate / Delete	

Stay 2069	
Avg Daily Rate	$617.06
	29 Days
PT/OT	TK
SLP	SA
Nursing	ES1
NTA	ND
HIPPS	KACD1
	Essex County Massachusetts
Duplicate / Delete	

$ Impact Isolation COVID-19 (MA) =

$617.06 - $453.05 =
$164.01 per day
x 100 days =
$16,401



*Courtesy of **Hopforce PDPM Calculator:** https://pdpm-calc.com/

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Medicare Coverage and Skilled Criteria

5. Observation and Assessment

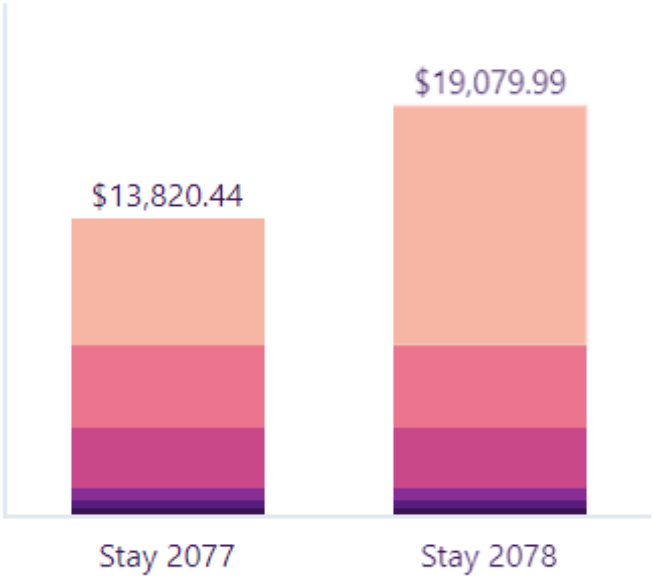
COVID-19 Reimbursement Medicare Part A Skilled Care

- The difference in reimbursement for accurately coding **isolation** for a patient with **active infectious disease** in urban Massachusetts.

Stay 2077	Stay 2078
Avg Daily Rate	Avg Daily Rate
$476.57	$657.93
29 Days	29 Days
PT/OT: TK	PT/OT: TK
SLP: SA	SLP: SA
Nursing: CBC2	Nursing: ES1
NTA: ND	NTA: ND
HIPPS: KAND1	HIPPS: KACD1
Norfolk County Massachusetts	Norfolk County Massachusetts
Duplicate / Delete	Duplicate / Delete

$ Impact Isolation COVID-19 (MA) =

$657.93 - $476.57 =
$181.36 per day
x 100 days =
$18,136



*Courtesy of **Hopforce PDPM Calculator:** https://pdpm-calc.com/

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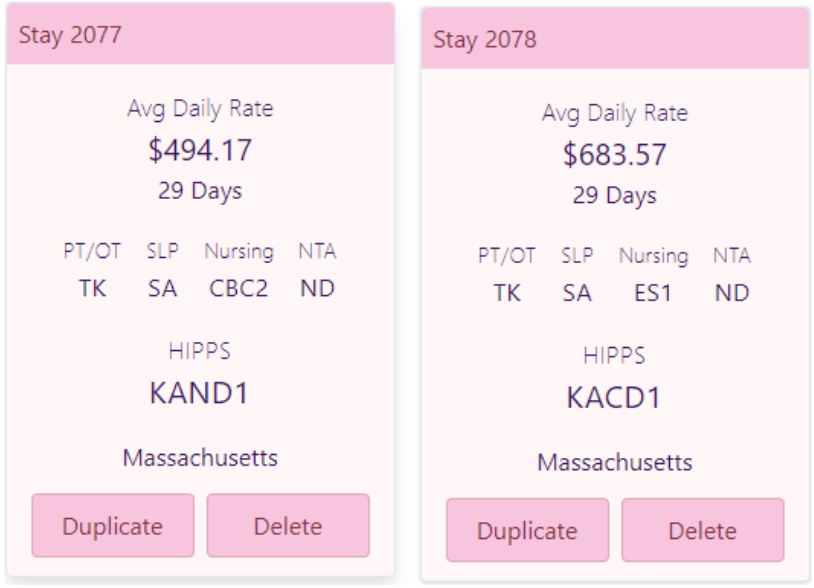
Medicare Coverage and Skilled Criteria

5. Observation and Assessment

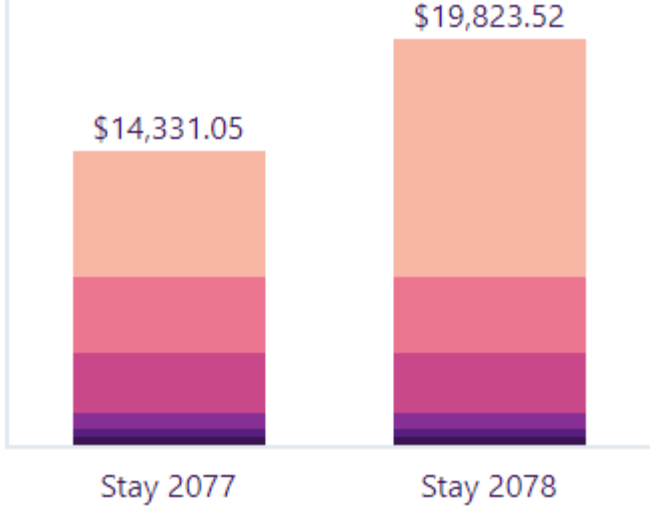
COVID-19 Reimbursement Medicare Part A Skilled Care

- The difference in reimbursement for accurately coding **isolation** for a patient with **active infectious disease** in rural Massachusetts.



$ Impact Isolation COVID-19 (MA) =

$683.57 - $494.17 =
$189.40 per day
x 100 days =
$18,940



*Courtesy of **Hopforce PDPM Calculator:** https://pdpm-calc.com/

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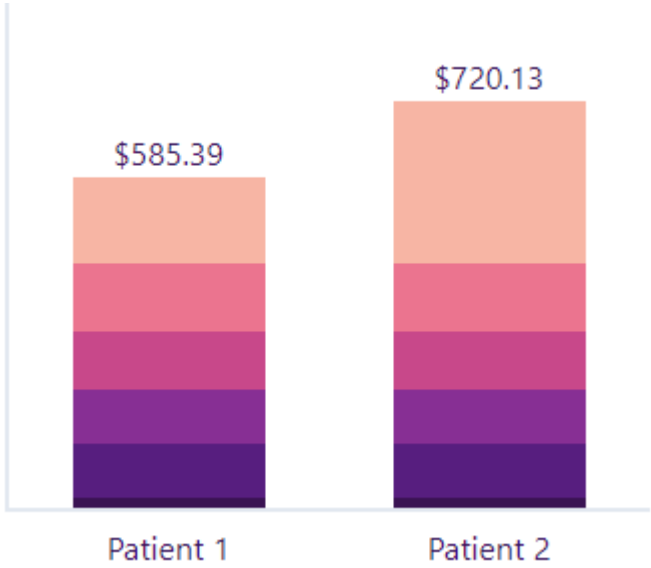
5. Observation and Assessment
COVID-19 Reimbursement Medicare Part A Skilled Care

- The difference in reimbursement for accurately coding **isolation** for a patient with **active infectious disease** in rural Vermont:

Patient 1	Patient 2
Avg Daily Rate	Avg Daily Rate
$585.39	$720.13
30 days	30 days
PT/OT: TK	PT/OT: TK
SLP: SA	SLP: SA
Nursing: CBC2	Nursing: ES1
NTA: ND	NTA: ND
HIPPS: KAND1	HIPPS: KACD1
Vermont	Vermont
Duplicate / Delete	Duplicate / Delete

$ Impact Isolation COVID-19 (VT) =

$720.13 - $585.39 =
$134.74 per day
x 100 days =
$13,474



*Courtesy of **Hopforce PDPM Calculator:** https://pdpm-calc.com/

Medicare Coverage and Skilled Criteria

5. Observation and Assessment

COVID-19 Reimbursement Medicare Part A Skilled Care

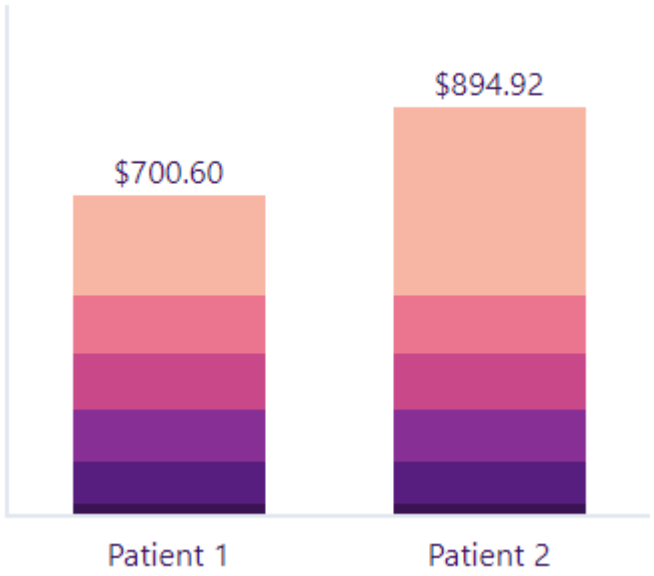
- The difference in reimbursement for accurately coding **isolation** for a patient with **active infectious disease** in urban New York:

Patient 1	
Avg Daily Rate	$700.60
	30 days
PT/OT	TK
SLP	SA
Nursing	CBC2
NTA	ND
HIPPS	KAND1
	New York County, New York
Duplicate / Delete	

Patient 2	
Avg Daily Rate	$894.92
	30 days
PT/OT	TK
SLP	SA
Nursing	ES1
NTA	ND
HIPPS	KACD1
	New York County, New York
Duplicate / Delete	

$ Impact Isolation COVID-19 (NY) =

$894.92 - $700.60 =
$194.32 per day
x 100 days =
$19,432



*Courtesy of **Hopforce PDPM Calculator:** https://pdpm-calc.com/

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5. Observation and Assessment
COVID-19 Reimbursement Medicare Part A Skilled Care

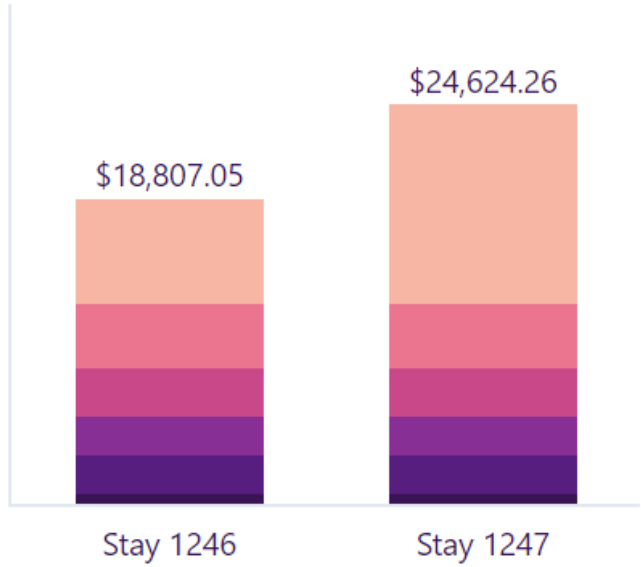
- The difference in reimbursement for accurately coding **isolation** for a patient with **active infectious disease** in urban Hawaii.

Stay 1246	
Avg Daily Rate	$626.90
	30 Days
PT/OT	TK
SLP	SA
Nursing	CBC2
NTA	ND
HIPPS	KAND1
	Honolulu County Hawaii
Duplicate / Delete	

Stay 1247	
Avg Daily Rate	$820.81
	30 Days
PT/OT	TK
SLP	SA
Nursing	ES1
NTA	ND
HIPPS	KACD1
	Honolulu County Hawaii
Duplicate / Delete	

$ Impact Isolation COVID-19 (HI) =

$820.81 - $626.90 =
$193.91 per day
x 100 days =
$19,391.00



*Courtesy of **Hopforce PDPM Calculator:** https://pdpm-calc.com/

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Medicare Coverage and Skilled Criteria

5. Observation and Assessment

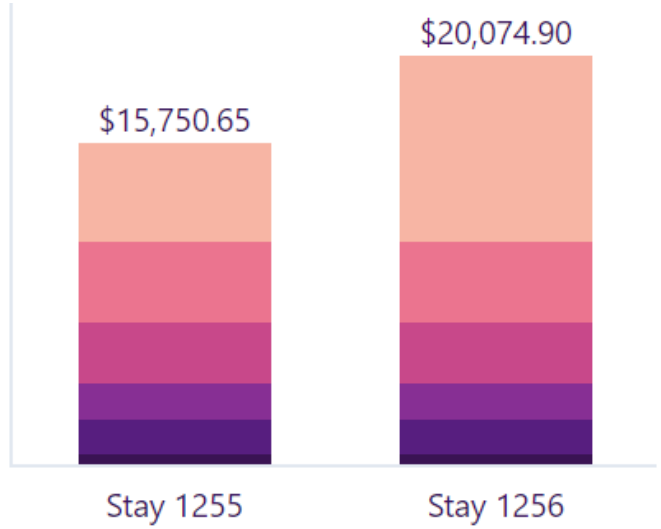
COVID-19 Reimbursement Medicare Part A Skilled Care

- The difference in reimbursement for accurately coding **isolation** for a patient with **active infectious disease** in urban New Hampshire.

Stay 1253	Stay 1252
Avg Daily Rate	Avg Daily Rate
$525.02	$669.16
30 Days	30 Days
PT/OT: TK	PT/OT: TK
SLP: SA	SLP: SA
Nursing: CBC2	Nursing: ES1
NTA: ND	NTA: ND
HIPPS	HIPPS
KAND1	KACD1
Hillsborough County New Hampshire	Hillsborough County New Hampshire
Duplicate / Delete	Duplicate / Delete

$ Impact Isolation COVID-19 (NH) =

$669.16 - $525.02 =
$144.14 per day
x 100 days =
$14,414.00



*Courtesy of **Hopforce PDPM Calculator:** https://pdpm-calc.com/

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Medicare Coverage and Skilled Criteria

5. Observation and Assessment

COVID-19 Reimbursement Medicare Part A Skilled Care

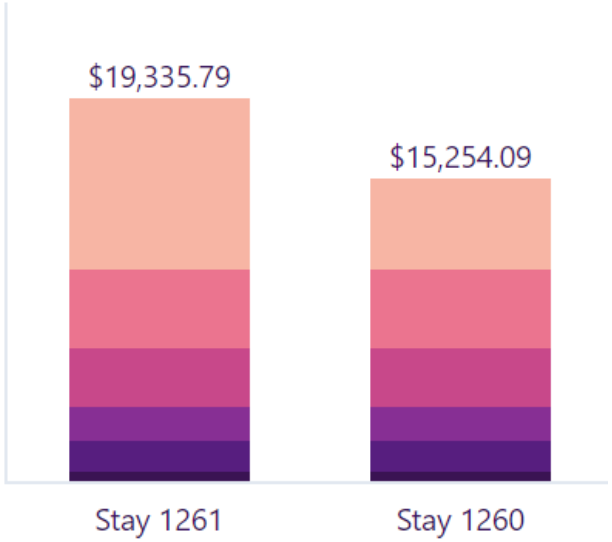
- The difference in reimbursement for accurately coding **isolation** for a patient with **active infectious disease** in urban Florida.

Stay 1261			
Avg Daily Rate			
$644.53			
30 Days			
PT/OT	SLP	Nursing	NTA
TK	SA	ES1	ND
HIPPS			
KACD1			
Orange County			
Florida			
Duplicate	Delete		

Stay 1260			
Avg Daily Rate			
$508.47			
30 Days			
PT/OT	SLP	Nursing	NTA
TK	SA	CBC2	ND
HIPPS			
KAND1			
Orange County			
Florida			
Duplicate	Delete		

$ Impact Isolation COVID-19 (FL) =

$644.53 - $508.47 =
$136.06 per day
x 100 days =
$13,606.00



*Courtesy of **Hopforce PDPM Calculator:** https://pdpm-calc.com/

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5. Observation and Assessment
COVID-19 Reimbursement Medicaid Case Mix – D.C.

- In D.C., the coding of isolation also impacts the **Medicaid Case Mix** Index An **ES1** Level for Isolation yields 2.22 CMI.
- Conservatively, the **CMI Impact Isolation:**

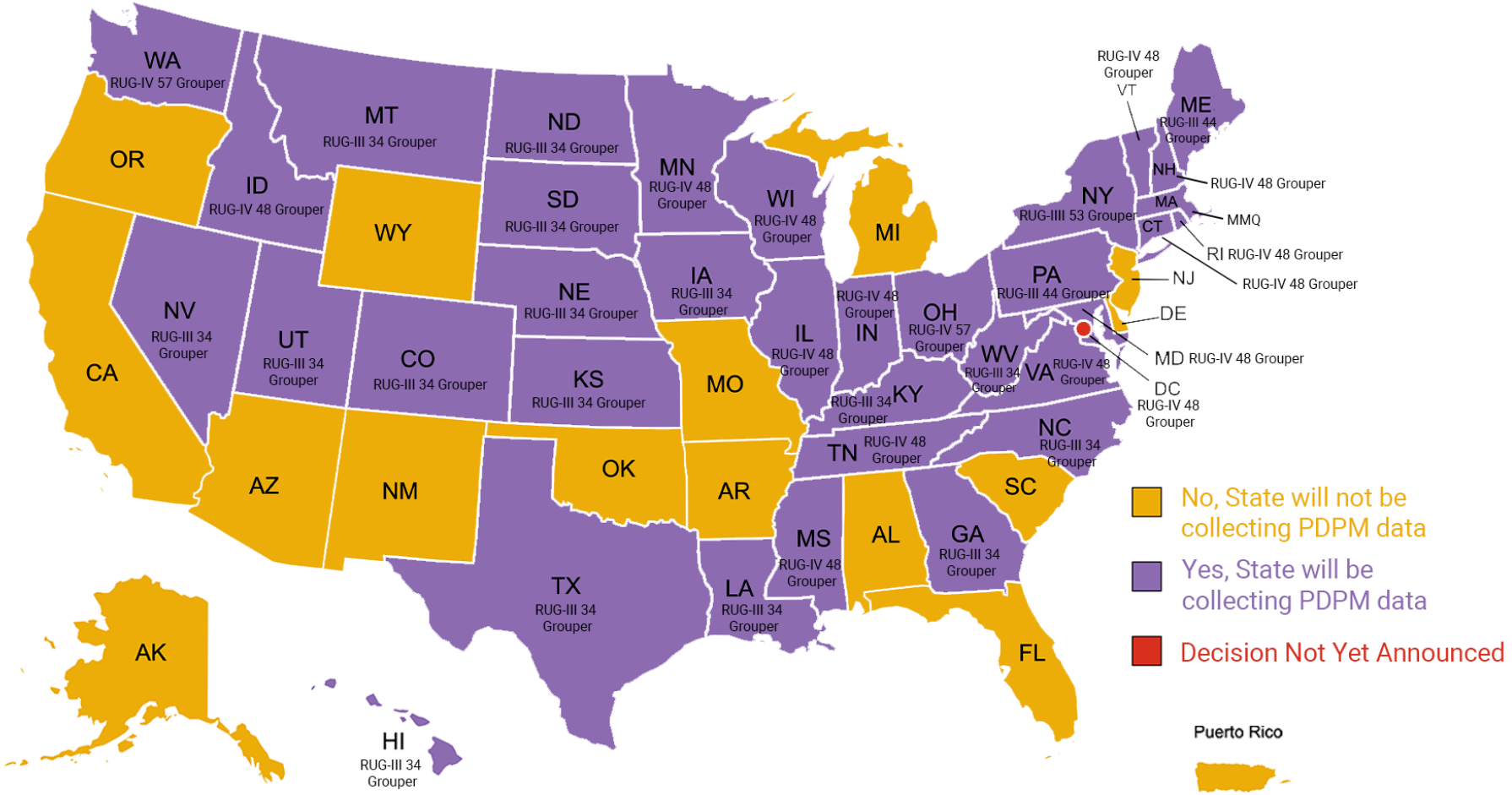
  COVID-19 = ES1 versus CB2 = 2.22 - .95 = 1.27

- When identifying patients who are isolated and quarantined, it is imperative to assess **if the condition warrants skilled care.**
- Currently, each state uses its own **Medicaid reimbursement** system.
- Multiple states are collecting data in preparation for **applying the PDPM model.**

Medicare Coverage and Skilled Criteria

5. Observation and Assessment

PDPM Conversion MDS Collection OBRA Assessments



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5. Observation and Assessment
COVID-19 ICD-10 Active Infectious Disease

- The **ICD-10-CM Diagnosis Code** is **U07.1, Virus Identified:**
  - **U07.1** is a billable/specific ICD-10-CM code that can be used to indicate a diagnosis for reimbursement purposes.
  - **ICD-10-CM U07.1** is a new 2021 ICD-10-CM code that became effective on **October 1, 2020.**
  - This is the American ICD-10-CM version of U07.1 - other international versions of ICD-10 U07.1 may differ.

Medicare Coverage and Skilled Criteria
5. Observation and Assessment
COVID-19 ICD-10 Active Infectious Disease

- **ICD-10-CM U07.1** is grouped within Diagnostic Related Group(s) (MS-DRG v38.0):
  - 177 Respiratory infections and inflammations with mcc.
  - 178 Respiratory infections and inflammations with cc.
  - 179 Respiratory infections and inflammations without cc/mcc.
  - 791 Prematurity with major problems.
  - 793 Full term neonate with major problems.

Medicare Coverage and Skilled Criteria

5. Observation and Assessment

COVID-19 ICD-10 Active Infectious Disease

- **ICD-10-CM U07.1** is grouped within Diagnostic Related Group(s) (MS-DRG v38.0) (continued):
  - 974 HIV with major related condition with mcc.
  - 975 HIV with major related condition with cc.
  - 976 HIV with major related condition without cc/mcc.

5. Observation and Assessment
COVID-19 ICD-10 Active Infectious Disease

- The **ICD-10-CM Diagnosis Code** is **U07.2, Virus NOT Identified:**
  - **Clinically-epidemiologically diagnosed.**
  - **Probable COVID-19.**
  - **Suspected COVID-19.**
- https://www.who.int/classifications/icd/icd10updates/en/

5. Observation and Assessment
COVID-19 ICD-10 Active Infectious Disease

- **9.29.2020 ICD-10 Update COVID-19.**
- A set of **additional categories** has been agreed to be able to **document or flag** conditions that occur in the context of COVID-19.
- Both, 3 character and 4-character codes have been **defined to respond** to the different levels of coding depth that is in place in **different countries.**

5. Observation and Assessment
COVID-19 ICD-10 Active Infectious Disease

Personal history of COVID-19:

- **U08.9 Personal history of COVID-19, unspecified.**
- This optional code is used to record an earlier episode of COVID-19, confirmed or probable that influences the person's health status, and the person no longer suffers from COVID-19. This code should not be used for primary mortality tabulation.

5. Observation and Assessment
COVID-19 ICD-10 Active Infectious Disease

Post COVID-19 condition:

- **U09.9 Post COVID-19 condition, unspecified.**
- This optional code serves to allow the establishment of a link with COVID-19 This code is not to be used in cases that still are presenting COVID-19.

5. Observation and Assessment
COVID-19 ICD-10 Active Infectious Disease

Multisystem inflammatory syndrome associated with COVID-19:

- **U10.9 Multisystem inflammatory syndrome associated with COVID-19, unspecified** (Temporarily associated with COVID-19).
- Cytokine storm.
- Kawasaki-like syndrome.
- Pediatric Inflammatory Multisystem Syndrome (PIMS).
- Multisystem Inflammatory Syndrome in Children (MIS-C).
- **Excludes:**
  - Mucocutaneous lymph node syndrome {Kawasaki} (M30.3).

Medicare Coverage and Skilled Criteria

5. Observation and Assessment
COVID-19 HHI Recommendations

- **Educate staff** on Skilled Coverage **Criteria.**
- **Educate staff** on **ICD-10 Coding.**
- **Educate staff** on **Isolation versus Quarantine.**
- Perform ongoing and retroactive **Medical Record Reviews.**
- All patients should be **reviewed immediately.**
- It may not be possible to **retroactively correcting any errors.**

Skilled Nursing
Four Pillars
Documentation

6. Patient Education Services
Teaching and Training

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Medicare Coverage and Skilled Criteria

6. Patient Education Services Teaching and Training

- Education is necessary if the use of technical or professional personnel is necessary to **teach a patient or their caregiver's self-maintenance** for their chronic condition or self-care for their resolving acute condition.

Medicare Coverage and Skilled Criteria

6. Patient Education Services Teaching and Training

Examples:

- Providing a caregiver with a weight monitoring tool and explaining the process for daily weights for a patient at risk of fluid overload or deficit.
- Dietary education for the diabetic, malnourished, overweight patient or the patient with multiple or severe wounds.
- Providing a blood glucose monitoring log and explaining how to check fingerstick blood sugars.

Medicare Coverage and Skilled Criteria

6. Patient Education Services Teaching and Training

Examples (continued):

- Demonstrate hygiene techniques and provide hydration tips for persons with frequent urinary tract infections.
- Fall prevention techniques.
- Skilled if the use of technical or professional personnel is necessary to **teach a patient self-maintenance.**

Medicare Coverage and Skilled Criteria

6. Patient Education Services Teaching and Training

Example #1:

"A patient who has had a recent leg amputation needs skilled rehabilitation services provided by technical or professional personnel to provide **gait training** and to teach **prosthesis care**. Similarly, a patient newly diagnosed with diabetes requires instruction from technical or professional personnel to learn the **self-administration of insulin** or foot-care precautions."
(Final Rule 7/31/99.)

Medicare Coverage and Skilled Criteria

6. Patient Education Services Teaching and Training

- Colostomy Care
- Insulin Administration
- Prosthesis Management
- Catheter Care
- G-tube Feedings
- Diet Teaching
- S/S of Disease Process
- IV Access Sites
- Braces, Splints and Orthotics
- Wound Dressings
- Skin Treatments
- Medication Management
- Orthopedic Precautions

Medicare Coverage and Skilled Criteria

6. Patient Education Services Teaching and Training

- Education must be documented:
  - Who was taught?
  - What was taught?
  - How was the information presented?
  - How did they respond?

Medicare Coverage and Skilled Criteria

6. Patient Education Services Teaching and Training

- Use prepared, approved materials for teaching that can be copied or printed and sent home at discharge:
  - Printed materials from a facility document set can be scanned into the electronic medical record and referred to in the skilled documentation.
  - Education templates can be built into the electronic medical record in a note or observation format, then printed and sent home at discharge.

Medicare Coverage and Skilled Criteria

6. Patient Education Services Teaching and Training

- Colostomy Care.
- Stump Wrapping.
- Medication Management.
- Self Administration Insulin.
- Bowel and Bladder Training.

“Teaching and Training”

Medicare
Coverage and Skilled Care

7. Skilled Rehabilitation

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Medicare Coverage and Skilled Criteria
7. Skilled Rehabilitation

- **Transmittal 262:**
  - On a **daily** basis.
  - Services rendered are **reasonable and necessary.**
  - **Physician** ordered.
  - **Practical matter.**
  - An appropriately licensed or certified individual must provide or **directly supervise** the therapeutic service and coordinate the intervention with nursing services.

Medicare Coverage and Skilled Criteria

7. Skilled Rehabilitation
MD Involvement

- The service must be **ordered by a physician.**
- The therapy intervention must **relate directly and specifically to an active written treatment** regimen established by the physician after any needed consultation with the qualified rehabilitation therapy professional and must be **reasonable and necessary** to the treatment of the beneficiary's illness or injury necessary to the treatment of the beneficiary's illness or injury.

Medicare Coverage and Skilled Criteria

7. Skilled Rehabilitation
MD Involvement

- MD involvement to **prevent injuries.**
- Medicare allows the professional therapist to develop a **suggested plan** of treatment and to begin providing services based on the plan prior to MD signature.
- **MD signature** required before facility bills Medicare.
- MD **faxed signatures** acceptable.

Jimmo v. Sebelius
2013

The False Improvement Standard

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Jimmo v. Sebelius
Skilled Care Historical Perspective

- Expectation of improvement.
- Actual improvement over a reasonable amount of time.
- Prior level of function.

Jimmo v. Sebelius
Improvement Standard

- **"Improvement Standard"** is not to be applied in determining Medicare coverage for maintenance claims in which skilled care is required.
- Medicare has long recognized that even in situations where **no improvement is expected**, skilled care may nevertheless be needed for maintenance purposes (i.e., to prevent or slow a decline in condition).

Jimmo v. Sebelius

- The Jimmo v. Sebelius case challenged Medicare's use of an "Improvement Standard" to make coverage determinations.
- The lawsuit was brought on behalf of:
  - **Six individuals** representing a Nationwide class of Medicare beneficiaries.
  - **National organizations** representing people with chronic conditions.

Jimmo v. Sebelius
Individual Plaintiffs

- Lead plaintiff, **Glenda Jimmo**, is a 76-year-old Medicare beneficiary from Bristol, Vermont.
- **Blind** since birth and has had her right **leg amputated** due to complications from **diabetes**.
- Requires a wheelchair and receives **multiple home health care visits** per week for various treatments for her complex condition.
- Medicare denied coverage for these services, saying that she was **unlikely to improve.**

Jimmo v. Sebelius

Individual Plaintiffs

Glenda Jimmo

Paul O. Boisvert for New York Times

Jimmo v. Sebelius

Individual Plaintiffs

Rosalie J. Berkowitz

New York Times October 22, 2012

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The Jimmo Settlement

- In 2013, a U.S. District Court approved the settlement agreement in **Jimmo v. Sebelius,**
- [1] requiring the Centers for Medicare & Medicaid Services (CMS) to confirm that Medicare coverage of **home health, skilled nursing facility (SNF), and outpatient therapy** services is determined by a beneficiary's need for skilled nursing and/or therapy, **not on a beneficiary's potential for improvement.**

The Jimmo Settlement

- [2] The Jimmo Settlement clearly directs that **Medicare covers skilled services** not only to **improve a resident's condition**, but equally to **maintain or slow the decline** of a patient's condition.
- Sadly, **seven years later**, beneficiaries and their families are still being denied skilled care on the basis of an erroneous "Improvement Standard."

The Jimmo Case Study
Center for Medicare Advocacy (CMA)

- **In early 2020**, the son of a Medicare beneficiary in traditional Medicare wrote the **Center for Medicare Advocacy (the Center)** to describe his experience with the poor implementation of the Jimmo Settlement.
- He stated that his father's Medicare coverage in a SNF was terminated because he had "**plateaued**" and was purportedly no longer making progress in skilled therapy.

The Jimmo Case Study
Center for Medicare Advocacy (CMA)

- During the expedited appeals process, Medicare contractors "stressed . . in advance over the phone that they would **only consider medical records as evidence, and they would absolutely refuse to consider any violations of Jimmo law when they ruled on our appeal."**
- A 1-800-MEDICARE representative told him that "[t]he Jimmo regulations were from **2014, and they are outdated now and don't apply anymore**." After pointing to CMS's Jimmo-dedicated webpage,[3] the Medicare representative escalated the case to the Advanced Resolution Center (ARC). Unfortunately, the ARC also refused to discuss the SNF's violation of the Jimmo Settlement.

The Jimmo Case Study
Center for Medicare Advocacy (CMA)

- Because the **SNF terminated Medicare coverage**, the beneficiary was responsible for the cost of any skilled care he received after the termination date (which amounted to over $10,000).
- The beneficiary's father asked the SNF twice to submit a **"demand bill"** to Medicare for the cost of those services, thereby setting up his father's right to file a standard appeal. Two months later, the SNF had yet to fulfill his request. During his conversation with the ARC, he was told there was no "such a thing as a Standard Medicare Appeal or a Demand Bill."

The Jimmo Case Study
Center for Medicare Advocacy (CMA)

- Contrary to what the Medicare representative told the beneficiary's son, the Jimmo Settlement absolutely still represents official Medicare policy. There is no end to the Settlement's conclusions.
- As noted on CMS's Jimmo webpage, "[t]he Jimmo Settlement Agreement is consistent with the Medicare program's regulations **governing maintenance nursing and therapy in skilled nursing facilities, home health services, and outpatient therapy . . . and nursing and therapy in inpatient rehabilitation hospitals for beneficiaries who need the level of care that such hospitals provide.**"

The Jimmo Case Study
Center for Medicare Advocacy (CMA)

- **The Settlement applies to all Medicare beneficiaries nationwide**, regardless of whether the individual is in real/traditional Medicare or a private Medicare Advantage plan.
- Thus, any SNF that has been certified to participate in the Medicare program may **not end Medicare-covered skilled services** solely on the basis that a beneficiary **lacks the potential to improve.**

The Jimmo Case Study
Center for Medicare Advocacy (CMA)

- Medicare contractors **cannot simply refuse** to follow the law or accept relevant evidence.
- Federal regulations state that **beneficiaries can submit evidence** to be considered by the Medicare contractors overseeing **expedited appeals** in making their decision.
- Additionally, the Medicare provider has the burden of proof to demonstrate that **"termination of coverage is the correct decision, either on the basis of medical necessity, or based on other Medicare coverage policies."**

The Jimmo Case Study
Center for Medicare Advocacy (CMA)

- Contrary to what the Advance Resolution Center (ARC) told the beneficiary's son, **demand bills and standards appeals are real**, important components of Medicare beneficiary appeal rights. The Medicare Claims Processing Manual (MCPM) states that "demand bills are both a principle and a mechanism of Medicare."

The Jimmo Case Study
Center for Medicare Advocacy (CMA)

- The principle goes back to the founding of the Program, reflected in the protection of the rights of the Program's beneficiaries being among the first **sections of Title XVIII**. The principle assures that beneficiaries have the right to demand that Medicare be billed for the services provided to them, whether or not that billing provides Medicare payment. By assuring claims are sent to and processed by Medicare, permitting official payment decisions to be made, beneficiaries retain the right to appeal payment decisions made on those claims, when they believe need to use that right exists.

The Jimmo Case Study
Center for Medicare Advocacy (CMA)

- **SNFs cannot refuse to submit demand bills to Medicare**.
- Medicare **beneficiaries** have the **right to demand that SNFs** submit claims to Medicare for services they have received.
- The refusal to bill Medicare for those services impedes a beneficiary's ability to exercise his or her right to a standard appeal.

The Jimmo Case Study
Center for Medicare Advocacy (CMA)

- CMS has opportunity to ensure that the Jimmo Settlement Agreement is being properly implemented in the applicable health care settings.
- Moreover, the **poor education of Medicare representatives** and contractors about the Settlement is continuing to harm Medicare beneficiaries in need of maintenance nursing and/or therapy services and is shifting the cost of Medicare-covered care onto beneficiaries and families.
- CMS must conduct a **meaningful education campaign** to ensure that Medicare providers, contractors, and adjudicators are correctly implementing the Jimmo Settlement (as well as other Medicare laws, regulations, and policies).

Questions?

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Kris B Harmony

Knowledge | Inspiration | Motivation

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About HHI

- HHI founded in 2001.
- Privately owned and operated.
- Female owned business.
- Ranked among Inc. Magazine's top 5,000 fastest growing private companies in America three years in a row.
- HHI active in all 50 states.
- HHI services over 1,000 Skilled Nursing Facilities.
- HHI trains thousands of clinicians every year.

HHI Process

- Prescribed medical record review process that encompasses HHI's core business
- HHI Specialists provide expertise through teaching and training and an extensive chart audit process in order to ensure:
  - MDS Accuracy
  - MDS Supporting Documentation
  - Billing Accuracy
  - Nursing Documentation
  - Therapy Documentation
  - Clinically Appropriate Care

HHI
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Gold C.A.R.E.S.
2 Year Service Plan

Platinum C.A.R.E.S.
3 Year Service Plan

List of HHI Services

PDPM Training and Audits | Medicare | Compliance | Rehab Program Development | Seminars | MMQ Audits | Mock RAC Audits | Rehab Certification | Mock Health Inspection Survey | MDS Competency | Talent Management | Denials Management | Compliance Certification | Clinically Appropriate Stay | QAPI | QIS | Medicare Part B Program | MDSC Mentor Program | Case Mix Consulting | Professional Development | Leadership Trainings | Regulatory and Survey Assistance | Five Star | PBJ | Quality Measures | Analysis | Staff Training | Infection Control and More!

Silver C.A.R.E.S.
1 Year Service Plan

A La C.A.R.E.S.
Customized Service Plan

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- HHI employs the best and brightest of the industry.
- All HHI Specialists are cross trained on the C.A.R.E.S. platform.
- HHI only employs positive, proactive and polite staff with a constant desire to learn, teach and improve patient care.
- HHI strives and thrives for Harmony within and outside of the work environment.

https://www.harmony-healthcare.com/harmonyhelp

Knowledge
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Available

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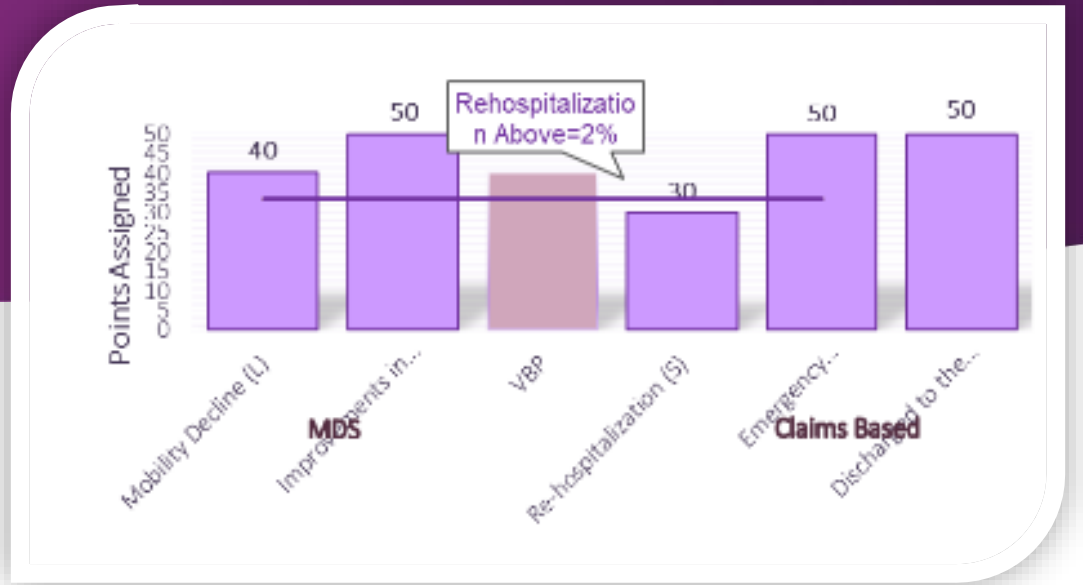
The **Knowledge Center** is loaded with **information** that will assist staff with daily responsibilities at the facility.

HarmonyHelp provides resources for the entire interdisciplinary team. Access HHI's vault of information on Compliance, Regulatory, Reimbursement, Survey, Education, Manuals (RAI, Medicare, Billing, ICD-10), PowerPoints, On Demand Training, Toolkits, Forms, Library of Final Rules, Kris's Brain and much more.

Manuals I Tools I On Demand WebinarsI Rules and Regulations

Month	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Apr 17
Total Part A Revenue	$189,711.70	$202,597.35	$228,482.48	$176,144.00	$192,332.99	$148,861.18
Rehab Revenue	$181,514.58	$201,631.41	$227,975.42	$175,546.71	$190,248.65	$146,559.14
Therapy Portion	$80,465.58	$83,667.77	$100,444.39	$79,055.93	$86,172.60	$67,534.29
% Therapy Portion	42.4%	41.3%	44.0%	44.9%	44.8%	45.4%
% Therapy of Total Revenue	95.7%	99.5%	99.8%	99.7%	98.9%	98.5%
% Therapy RUG Days (P)	93.9%	99.4%	99.6%	99.5%	98.6%	97.5%
Part A Rate	$442.22	$434.76	$464.40	$465.99	$453.62	$462.30
% of Max Rate	61.9%	60.9%	65.0%	65.3%	63.5%	64.8%
ADC	14.30	15.03	15.87	13.50	13.68	10.73



Complimentary HHI Offerings

- PDPM Revenue and Risk Analysis
- Medicare Part A Revenue and Risk Analysis
- Five-Star Quality Measure Points Analysis
- PEPPER Analysis

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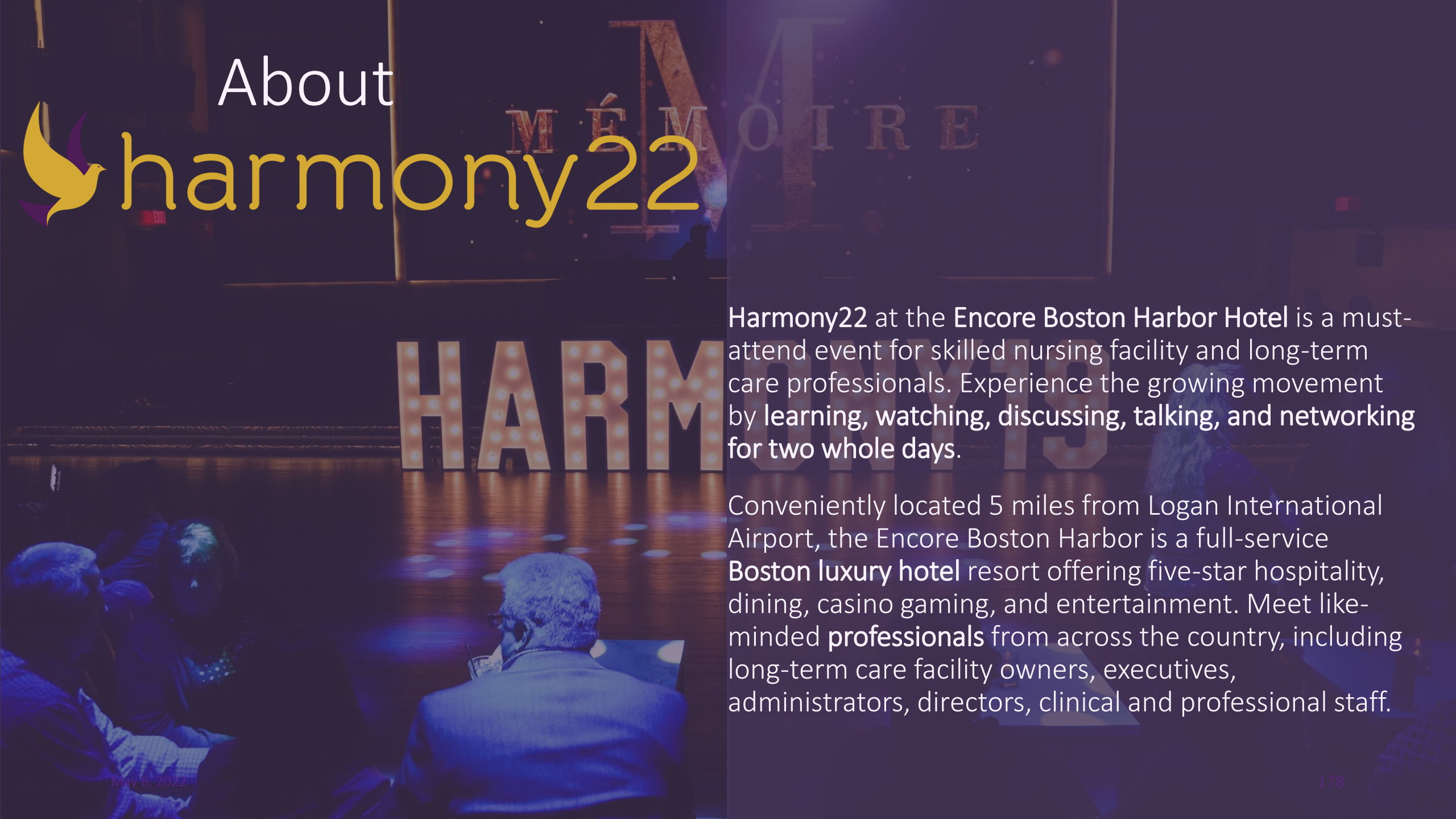

Harmony22 at the **Encore Boston Harbor Hotel** is a must-attend event for skilled nursing facility and long-term care professionals. Experience the growing movement by **learning, watching, discussing, talking, and networking for two whole days**.

Conveniently located 5 miles from Logan International Airport, the Encore Boston Harbor is a full-service **Boston luxury hotel** resort offering five-star hospitality, dining, casino gaming, and entertainment. Meet like-minded **professionals** from across the country, including long-term care facility owners, executives, administrators, directors, clinical and professional staff.

Thursday, October 20th, 2022
and
Friday, October 21st, 2022

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About (HHI) Media Team

Harmony Healthcare International, Inc. (HHI) recognizes the importance of marketing and releasing high-quality content, especially within the domain of education. An in-house, professional **media team** now supports HHI's continued commitment to delivering knowledge. This group supports the marketing, education, and public relations department powerfully delivering their messages. Through creative **videos and images**, we make this team readily available to our high-level sponsors. Together, we can bring forth compelling content which undoubtedly produces **quantifiable, measurable results** to the benefit of one's company.

harmony22 Agenda

Wednesday, October 19th, 2022

Arrival

Thursday, October 20th, 2022

7:30	Breakfast
8:30 - 4:00	Sessions
5:00 - 7:00	Networking Event
7:00 - 10:00	VIP Event (Invite Only)

Friday, October 21st, 2022

8:00	Breakfast
8:30 - 2:30	Sessions
2:30 - 3:30	HHI Dove Award and Closing Remarks

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Attendee Registration Fees

- Winter Rate (January 1st, 2022 - March 31st, 2022) $599 per person
- Spring Rate (April 1st, 2022 –June 30th, 2022) $650 per person
- Summer Rate (July 1st, 2022 – September 30th, 2022) $699 per person
- Last Minute Rate (October 1st, 2022 – Event Date) $799 per person

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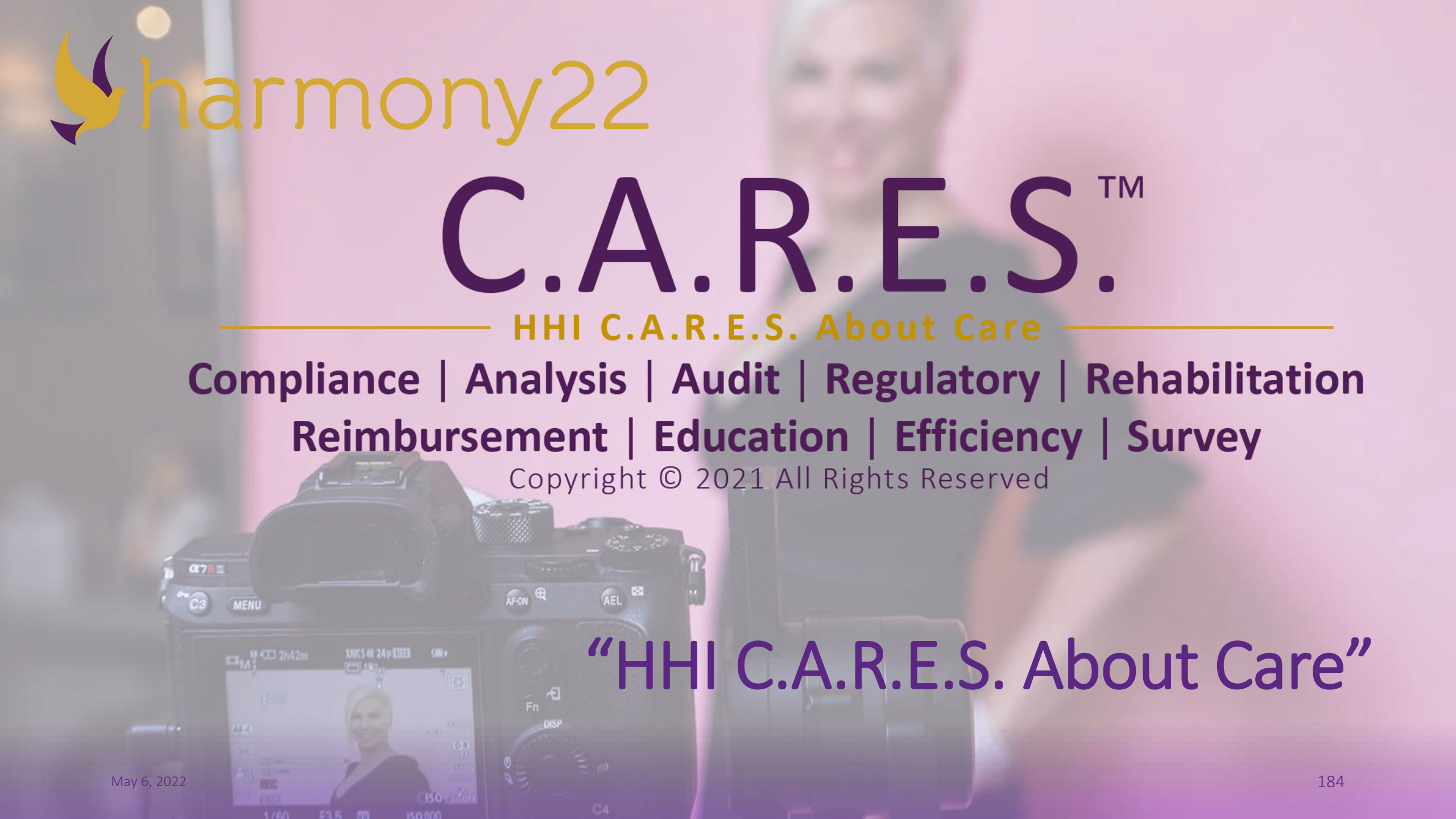

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