SHP

STRATEGIC HEALTHCARE PROGRAMS

IntelliLogix™

Industry Topic Webinar
Medicare Basics

With Guest Speaker:

POLARIS GROUP™
Strategic solutions for health care

Cynthia Wilkins

Senior Regulatory Consultant

Go To Webinar – Questions & Handouts

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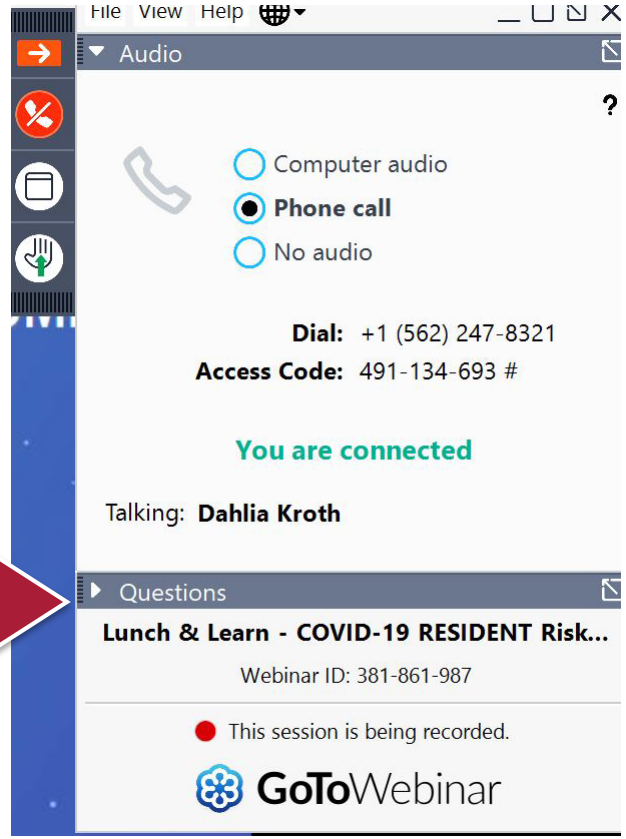

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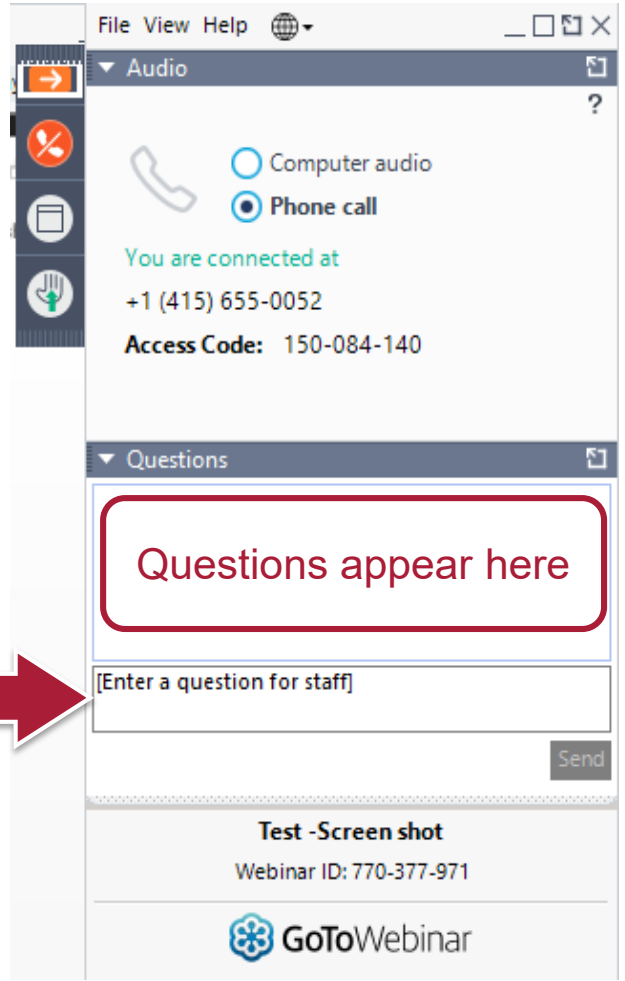

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SHP Business Intelligence Programs

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STRATEGIC HEALTHCARE PROGRAMS

Our Mission Statement: To help healthcare organizations improve performance through the utilization of real-time data.

Home Health

Improve quality & ratings with real-time data

Maximize revenue

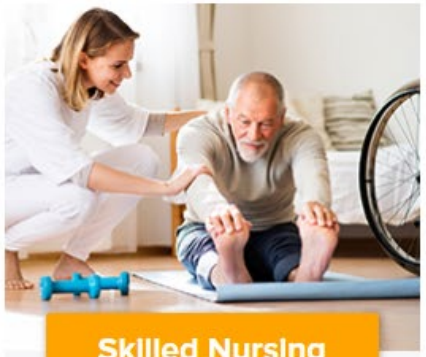
Improve documentation accuracy

Hospice

Automate reports

Ensure CMS compliance

Improve performance with real-time data



Skilled Nursing

Improve readmissions, quality of care and outcomes

Demonstrate value to referral partners and payers

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Manage patients across the continuum of care

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POLARIS GROUP™
Strategic solutions for health care

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MEDICARE BASICS

Medicare Basics

- **Hospital Insurance (Part A)** helps to pay for inpatient hospital care, inpatient care in a skilled nursing facility, and home health care. This coverage is automatically provided for persons entitled to Medicare (application must be completed). It is funded primarily by Social Security taxes, which are paid by all working individuals. Medicare Part A is financed through payroll contributions from employees, employers, and self-employed persons.

Medicare Basics

- **Hospital Insurance (Part B)** helps pay for medically necessary doctors' services, outpatient hospital, and nursing home services. Medical Insurance (Part B) can also help pay for home health services and a number of other medical services and supplies that are not covered by the hospital insurance part of Medicare. Part B is optional. Beneficiaries must pay for it separately through monthly premium payments. Part B is funded through these monthly premiums.

Medicare Basics

- **Medicare Part C** - also known as Medicare Advantage; a set of health care options created by the Balanced Budget Act (BBA); "managed care" plan; includes Health Maintenance Organization (HMO), Point of Service (POS), Provider Sponsored Organization (PSO), Preferred Provider Organization (PPO), Medical Savings Account (MSA), religious fraternal benefit society plan (RFP), and private fee-for-service plan. This manual does not address Medicare Part C health care options.

Medicare Basics

- **Medicare Part D** - provides beneficiaries with a Medicare drug benefit through private health plans. Anyone enrolled in Medicare Part A or B is eligible to join Part D. Beneficiaries can elect to receive prescription drug coverage through either drug-only or a Medicare Advantage plan that provides comprehensive benefits. Refer to local Prescription Drug Plans for detailed information.

Medicare Basics

- **Part D – Prescription Drug Coverage:**

  Medicare Part D coverage is optional. Beneficiaries who opt this coverage must enroll in a Prescription Drug Plan (PDP). All PDPs are approved by the Centers for Medicare and Medicaid Services. Beneficiaries must pay for Part D coverage separately through monthly premium payments.

Resources

CMS Manuals

- http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/index.html?redirect=/Manuals/

Skilled Nursing/PPS

- http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/index.html?redirect=/SNFPPS/

ABN/Denial

- http://www.cms.gov/Medicare/Medicare-General-Information/BNI/index.html?redirect=/BNI/

Resources

MDS 3.0

- http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/index.html?redirect=/nursinghomequalityinits/

Five Star

- http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/FSQRS.html

Physician Certification Rules

- https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ge101c04.pdf

Resources

SNF Consolidation Billing

- http://www.cms.gov/Medicare/Billing/SNFConsolidatedBilling/index.html?redirect=/SNFConsolidatedBilling/

Transmittals

- http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/index.html?redirect=/Transmittals/

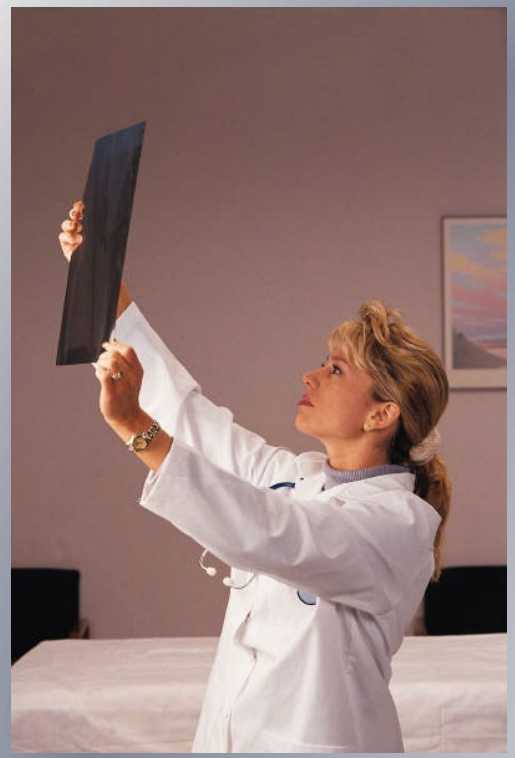
Overview of Covered Services

Hospital Services –

90 Days per benefit period, plus 60 days

Medicare covered services include:

- Semi-private room
- Meals
- Routine nursing care
- Lab tests and x-rays billed by hospital
- Medical supplies and equipment
- Rehabilitation therapies



Overview of Covered Services

Hospital Services

Beneficiary pays:

- **Deductible:**
  - CY2022 = $1,556.00
  - CY 2021 = $1,484.00
- **Co-payment Days: 61st through 90th day:**
  - CY2022 = $389.00
  - CY 2021 = $371.00
- **Lifetime Reserve Days:**
  - 60 days with co-payment
  - CY2022 = $778.00 - CY 2021 = $742.00
- **Expenses beyond 90 days, unless they choose to use their reserve days**

Overview of Covered Services

Skilled Nursing Facility Benefit

100 days per benefit period (based on need for daily skilled care)

Medicare covered services include:

- Semi-private room
- Meals
- Routine nursing care
- Rehabilitation therapies and services
- Drugs furnished by the facility
- Medical supplies and use of equipment

Overview of Covered Services

Skilled Nursing Facility Benefit

Beneficiary pays:

- Co-payment days 21st through 100th day
  - CY2022 = $194.50
  - CY2021 = $185.50
- Expenses beyond 100 days of treatment

Overview of Covered Services

Hospice Benefit:

- Unlimited coverage for services including nursing care, doctor's care, drugs, therapies including physical, speech and occupational, home health aide and homemaker services, medical supplies and appliances, respite care and counseling.

Beneficiary pays:

- No charge if requirements for Hospice Care are met. Beneficiaries should contact their local Hospice Agency to determine specific Medicare availability.

Overview of Covered Services

Physician – Part B

- **Physician**
  - 80% of Medicare allowed charges
- **Deductible**
  - CY2022 = $233.00 - CY 2021 = $203.00
- **Standard Monthly Premium**
  - CY2022 = $170.10 - CY 2021 = $148.50
- **Beneficiary Pays**
  - 20% coinsurance amount of allowed charges

Overview of Covered Services

Outpatient Services – Part B

- Only covered if medically necessary and reasonable.
- Once annual threshold is met, the KX Modifier must be used on claim attesting to Medical Necessity
  - Physical Therapy (PT) and Speech-Language Pathology (SLP) together and the other is for Occupational Therapy (OT) separately
    - CY 2022 = $2,150.00 PT & ST
    - CY 2022 = $2,150.00 OT
    - CY 2021 = $2,110 PT & ST
    - CY 2021 = $2,110 OT
- The dollar amounts are beneficiary-specific
- The deductible and the co-pay are included in amounts
- Outpatient therapy services billed by hospitals are included in the amounts

Overview of Covered Services

Consolidated Billing – Liability for SNFs for Part A

Part A SNF daily rate pays for most services (falls under consolidated billing):

- Nursing costs/routine care
- Therapy costs
- Other ancillary costs
- Pharmacy, supplies, lab, diagnostics, x-rays…
- Overhead and capital
- Certain ambulance transportation
- MOST EVERYTHING……..per Consolidated billing rules

Overview of Covered Services

Consolidated Billing – Liability for SNF Part A

The SNF must process claims from vendors who fall under consolidated billing:

- When sending a Part A resident out for services, the SNF should notify the provider that the resident is Part A and consolidated billing requirements apply. Examples include physician office visits or outpatient hospital visits.

ELIGIBILITY REQUIREMENTS

Eligibility

Entitlement of Part A Coverage begins:

- The first day of the month in which a person turns 65 and becomes eligible for Social Security or Railroad Retirement;
- 24 months after a younger person has been receiving Social Security Disability or Railroad Retirement Disability;
- 12 months after a younger person has been diagnosed with End Stage Renal Disease (ESRD);
- ALS benefit begins the 1st month of disability.

Eligibility Requirements

- Three (3) consecutive midnight stays as an inpatient in an acute care hospital
  - Acute
  - Psych
  - Rehab
- Daily Skilled Service Provided by Licensed Personnel
- As a Practical Matter must be provided in a SNF

Additional Requirements

- Physician Orders for skilled services
- Physician Certification required at admission, on or before day 14, and within 30 days from last signed recertification date for subsequent recertifications.
- The beneficiary must be admitted to the SNF for skilled care within 30 days of hospital discharge. The exception to this is medical predictability. "30-day Transfer Rule"

Additional Requirements

- Must be placed in a Medicare-certified bed to receive payment.
- 100-day SNF benefit
- Continued need for daily skilled service and documented medical necessity for skilled services provided. In addition, skilled services must be reasonable and necessary.
- Continue to meet practical matter test.

Additional Requirements

- Physician orders for therapy
  - Evaluation and Treatment orders
  - Order good for a maximum of 90 days
- UB-04 billing must be completed and billed monthly
- 100% coverage for the first twenty (20) days of approved covered days.
  - Coinsurance applies from days 21-100.

Practical Matter Test

- Based on the individual's condition and the availability and feasibility of using more economical alternatives.
- As a practical matter skilled services can only be provided in a SNF if they are not available on an outpatient basis OR……

Practical Matter Test

- If transportation to the closest facility would be:
  - An excessive physical hardship
  - Less economical
  - Less efficient or effective than an inpatient institutional setting

Practical Matter Test

- The availability at home of capable and willing family or feasibility of obtaining other assistance should be considered.
- No longer is there an assumption that PMT is met.
- Questions?
  - What is nursing doing to support therapy that requires a Part A stay?
  - Support available at home?
  - Suggest documentation if "Practical Matter Test is met"

Reasonable and Necessary

- Services must be reasonable and necessary to the nature and severity of illness or injury, patient medical needs, and within standards as to duration and quality.
- Questions?
  - Does therapy documentation/diagnosis support unique services of a therapist?
  - Would resident spontaneously recover?
  - Does nursing documentation support Part A stay?
  - Practical Matter Test met?

Administrative Presumption

- When a new admit directly from hospital achieves certain Case Mix Groups under PDPM via the 5-day Medicare MDS, there is a presumption that level of care requirements are met.
- Deemed met up to and including the ARD of the 5-day MDS.
  - Presumption does not apply if not admitted directly from hospital
  - Presumption does not apply if readmitted during Interrupted Stay Window
- THERE MUST BE DOCUMENTATION THAT SUPPORTS THE NEED AND PROVISION OF SKILLED SERVICES IN THE SNF.

Administrative Presumption

Presumption of Coverage: Any ONE CMG in ANY component

Major Joint/Spinal	TA
	TB
	TC
	TD
Other Ortho	TE
	TF
	TG
	TH
Acute Neuro & Non-ortho Surgery	TI
	TJ
	TK
	TL
Medical Management	TM
	TN
	TO
	TP

Acute neuro SLP Comorbid Cog Impairment	Mechanically Altered Diet or Swallowing Disorder	SLP Case-Mix Group
None	Neither	SA
	Either	SB
	Both	SC
One	Neither	SD
	Either	SE
	Both	SF
Two	Neither	SG
	Either	SH
	Both	SI
Three	Neither	SJ
	Either	SK
	Both	SL

AHCA NCAL

Administrative Presumption

Presumption of Coverage: Any ONE CMG in ANY component

- Extensive Services
- Special Care High
- Special Care Low
- Clinically Complex
- Behavioral Symptoms & Cognitive Performance
- Reduced Physical Functioning

NTA Score	NTA CMG
12+	NA
9 - 11	NB
6 - 8	NC
3 - 5	ND
1 - 2	NE
0	NF

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AMERICAN HEALTH CARE ASSOCIATION
NCAL
NATIONAL CENTER FOR ASSISTED LIVING

Medical Predictability

The patient may be eligible for coverage at a time greater than 30 days post acute discharge if predicted at the time of discharge from acute care.

- Applies only at time of discharge from the hospital.
- Can be admitted Medicare or private pay initially, then taken off and still apply **IF predicted** at time of discharge from hospital.
- Documentation by physician must be on transfer sheet or admission orders; can be modified if needed.
- Code Claim with 56.

Medical Predictability: Example

The discharging physician at the hospital or the admitting physician at the nursing facility can write the order.

- Mr. Y is an 86 year-old gentleman with a fractured right hip. He has a Knowles pins fixation and will be non-weight bearing for at least six weeks.

M.D.'s treatment plan should read:

> Non-weight bearing transfers and ambulation. To be seen by myself as outpatient six weeks from date of surgery, at which time he will be x-rayed. Hopeful progression to partial weight bearing at that time OR patient to begin skilled therapy when cast is removed.

Managing Spell of Illness

Benefit Periods

Spell of Illness

- A Medicare beneficiary is eligible for another **"spell of illness"** when there is a 60-day break (well-period) in which the resident is not an inpatient of a hospital nor inpatient of a SNF receiving a Medicare defined daily skilled service.
  - **Not inpatient of hospital -** ER/Observation days do not impact well-period.

30-day Transfer Rule

- The **30-day transfer period** begins on the day after the patient's discharge from the acute hospital stay or SNF.
  - If changing payer source, day one is first day on new payer and off Part A
- Medicare requires that the patient be admitted and receive a skilled level of care within those 30 days.
- It is not enough that the patient be admitted to the certified area, the patient must actually be receiving skilled care within those thirty days or else another 3-day qualifying stay will be required for coverage of care.

Benefit Period

- Requires SNF care between day 30 and day 60; requires 3-day hospital stay, continue with same benefit period.
- Requires SNF care after 60-day well-period; requires 3-day hospital stay; starts new benefit period.
- If exhausts benefits and continues to required skilled service e.g. tube feeding, the well-period does not start until skilled service stops.

Case Studies

- Patient A was admitted to the hospital.
- On day two of her hospital stay, it was necessary to transfer her to a second hospital where she remained for two additional days.
- Does this denote a Medicare qualifying stay?

Case Studies

- Patient B was originally admitted to the SNF for a fractured hip.
- Her rehabilitative treatment progressed well for 40 days, however on day 41 Patient B suffered a stroke and was readmitted to the hospital.
- As this second qualifying stay was for an unrelated condition, will the patient be granted another 100 days of Medicare coverage?

Case Studies

- Patient C, who has a G-Tube meeting nutrition and fluid requirements, had recently been admitted to the hospital.
- The patient had previously used 100 days for tube feeding.
- After 3-day qualifying stay, the patient was discharged to the SNF for skilled care.
- Will the care be covered by Medicare Part A?

Case Studies

- Patient D was discharged home from a Medicare SNF stay.
- The patient's condition necessitated the use of home health and Part B therapy services.
- Sixty-five days later the patient had a 3-day qualifying hospital stay and required a SNF placement.
- Does the home care receive impact eligibility for a second spell of illness in any way?

Case Studies

- Patient E was discharged from the SNF.
- On day 41, resident required inpatient hospital stay for two days.
- On day 62, the resident has a 3-day qualifying stay.
- Does the resident qualify for a new benefit period?

Case Studies

- Patient A was admitted to the hospital. On day two of her hospital stay, it was necessary to transfer her to a second hospital where she remained for two additional days. Is this a Medicare qualifying stay?

Physician Certifications

Physician Orders/Certification and Re-certification

Physician Orders/Certification and re-certification

- Certification and re-certification rules
- Delayed Certifications
- Certification Tracking log

Physician Certifications and Re-certifications

- Certification at time of admission
  - Must be signed on admission or as soon thereafter (within 48-72 hours).
  - Must be signed and dated by physician.
  - Hospital transfer form – may be used if exact cert language and dated day of discharge/admission.

Physician Certifications and Re-certifications

- First re-certification must be signed and dated by physician on or before the 14th day of admission (Entry date + 13 days).
- Certification and 1st re-certification can be signed at same time.
- Must contain reason for continued stay (skilled service), estimated time skilled services are expected, discharge plan.

Physician Certifications and Re-certifications

Certifications and re-certifications can be signed by:

- The Admitting/Attending Physician
  - A Nurse Practitioner
  - A Clinical Nurse Specialist
  - A Physician Assistant

  } Working in collaboration with the physician

- A physician with knowledge of resident such as the Medical Director

Physician Certifications and Re-certifications

CERTIFICATION AND RE-CERTIFICATION (SKILLED NURSING FACILITY)

RESIDENT	ADMISSION DATE	HEALTH INSURANCE CLAIM NUMBER
Mary Smith	July 1, XXXX	XXXX

CERTIFICATION
of a patient admission. Required at time of Admission

I certify that SNF services are required to be given on an inpatient basis because of the above named patient's needs for daily skilled nursing care or other daily skilled rehabilitation services, that as a practical matter, can only be provided in the SNF and are for an ongoing condition for which the individual received inpatient care in a participating or qualified hospital. The individual has been correctly assigned one of the case-mix classifiers that CMS designates as representing the required SNF level of care.

Dr. Joe Smith (PHYSICIAN'S SIGNATURE) 07/02/XX (DATE)

RE-CERTIFICATION
of continued daily SNF inpatient care. On or before the 14th day.

I certify that continued daily SNF inpatient care is necessary for the following reason(s):
PT 5X week for gait training and strengthening, OT 3X week for ROM. Nursing observation of functional loss and change in meds

I estimate that the additional period of SNF inpatient care will be 30 days
Plans for post-SNF care are: ___Home Health Agency _X_ Office Care ___Other (specify) Discharge home

Continued SNF care is for an ongoing condition(s) for which patient received inpatient hospital services or for a new condition that arose while being treated in the SNF for that ongoing condition: _X_ Yes ___No

Date Due: July 14, XXXX

(PHYSICIAN'S SIGNATURE) Dr. Joe Smith (DATE) 07/02/XX

All subsequent re-certifications must be signed and dated by physician at intervals not to exceed 30 days from the last signed re-certification date.

Physician Certifications and Re-certifications

- Nursing can complete required information PRIOR to physician signature.
- Requires physician signature & date of signature
  - Must have indication of when MD signed cert/recert
    - Date stamp when received and note that date.
    - Fax date
    - Note "Date signed" and then nurse's initials

Physician Certifications and Re-certifications

- Information must be complete
- Have physician signature log
- If electronic and physician's name prints out, then that physician must be signing cert.
- **Procedures for delayed certifications and re-certifications**
  - Include copies with any Intermediary chart requests

(NAME OF FACILITY)

DELAYED CERTIFICATION/RE-CERTIFICATION
Skilled Nursing Facility – Level of Care

_____ _____ _____
(Patient Name) (Admit Date) (Medicare #)

Post-hospital extended care services were required on an inpatient basis for the above named patient because of the individual's need on a daily basis, for skilled nursing or rehab services, for either a condition for which he/she received inpatient hospital services prior to the transfer to the SNF, or for a condition which arose after transfer while he/she was still in the SNF for a treatment of a condition for which he/she received inpatient hospital service; or

I certify that SNF services were required to be given on an inpatient basis due to the need for skilled nursing and/or skilled rehabilitation on a continuing basis.

I certify that continued inpatient skilled care was necessary for the following:

☐ Nursing Observation	☐ Physical Therapy	☐ Speech Therapy
☐ Occupation Therapy	☐ Tube Feeding	☐ Medication Injections
☐ Wound/Skin Care	☐ Pulmonary Care	☐ Special Catheter Care
☐ Dialysis	☐ Chemotherapy	☐ Radiation Therapy
☐ Diabetes Mellitus	☐ Respiratory Therapy	

☐ Other: _____

The duration of inpatient skilled care is expected to be _____ days.
(For missed certs or recerts while patient is still on Medicare Part A) **OR**

The actual length of stay was _____ days.
(For complete stays of already discharged patients)

Dates of hospitalization were from _____ to _____.

Plans for post Skilled Care are/were:
☐ Home Health Agency ☐ Office Care ☐ Long Term Care
☐ Other: _____

Reason for delayed cert/recert (insert reason or see statement below):
_____

The omission of my signature or the omission of any of the above information was an inadvertent oversight during my facility visits. This delayed certification is to supplement or replace timely certification.

_____ _____
(Physician's signature)

Identifying Skilled Level of Care

Nursing Skilled Level of Care

1. Overall Management and Evaluation of care plan
2. Observation and Assessment of resident's changing condition
3. Patient Education
4. Intravenous or intramuscular injections and intravenous feeding
5. Enteral feeding that comprises at least **>=51% of calories or calories 26-50% and fluid >=501cc**
6. Nasopharyngeal and tracheostomy aspiration;
7. Insertion and sterile irrigation and replacement of suprapubic catheters

Nursing Skilled Level of Care

8. Application of dressings involving prescription medications and aseptic techniques;
9. Treatment of extensive decubitus ulcers or other widespread skin disorder; Stage 3 or 4
10. Heat treatments which have been specifically ordered by a physician as part of active treatment and which require observation by nurses to adequately evaluate the patient's progress;
11. Initial phases of a regimen involving administration of medical gases

Nursing Skilled Level of Care

12. Rehabilitation nursing procedures, including the related teaching and adaptive aspects of nursing that are part of active treatment, e.g., the institution and supervision of bowel and bladder training programs.
13. Dialysis – depends if receiving a daily skilled service
14. Chronic conditions are not considered skilled unless with complications
    1. Stasis Ulcers
15. Prognosis is not a factor in determination of skilled services
    1. Terminal resident may or may not be skilled depending on daily skilled service

Non-skilled Supportive Services

- Routine medications
- Maintenance care of colostomy or ileostomy
- Maintain functioning indwelling catheter
- Changes of dressings for non-infected post-op or chronic conditions
- Maintenance of plaster cast
- Routine care connected to braces or similar devices
- Restorative maintenance program

Therapy Skilled Services

- Ongoing assessment of rehabilitation needs and potential
- Therapeutic exercises or activities
- Gait evaluation and training
- Range of motion exercises
- Maintenance therapy
- Ultrasound, short-wave, and microwave therapy
- Services of a speech pathologist or audiologist

Daily Skilled Services

- Meets eligibility requirements
- Physician Certification in compliance
- Documentation must reflect a daily skilled service
- Must require a daily skilled service
- 5 days a week by therapy
- 7 days a week by nursing

Continued Stay Requirements

Daily Nursing Documentation

Documentation should create a clear picture

Documentation must validate the services billed to Medicare

Documentation must support skilled interventions

Part A services may be required to treat conditions that are unstable or potentially unstable

Medical record must identify unstable/potentially unstable conditions

Nursing Supports Therapy

- Documentation should reflect collaboration
- DO NOT document – "Resident is going to therapy for gait training" over and over again
- Document how the resident is doing since going to therapy
- Document what happens on the unit as it relates to ADLs, documentation should elaborate on how therapy is helping (or not) to achieve ADL goals.

Nursing Supports Therapy

- What is therapy working on?
  - On ST – Nursing documents resident cries easily when trying to express self, or problems trying to form words, but today started using hand gestures.
  - On OT – Resident's ability to use an adaptive device for eating. Status and progress.
  - On PT – Resident expresses "PT makes me feel better. I can even walk a little."

Nursing Supports Therapy

- **Weekly Medicare Meeting – Communication of prior week and plans for next week.**
  - Review status in therapy – what is therapy working on
  - Review status of ADLs on unit related to ADL goals
  - Review medical status and skilled nursing services
  - Discharge plan

Nursing Supports Therapy

- **Weekly IDT or Nursing Summary Note is recommended**
  - Document a weekly summary note if daily documentation is incomplete
  - Includes same information as a daily note but reflects entire week
  - Summarizes the "chapters in the book" for the week

SNFABNs

- **Admission**
  - **No available Medicare-certified bed or waives benefit or does not meet 3 midnight qualifying stay (technical requirement)**
    - Voluntary - SNFABN CMS-10055
    - Resident does not select "Option"
  - **Does not Qualify for Part A level of care; Level of care decision**
    - Issue SNFABN CMS-10055

SNFABNs

- **Continued Stay**
  - Issue letter on or before last covered day
  - Must be staying in facility to give this notice
  - SNFABN CMS-10055

SNFABNs

- **Exhaustion of Benefits**
  - Benefits Exhausted Letter-issue facility letter when benefits are exhausted or voluntary SNFABN CMS-10055
  - Notices are voluntary since the benefit is exhausted and there is nothing to appeal.
  - Resident should not select "Option" or sign SNFABN.

Generic Notice/NOMNC/Expedited Reviews Part A

- Notifies resident of right to an expedited review by an independent entity – QIO
- Do NOT issue at admission (one exception) or exhaustion of benefits
- **Part A** – issued 2 days before last paid/covered day.
  – Generic Notice CMS-10123

Determine If an Individual or Entity is Excluded

- In order to avoid potential CMP liability, the OIG urges health care providers and entities to check the OIG List of Excluded Individuals/Entities on the OIG website: https://exclusions.oig.hhs.gov/ prior to hiring or contracting with individuals or entities.

Determine If an Individual or Entity is Excluded

- Ongoing - Recommend routine checks.
  - Includes all nurses, therapists, and physicians, NP, etc.
  - Compliance Lawyers recommend checking monthly
- To obtain lists with debarment actions taken by various federal agencies, including exclusion actions taken by the OIG. You may also access the System for Award Management at https://www.sam.gov

Part A Systems Set-up or Review

- Review systems needed for Part A
- Determine if system in place
- Determine who does what within your organization
  1. Inquiry / Admission process
  2. Physician orders and Certifications
  3. Continued Stay Determinations/Documentation
  4. Denial Notices
  5. Quality Assurance

Part A Systems Set-up or Review

- Quality Assurance
  - QA Admission process
  - QA Physician Certifications
  - Triple Check prior to billing

Numbers to Live By

100 days in a Benefit Period. As long as skilled care is reasonable and necessary

60 days in a Well Period. No inpatient stay starts new 100 benefit days.

30 days in the Transfer Rule. Can resume skilled care without another qualifying stay.

QUESTIONS

SHP

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We want to hear from you !

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