CMS Issues Waivers for Three Day Qualifying Hospital Stay and Spell of Illness

Updated April 3, 2020 to add documentation guidelines
Updated July 2, 2020 to update the Benefit Period Waiver

On Friday March 13, 2020 the Secretary of the Department of Health and Human Services authorized waivers of both the Skilled Nursing Facility 3 day qualifying stay and the spell of illness requirement under the Section 1135 of the Social Security Act retroactive to March 1, 2020. The waiver is available as a result of the national emergency declared by President Trump on March 13, 2020 and further approved by the Secretary on March 14, 2020. The waiver is broad based and applies to ALL Skilled Nursing Facilities regardless of whether there is a COVID 19 outbreak in the discharging hospital. With the Secretary issuing a broad based "blanket" waiver this eliminates the requirement for a SNF to obtain a provider specific waiver. Essentially, all skilled nursing facilities are included in the waiver.

Both waivers are intended to keep acute care hospital beds open and available as COVID 19 cases increase nationwide.

Waiver to the 3-day Qualifying Stay

Medicare Beneficiaries who are affected by this emergency will be able to use their Medicare Part A SNF benefits without having a 3-day qualifying hospital stay. Circumstances where this waiver may apply:

- Beneficiary may be discharged from a hospital early and without three consecutive inpatient days
- A Beneficiary may be admitted directly from home and skip the hospital stay entirely
- A Beneficiary may be admitted directly from the hospital ER without three consecutive inpatient days
- A current SNF patient who has days available in their spell of illness may "skill in place" without the need for a three hospital stay

What we learned from Hurricane Katrina; we believe that while the overall intent is to free up hospital beds for COVID 19 patients, the SNF should document the specific conditions prompting each specific admission and how that admission frees up hospital space for COVID 19 patients in compliance with the waiver.

As discussed below, is it imperative to document the need for skilled care under standard Medicare guidelines.

Waiver of Spell of Illness

This waiver applies to beneficiaries who had expended, or are ready to begin the process of ending their spell of illness after utilizing all their available SNF days. CMS is utilizing the authority under section 1812(f) of the Act to provide renewed coverage for extended care services without requiring beneficiaries to have had a new spell of illness. Such beneficiaries can then receive up to an additional 100 days of SNF Part A coverage for care needed as a result of the above-captioned emergency.

To qualify for the benefit period waiver, it must be demonstrated that a beneficiary's continued receipt of skilled care in the SNF is in some way related to the Public Health Emergency. A beneficiaries who do not themselves have a COVID-19 diagnosis may nevertheless be affected by the Public Health Emergency.

Example:
When a beneficiary who had been receiving daily skilled therapy, then develops COVID-19 and requires a respirator and a feeding tube.

Example:
When disruptions from the PHE cause delays in obtaining treatment for another condition.

Golden Rule:
In order to determine whether the wavier applies, a SNF resident's ongoing skilled care is considered to be emergency-related unless it is altogether unaffected by the COVID-19 emergency itself (that is, the beneficiary is receiving the very same course of treatment as if the emergency had never occurred). This determination basically involves comparing the course of treatment that the beneficiary has actually received to what would have been furnished absent the emergency. Unless the two are exactly the same, the provider would determine that the treatment has been affected by – and, therefore, is related to–the emergency.

Medicare Beneficiaries who exhausted their 100 days but did not discharge from a SNF and are only receiving custodial care but have not gone 60 consecutive days without receiving skilled care and therefore are not eligible for a new benefit period would be granted an additional 100 days under this waiver.

This extension of coverage does not apply to a beneficiary who previously exhausted their 100 day benefit, is still residing in a SNF and still receiving skilled care. A scenario that would have the effect of prolonging the current benefit period and precluding a benefit period renewal even under normal circumstances then the beneficiary cannot renew his or her SNF benefits under the section 1812(f) waiver as itis this continued skilled care in the SNF rather than the emergency that is preventing the beneficiary from beginning the 60 day "wellness period."

Example:
If the patient has a continued skilled care need (such as a feeding tube) that is unrelated to the COVID-19 emergency.

Medicare Skilled Coverage
The critical issue in waiving the three day hospital stay requirement and/or the Spell of Illness Requirement is that the patient must still meet the requirement of skilled care found at Medicare Benefit Policy Manual Chapter 8 Section 30. Essentially, this means that the beneficiary **requires the skills of licensed professional on daily basis.**

Care in a SNF may be covered if all of the following four factors are met:

- *The patient requires skilled nursing services or skilled rehabilitation services, i.e., services that must be performed by or under the supervision of professional or technical personnel (see §§30.2 - 30.4); are ordered by a physician and the services are rendered for a condition for which the patient received inpatient hospital services or for a condition that arose while receiving care in a SNF for a condition for which he received inpatient hospital services;*
- *The patient requires these skilled services on a daily basis (see §30.6); and*

- *As a practical matter, considering economy and efficiency, the daily skilled services can be provided only on an inpatient basis in a SNF. (See §30.7.)*
- *The services delivered are reasonable and necessary for the treatment of a patient's illness or injury, i.e., are consistent with the nature and severity of the individual's illness or injury, the individual's particular medical needs, and accepted standards of medical practice. The services must also be reasonable in terms of duration and quantity.*

These medical necessity criteria are not waived. Therefore it is critically important that clinical documentation support the need for skilled care on a daily basis.

Medicare Documentation

Each patient regardless of whether subject to a waiver must have a physician certify and recertify the need for skilled care. The requirements for physician certification are found in the Medicare Benefit Policy Manual, Chapter 8 Section 40 and state in part:

> *Payment for covered posthospital extended care services may be made only if a physician (or, as discussed in §40.1 of this chapter, a physician extender) makes the required certification, and where services are furnished over a period of time, the required recertification regarding the services furnished. The SNF must obtain and retain the required certification and recertification statements.*

These certifications must be in place prior to billing.

A primary diagnosis of COVID 19 [U07.1, effective April 1, 2020] may be used on the MDS in section I0020B. This groups to pulmonary which is part of the Medical Management payment group for PT & OT and non-neurological for SLP.

In addition to the physician certification, the provider should be documenting daily skilled care. For those patients being monitored for COVID 19 signs and symptoms and that monitoring requires the skills of a licensed professional, nursing should document what skilled services were provided each day. Chapter 8 section 30.2.2.1 outlines documentation standards:

> *Claims for skilled care coverage need to include sufficient documentation to enable a reviewer to determine whether—*
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> - *Skilled involvement is required in order for the services in question to be furnished safely and effectively; and*
> - *The services themselves are, in fact, reasonable and necessary for the treatment of a patient's illness or injury, i.e., are consistent with the nature and severity of the individual's illness or injury, the individual's particular medical needs, and accepted standards of medical practice. The documentation must also show that the services are appropriate in terms of duration and quantity, and that the services promote the documented therapeutic goals.*
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> *It is expected that the documentation in the patient's medical record will reflect the need for the skilled services provided. The patient's medical record is also expected to provide important communication among all members of the care team regarding the development, course, and outcomes of the skilled observations, assessments, treatment, and training performed. Taken as a whole, then, the documentation in the patient's medical record should illustrate the degree to*

which the patient is accomplishing the goals as outlined in the care plan. In this way, the documentation will serve to demonstrate why a skilled service is needed

In addition to information from the Medicare Benefit Policy Manual, Chapter 8 Section 30; we wanted to provide an example of **insufficient skilled documentation**:

> "Resident alert and able to make needs known. Uses wheelchair for mobility. She is able to feed self after setup. Resident is a one person with ADL's and transfers. She is continent of bowel and bladder. No c/o pain or discomfort noted. Took all medications as ordered with no issues. Will continue to monitor for changes. No education/teaching provided."

With only this documentation in the Medical Record, we very much doubt this amount of documentation would substantiate a skilled level of care.

For the Benefit Period Waiver, CMS expects those providers to work with their respective MACs to provide any documentation needed to establish that the COVID-19 emergency applies for the benefit period waiver under §1812(f) for each benefit period waiver claim.

SNF providers that have not yet submitted the PPS assessments for the benefit period waiver may utilize the Health Insurance Prospective Payment System (HIPPS) code that was being billed when the beneficiary reached the end of their SNF benefit period.

Completing the UB-04

Medicare claims for beneficiaries must have the condition code "DR" (disaster related). This code will allow the claim to bypass the 3-day QHS requirement. Occurrence span code "70" does not need to be reported on these claims. It is also recommended to include the remark "Declared Emergency/Disaster on the remarks page.

Billing for the Benefit Period Waiver

- Submit a final discharge claim with patient status 01.
- Readmit the beneficiary (Day 101) to start the benefit period waiver.
- For admission under the benefit period waiver complete a 5-day PPS Assessment
  - . (The interrupted stay policy does not apply.)
- Follow all SNF Patient Driven Payment Model (PDPM) assessment rules.
- Include the HIPPS code derived from the new 5-day assessment on the claim.
- The variable per diem schedule begins from Day 1
- Condition code DR - identifies the claims as related to the PHE
- Condition code 57 (readmission) - this will bypass edits related to the 3-day stay being within 30 days
- COVID100 in the remarks - this identifies the claim as a benefit period waiver request.