Understanding the observation stay ‘loophole’

Hospital observation stays can be difficult for any SNF or staff member to fully understand. To begin, let’s consider the following example.

A family member of Marilyn Mines was recently in the hospital and wound up staying overnight in a regular room. This was good, from Marilyn’s standpoint, as the stay would allow the family member’s Medicare Part A coverage to pay for several of the procedures needed while in the hospital.

However, it was discovered that instead of receiving Part A coverage, the relative was on the hook for the expenses. It turned out that she was never actually admitted to the hospital, but instead was being held on an observation stay. The distinction between admission and observation is very subtle and catches many residents unaware.

How subtle is the difference?

Mines is the senior manager of clinical services at Frost, Ruttenberg & Rothblatt, PC, in Deerfield, Ill.—and even she was caught off guard by the distinction between inpatient and observation stays when helping with her own family.

As shown in the preceding example, without the qualifying hospital admission, the patient did not meet the criteria for Medicare Part A coverage. And that’s a problem not only for patients, but also for facilities that believe new or returning residents are eligible for Medicare Part A coverage based on the hospital stay. Facilities may believe that one of their residents was admitted for inpatient services—only to find out later that the resident has been staying for days at the hospital in an outpatient classification, through an observation stay.

“Even if they were in a hospital for seven midnights, it doesn’t count as a three-day qualifying stay,” says Betsy Anderson, president and director of healthcare services at Frost, Ruttenberg & Rothblatt, PC. “Because [an observation stay] is considered outpatient services, when they come to the skilled nursing facility, or back to it, they are not eligible for the Medicare Part A benefit period to start.”

A growing problem

This confusion is a problem SNFs are familiar with, but it’s also a problem that’s growing, according to a recent study authored by Brown University’s Zhanlian Feng, Brad Wright, and Vincent Mor.
According to an abstract of the study, the researchers used nationwide Medicare enrollment and claims data to document a growing trend in the prevalence and duration of hospital observation services in the fee-for-service Medicare population during 2007–2009, accompanied by a drop in inpatient admissions.

Researchers found that the ratio of observation stays to inpatient admissions increased 34%, from an average of 86.9 observation stay events per 1,000 inpatient admissions per month in 2007 to 116.6 in 2009, according to an abstract of the study.

“Medicare beneficiaries were increasingly subjected to hospital observation care and treated as outpatients instead of inpatients, which can expose them to greater out-of-pocket expenses if they are eventually admitted to skilled nursing facilities,” the authors wrote. “Additionally, the nearly one million beneficiaries receiving observation services each year were, on average, being held in observation for a longer period of time per episode—some for longer than seventy-two hours.”

“In the last five years, we have definitely seen an increase,” confirms Anderson. “From what we have seen, it appears to be on a national level.”

The financial impact for SNF and beneficiaries

Mines notes that if beneficiaries need postacute care at a SNF, they may find themselves stymied by the so-called observation stay loophole.

“We’re seeing it a lot—and unfortunately it is costing the beneficiaries a lot of money,” says Mines. “[The loophole] is negatively impacting our beneficiaries, which is really a shame. They can’t use their benefits, and in some instances, the nursing facilities don’t realize it’s not a Medicare Part A covered stay.”

Mines says facilities can end up being provider liable for a certain number of days if they admit patients thinking they’ll be Medicare-eligible when they are not.

“If the provider does not give an advance beneficiary notice or noncoverage letter to the beneficiary at the time of admission stating that Medicare is not going to be covering their stay—for any reason—and it ends up the beneficiary is assuming Medicare is covering the stay, the facility cannot turn around and bill the family. [The facility] ends up being provider liable for the cost of the stay,” she explains.

So what’s driving this trend?

Taking a deeper look into the driving factors behind the trend of increased observation stays is important for facilities. Some of the suggested factors include:

- An unintended consequence of Medicare payment policies. The Brown University study authors suggest that the trend may be an unintended consequence of Medicare payment policies designed to constrain hospital admissions.
- Scrutiny toward hospital admissions. Anderson says she thinks a big part of the reason behind increased use of observation stays comes from the
When you admit a patient from a hospital, check with the hospital’s billing office about the billing status of that stay prior to admission to the SNF.

“It’s even more important to be proactive and develop contacts at the hospitals and work as a partner with the hospitals so no one has a surprise,” said Anderson.

➤ If you have a resident going to a hospital, talk with the billing office there about how it’s billing that stay—is it inpatient or outpatient? Always check with the billing office; even a nursing supervisor at the hospital may not know whether a patient had an inpatient or outpatient stay.

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“It’s even more important to be proactive and develop contacts at the hospitals and work as a partner with the hospitals so no one has a surprise,” said Anderson.

In addition to the potential billing problems, keeping a patient under an outpatient observation stay often leads to the beneficiary paying more for out-of-pocket expenses, Anderson notes, from over-the-counter drugs to prescriptions and other services not covered by Part B observation.

Hospitals, she says, are becoming more aware of the potential problems these observation stays cause for patients and SNFs—especially because more and more hospitals are partnering with their community SNFs.

“Because of rehospitalization criteria, we’re finding the best way for skilled nursing facilities to deal with some of these issues is to really work with the discharging hospitals up front, look at the admission protocols, really be involved from day one—especially when it’s their own residents going to the hospital,” says Anderson, “but also in the discharge process, if the hospital is referring the patient to a skilled nursing facility.”

So what should a SNF do?

While observation stays may not always be avoided, communication with hospitals is vital in limiting potential billing problems associated with these stays. Anderson and Mines offer the following advice to facilities when communicating with a hospital:

If you admit a patient from a hospital, check with the hospital’s billing office about the billing status of that stay prior to admission to the SNF. It’s even more important to be proactive and develop contacts at the hospitals and work as a partner with the hospitals so no one has a surprise,” said Anderson.

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Are you a hospital inpatient or outpatient? If you have Medicare—ask!

Editor’s note: This sidebar is an excerpt from the CMS pamphlet, Are You a Hospital Inpatient or Outpatient? If You Have Medicare—Ask! Facilities may consider using this information both to understand the difference between inpatient and outpatient services, and to educate residents and caregivers. To see the complete pamphlet, visit http://tinyurl.com/26dcoto.

Did you know that even if you stay in the hospital overnight, you might still be considered an “outpatient?”

Your hospital status (whether the hospital considers you an “inpatient” or “outpatient”) affects how much you pay for hospital services (like x-rays, drugs, and lab tests) and may also affect whether Medicare will cover care you get in a skilled nursing facility.

You’re an inpatient starting the day you’re formally admitted to the hospital with a doctor’s order. The day before you’re discharged is your last inpatient day.

You’re an outpatient if you’re getting emergency department services, observation services, outpatient surgery, lab tests, or x-rays, and the doctor hasn’t written an order to admit you to the hospital as an inpatient. In these cases, you’re an outpatient even if you spend the night at the hospital.

Note: Observation services are hospital outpatient services given to help the doctor decide if the patient needs to be admitted as an inpatient or can be discharged. Observation services may be given in the emergency department or another area of the hospital.

If you’re in the hospital more than a few hours, always ask your doctor or the hospital staff if you’re an inpatient or an outpatient.
Handling the growing trend of hospice care in SNFs

A recent University of Rochester Medical Center study notes that nursing homes are increasingly becoming the place where the elderly go to die, estimating that by 2020, the percentage of Americans who die in such facilities will grow to 40%, up from the current 30%.

With such a trend unfolding, the importance of hospice expertise grows. Currently, according to the study, about 33% of nursing home residents received hospice care at the time of their death—and that number’s on the rise, says Karen Connor, MHA, senior consultant/owner of Connor LTC Consulting of Haverhill, Mass.

“Hospice has been on the rise for quite some time. Hospice facilities are more prominent now as well as the SNF identifying these types of residents,” notes Connor. “I believe the need and part of the reason you see more hospice patients is that SNFs see the benefit to hospice care and are more willing to evaluate for the need and contact the local hospice agencies. Previously, there were a few entities to call, but now more and more agencies are providing the hospice care—which means more classification.”

How valuable is hospice care for SNFs?

The value of hospice in a SNF is clear, says Frosini Rubertino, RN, CPRA, CDONA/LTC, the founder and executive director of TrainingInMotion.org.

“Residents receive focused pain management while in the SNF as well as staff and family education,” says Rubertino, adding that it can be difficult for a SNF nurse to handle pain management for an end-of-life resident when he or she is also administering medications to 25 other residents. Hospice and skilled nursing are intended to compliment each other’s services through communication and coordinated efforts to manage the resident’s condition.

In addition, she says, hospice workers also offer grief counseling for families.

“SNFs are not prepared for grief counseling for the entire family. We’re not as intensely trained as the hospice staff is,” Rubertino says. “SNFs’ specialty is sub-acute care—not end-of-life care.”

Connor notes that SNFs are looking at the value of hospice as it eases the patient into end-of-life care and aids the family through this process.

“The last days that the resident has is supposed to be embraced with care—comfort, dignity, and an opportunity for the family and the resident to be at peace with the last phase of life,” she says. “Hospice is more looked upon as a blessing to aid the facility on how to handle the terminal illness, for the clinical and the emotional side of the care.”

The billing challenge

Although there are notable benefits of working with hospice providers, this partnership also creates some challenges for billing.

SNFs can’t bill Medicare Part A for hospice care, Rubertino warns, and while hospice bills Part A for its care, it must be for care related to the terminal diagnosis. At the same time, the SNF can bill Part A, but for other care.

“Say a resident also happens to have multiple pressure ulcers, a stage three and a stage two—which requires dressing changes and monitoring of the wound condition,” explains Rubertino. “This is a skilled service that the skilled nursing facility could bill Medicare Part A while the resident is also on hospice.”

There are times when therapy can be provided and billed to Medicare Part B when the resident is on hospice, adds Connor. Often this involves speech therapy so the patient can swallow liquids and medications for care and comfort measures, Connor says.

“With the correct coding on the Medicare claim, this is an added revenue area that most facilities do not capture because they are not aware that they can bill for these services while on the hospice program,” she says.

Rubertino advises facilities to remember that the patient’s care plan should reflect the collaboration and coordination of care between the SNF and hospice, and
clearly spell out both care and services. Communication with billing is also important in this case.

**Recognize the components of hospice**

There are different components to hospice services, which facilities should be aware of. Connor details some of the different components to hospice:

- **A general inpatient (GIP) level of care** is typically employed when a resident’s passing is considered imminent. In this situation, a resident will typically use a maximum of 14 days of the benefit. GIP is a Medicare hospice program—the rate is higher and follows the Medicare program. Residents using this benefit are terminal and are expected to pass away within two weeks.

- **The long-term hospice benefit** typically lasts up to six months, and follows the Medicaid program. In this situation, the resident usually has a terminal illness, but is not expecting to pass immediately.

- **Respite hospice care** is a hospice service where the room and board is paid privately (by a resident’s family, responsible party, etc.) but medications and services are billed to the hospice agency. Counseling is provided to the family, and a CNA is assigned to the resident during the hospice time.

Medications related to the terminal illness are billed to the long-term care pharmacy, and the facility only pays the pharmacy charges related to the non-terminal illness, notes Connor. A CNA is usually given to follow the patient during the hospice stay. Most hospice agencies will provide grief counseling from six months to a year for the family after the passing.

The one thing to consider for billing is that often a patient is on hospice, but depending on the program, can cause confusion with billing side, Connor says.

“The important thing to remember when billing for hospice is getting the accurate information—verifying the day the patient was accepted to the program and the day the family/responsible party agreed for the placement,” advises Connor. “The second topic would be to verify which program the resident is enrolled in—this way the bills can be submitted appropriately. There is a vast difference in all three programs.”

Most hospice programs will pay the date of death for the resident where other programs do not pay on the date of death or discharge, Connor adds.

A few key points to remember:

- **Verifying with the case worker that the resident is qualified for hospice.** A patient can be disenrolled anytime if he or she does not meet the proper requirements.

- **Sometimes a patient is enrolled into the Medicare program, but then disenrolls from Medicare to be placed on hospice.** If the patient decides to stop hospice, he or she must verify that the hospice agency has disenrolled the patient from its program, otherwise the bills for the insurance (Medicare) will state that Medicare cannot pay the claim as there is hospice involvement.

- **Medicare Advantage programs do not pay for hospice.** The hospice will bill Part A for its services when a Medicare Advantage resident chooses hospice services.

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Don’t leave billing to chance with leaves of absence

High school students get hall passes. Sailors get shore leave. Professors get sabbaticals. And SNF residents get leaves of absence.

Just because a resident needs Medicare postacute care doesn’t mean he or she can’t leave the SNF on occasion. It is, in fact, the resident’s right to have a leave of absence (LOA), though the exact definition of that term is a bit foggy—it’s subject to policy definitions that differ from facility to facility.

How to define LOA

“How people define a leave of absence varies by facilities. Some people call them therapeutic passes, therapeutic leaves, some call them leave of absences,” explains Theresa Lang, RN, BSN, WCC, vice president of clinical consulting at Specialized Medical Services, Inc., in Milwaukee. “For Medicare purposes, a leave of absence is when a person is not in the facility at 12 o’clock midnight and has not been admitted as an inpatient to another facility,” says Lang.

Facilities should take the following situations into consideration when determining a leave of absence:

➤ A medical LOA. If the person is out of the facility at 12 midnight and they’re in a hospital observation stay or emergency room for less than 24 hours, then it is an LOA, says Lang, in that case commonly known as a medical leave of absence.

➤ A therapeutic pass. A leave can also be a therapeutic pass, where the resident is going out with a family member for a special event or occasion and will be gone past midnight, Lang adds.

The official definition from the Medicare Claims Processing Manual (40.3.5.2) reads:

➤ A leave of absence for the purposes of this instruction is a situation where the resident is absent, but not discharged, for reasons other than admission to a hospital, other SNF, or distinct part of the same SNF. If the absence exceeds 30 consecutive days, the three-day prior and 30-day transfer requirements, as appropriate, must again be met to establish re-entitlement to SNF benefits.

➤ Leave of absence (LOA) days are shown on the bill with revenue code 018X and LOA days as units. However, charges for LOA days are shown as zero on the bill, and the SNF cannot bill the beneficiary for them except as specified in Chapter 1 of this manual at §30.1.1.1. Occurrence span code 74 is used to report the LOA from and through dates.

Should the resident be discharged?

The confusion between whether a patient is on a LOA or has left a facility completely can lead to both documentation and billing errors. Where many SNFs make mistakes, says Lang, is when a resident is not in bed at midnight. He or she may be on an LOA—for example, a quick visit to the local emergency room—but is discharged for billing purposes, she says.

That can be a significant problem, says Tammy Davis, senior consultant with ECS Billing & Consulting, Inc., in Dublin, Ohio. If a resident is discharged, the MDSs have to be restarted if the resident returns to the facility. However, if a resident is out on an LOA, the facility doesn’t have to restart the MDS cycle upon the resident’s return.

Facilities should also be aware of the following:

➤ LOA doesn’t require a new therapy evaluation. Lang says an LOA doesn’t require a new therapy evaluation, as a true hospitalization would. The LOA does, she notes, change the scheduled PPS assessments—those get extended by a day. For
unscheduled PPS assessments such as end of therapy, change of therapy, etc., an LOA is counted in the look-back days and the unscheduled assessment can be scheduled on an LOA day, she says.

➤ **Always determine if the resident was actually admitted to the hospital.** According to Davis, it becomes very important for the SNF to determine whether the resident was admitted to the hospital, or whether it was just an observation stay. (See p. 1 of this issue for more on observation stays.) An admission would mean the SNF has to restart the PPS resident’s assessments. “If they miss an assessment, it could have a negative impact on the facility from a financial and compliance standpoint,” she adds. A missed assessment results in provider-liable billing to Medicare.

**Make staff accountable for communication**

One of the most important areas in accounting for LOAs is to make sure someone is managing the midnight census count, checking to see who is in bed and who is not—and properly noting where those who are absent are. And, of course, that information has to be passed on to the billing office.

If your billing department isn’t getting all of the information needed for leaves of absence, don’t wait for clinical staff to make the necessary changes—this could result in noncompliance. Instead, to be proactive, the billing office should:

➤ **Stress the need for internal communication.** The importance of communication, for billing reasons, must be stressed to whoever is doing the census, says Davis. Sometimes a nursing manager might figure the resident was only gone from 10 p.m. until 2 a.m., so the absence isn’t important, she says. But that absence spanned a midnight, and must be accounted for, Davis says.

➤ **Don’t leave room for confusion when working with hospitals.** “When a person goes to the emergency room, figure out what was their status. Were they emergency room? Did they wind up in observation? Were they actually admitted? If you don’t have that piece right, you’re not going to bill right, your MDS people are going to make mistakes, and it’s a slippery slope,” says Davis. “Don’t ask the floor staff at the hospital. On Monday morning, call the hospital billing office.”

**Recognize resident rights**

Adhering to the rights of each resident is vital for facilities, and yet facilities may be unknowingly violating these rights in LOA situations. Lang says some facilities don’t realize that residents have a right to LOAs.

“There are organizations that absolutely tell people, ‘If you’re on Medicare you can’t leave the facility for any reason except medical appointments.’ Which is an absolute violation of their rights,” she says. “If a resident wants to go to a parade on Wednesday with their family, they have the right to go to the parade.”

When working with LOA situations, facilities should understand how to bill properly without compromising the rights of the resident.

While SNFs can’t bill Medicare for LOA days, in many cases, they can charge Medicaid or the private payer for a bed-hold day provided the resident receives the appropriate notifications.

“It’s just a way of compensating the facility for their overhead expenses on the day the person isn’t in that building,” explains Lang.

Just remember, she says, that in most cases the resident must be informed of the bed-hold fees ahead of time.

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Filling the gaps in emergency planning for nursing facilities

Editor’s note: This article originally appeared in the August issue of PPS Alert for Long-Term Care. For more information on this newsletter, please visit www.hcmarketplace.com/prod-60.

In 2007, CMS published a checklist for nursing homes as a guideline to key in on specific areas of emergency preparedness. Subsequently, the OIG published a study entitled Gaps Continue to Exist in Nursing Home Emergency Preparedness and Response During Disasters: 2007–2010, which identified areas of weakness in 24 nursing homes affected by disasters, and then compared those weaknesses to the elements highlighted on the CMS checklist.

In April 2012, the OIG published a memorandum of supplemental information regarding the recent study that identified five areas of concern where nursing homes didn’t fully address the guidance on the checklist, calling on CMS to consider providing additional guidance to fill these gaps. The five identified areas were as follows:

➤ Missing patients
➤ Unidentified quantities of supplies
➤ Recommended emergency response practices
➤ Emergency planning templates
➤ Healthcare coalitions

“I think that overall, skilled nursing facilities do have plans in place, but the plans probably aren’t as involved or detailed as they really need to be when an emergency happens,” says Julia Hopp, MS, RN, CNAA, BC, vice president of patient accounting at Paramount Health Care Company in San Antonio. “They definitely put the basics in place, but there are always things that you didn’t realize would be occurring or that they forgot to plan for, so I think there are some areas that they need to work on.”

Ultimately, nursing facilities are much different than hospitals when it comes to disaster preparedness. They have fewer staff members and physicians on-site, meaning they need to do more prep work in order to care for residents during an emergency. Below are several recommendations for nursing facilities to strengthen their emergency preparedness plans.

Track your patients

The best way to minimize the risk of missing residents is to develop a system that will inform staff when residents have left the building. The nursing home environment is slightly different than the hospital environment, and residents may be out with family members or at a doctor’s appointment, so tracking their whereabouts when they leave the campus is paramount.

“You always need to know where all of your residents are, even if they aren’t at your facility,” Hopp says.

The rise in Alzheimer’s and dementia patients has had a significant impact on the number of missing patients during disasters, says Deborah Franklin, director of operations at Florida Living Options in Dover and president of the Florida Health Care Association (FHCA). Florida has implemented a silver alert system for elderly residents who have gone missing, similar to the AMBER Alert. However, Franklin admits it’s still an area of weakness, and nursing facilities should have procedures in place should a resident go missing during a disaster or evacuation.

Go outside your borders

Supplies are a hot commodity for all healthcare organizations during a disaster. Unfortunately for nursing facilities, hospitals often take priority with vendors since they have the most critical patients and handle a high volume of patients coming in for care. Therefore, nursing facilities need double and triple backup plans to ensure that they can effectively treat residents.

Every facility should know:
➤ The amount of backup supplies it has at any given time
➤ How long the supplies will last without backup
➤ Whether it needs to stockpile more supplies

It is also important to consider the following when establishing or reviewing a disaster plan:

➤ Vendors won’t always be available. During the 2005 hurricane season in Florida, many healthcare facilities learned the hard way that vendors wouldn’t always be available to bring more supplies. Water and gas companies, along with oxygen suppliers, couldn’t even get into some communities to provide equipment or fuel, Franklin says. “You can’t just have that one provider,” she says. “When there is a storm coming now, we put everyone on alert and we have generators waiting at the state lines to come in. You have to reach out farther than your normal borders for your disaster planning.”

➤ Even well-established plans can be overridden. In 2005, nursing facilities in Florida also realized that the government could supersede their plans at any time. For example, some facilities had agreements with schools to use their buses to transport residents, but the government stepped in and used the buses to transport people in special needs communities instead. “There were some kinks like that and we had to step back and come up with different plans,” Franklin says.

Practice for perfection

In recent years, more emphasis has been placed on involving the entire community during disaster drills, rather than running exercises in isolation.

“Basically it was probably paper compliance before where someone is verbally telling staff, ‘This is what we would have done during a disaster,’ ” Franklin says. “But now we are seeing more community disaster drills with the emergency planning operation where facilities are coming together and actually transferring residents like it was a real drill.” These drills help engage staff and provide hands-on training so they know exactly what they should be doing and whom they should report to during an emergency.
Afterwards there should be a follow-up evaluation that examines what went well, what went poorly, and what lessons can be learned for future planning and disaster management.

**Get on the same page**

Although drills and exercises provide an important opportunity to fix mistakes and gaps, getting everyone on the same page from the start helps ensure your processes will run smoothly. Utilizing emergency management templates such as an incident command chart lets everyone know who the decision-makers are for each aspect of an emergency.

In 2006, the FHCA was awarded a grant from the John A. Hartford Foundation to support development and training for disaster preparedness in long-term care facilities. Using that money, the FHCA developed structured templates that nursing facilities could use for planning purposes.

“Some of the regulations are kind of vague that say you need to have a disaster plan, but when you use a proven template, you’re going to make sure you cover everything and everyone is on the same page, which is so important during a disaster,” Franklin says.

But these templates were also made to be individualized. For example, some facilities may have different titles or terminology (e.g., housekeeping vs. environmental services). The template should be a tool to get you thinking about all the issues that come up during a disaster, but it should be tailored to your facility’s needs.

**Identify your risk factors**

Every facility has unique risk factors during a disaster depending on its size and patient population. Those risk factors also vary depending on geographic location. For example, while Florida clearly plans heavily for hurricanes, California facilities may place much more emphasis on planning for an earthquake, and nursing facilities in Wisconsin are more concerned about a blizzard.

“What you want to do is look at what are the potential emergencies you could have, and then what is the highest potential emergency, and plan for those,” Hopp explains.

From there, your emergency templates should be built around your facility’s potential vulnerabilities during a large-scale disaster. If you’re worried about a blizzard, you may need to stock up on generators to keep people warm. If you’re concerned about flooding, you will want to look at ways to protect your facility from water damage.

“In their disaster plan, everyone has to do an analysis of their building and what their building is able to withstand,” Franklin says.

When working with the community to establish a disaster plan for your facility, consider the following:

- **Community partners are key.** Reaching out to community partners should be a top priority, Franklin says. Hospitals, for example, will go into lockdown, and if you don’t have a plan in place with other community facilities, residents might not get the care they need.

- **Consider unexpected resources.** Even unexpected resources like the power company can be useful. In Florida, for example, facilities realized that after some of the hurricanes in 2005, power was being restored to restaurants and stores instead of the nursing facilities that had patients on oxygen. “For some reason we weren’t on the priority list to get turned on, so we brought the power companies to the table, and when we did that it really just worked out a whole bunch of bugs,” Franklin says.

**Use the community**

Just as community resources are invaluable during disaster drills, they are also helpful in the planning stages to find out what assets may be available to your facility. For example, in past years, facilities in Texas have contracted with schools or child care centers ahead of time to use school buses to transport residents during a hurricane. “It’s not only healthcare institutions but other people in the community coming together and helping each other,” Hopp says.

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Recently, our facility administrator had several questions about consolidated billing (CB). What is important for administrators to know?

Administrators need to understand a few basic rules when dealing with the CB system. The 7/5 rule states that residents must receive skilled nursing care seven days each week and rehabilitation services five days each week for Medicare Part A reimbursement under the skilled CB system. The midnight rule states that the facility is allowed to bill for all Medicare Part A residents who are in bed at midnight. The three-day-qualifying-stay rule says that a person who has Medicare Part A must have been admitted to a hospital for three qualifying days before he or she can be covered under Medicare Part A within a nursing home.

If the person qualifies for admission, there is a 30-day rule for transferring him or her to a nursing facility from the hospital. If the person meets the three-day requirement, Medicare Part A coverage will continue to exist for admission to a skilled nursing home for 30 days from hospital discharge.

Once the person is admitted, Medicare Part A will pay for up to 100 days, following a 20/80 split, with the first 20 days covered in full and the last 80 days covered with a copayment that is needed. Confusion here results when many people feel they are guaranteed a full 100 days. No such guarantee exists, and they must meet criteria to remain on Medicare. For a person to be able to qualify for a full 100 days of Medicare Part A, he or she must follow the 60-day-break-of-illness rule, which states that to requalify the person must not have skilled coverage in the nursing home or hospital; in other words, the person must be free from skilled intervention for a minimum of 60 days. These are just a few of the rules that exist, but these in particular are rules that the administrator should understand.

A skilled service that can be covered under Medicare Part A for skilled nursing home admission falls into at least one of three categories: overall management and evaluation, observation and assessment, or education and training. Overall management and evaluation are based on admission to a SNF where the physician care plan deems that it is necessary for the person to have skilled nursing services rendered and skilled rehabilitation services provided to aid in increasing his or her functional status. The observation and assessment area skills a person when he or she needs to be observed, his or her potential for change is imminent, and the possibility for changing his or her treatment regime is imminent as well. A person can be skilled under education and training if he or she needs educational and training activities from nursing or rehabilitation to aid in

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**QIS prep made simple**

Unannounced Quality Indicator Surveys (QIS) can surprise any nursing home staff and management, threatening even the most prepared facilities with Stage II investigations of their protocols. *QIS in Action: Establish a Culture of Continuous Readiness* is a 30-minute DVD that guides nursing home staff on what to expect during every step of a survey team’s visit to achieve ongoing readiness.

Realistic scenarios illustrate positive interaction with surveyors. The accompanying tools and resources will help staff educators and DONs guide a mock survey.

For more information on *QIS in Action: Establish a Culture of Continuous Readiness*, visit HCPro at [www.hcmarketplace.com/prod-9635](http://www.hcmarketplace.com/prod-9635).
enhancing his or her functional status. Remember that there must be interdisciplinary involvement in skilling residents for Medicare Part A reimbursement, and the care plans must be specific in addressing the goals for skilling a resident, as well as whether the resident is making progress toward achieving these goals. Failing to do so can lead to a loss of Medicare reimbursement.

It is important to have an understanding of services that are excluded from CB. These are services that are excluded from Medicare Part A bundling and often can be covered under Medicare Part B. CMS has divided the exclusionary codes into the following five major categories:

➤ Category I: exclusion of services beyond the scope of a SNF
➤ Category II: additional services excluded when rendered to specific beneficiaries
➤ Category III: additional excluded services rendered by certified providers
➤ Category IV: additional excluded preventive and screening services
➤ Category V: Part B services included in SNF CB

Within the preceding categories are the following services that are excluded from Part A CB:

➤ Physician services furnished to a SNF resident
➤ Services provided by physician assistants
➤ Services provided by nurse-midwives
➤ Certified nurse anesthetist services
➤ Psychiatric and qualified psychological services
➤ Institutional dialysis services and supplies associated with these services within the SNF setting
➤ Epoetin alfa and darbepoetin alfa (drugs used for end-stage renal disease)
➤ Hospice care within a SNF
➤ Preventive services (can be billed to Part B)
➤ Outpatient hospital emergency room services
➤ Ambulance trips that transport for SNF admission or to home, as well as to select outpatient procedures
➤ Designated hospital outpatient procedures that are often billed by these agencies
➤ Chemotherapy and administration services
➤ Radioisotope services
➤ Customized prosthetic devices

Remember that although these services are excluded from CB under the Part A PPS, some of the services can be billed under Part B services if appropriate under specific guidelines, such as certain preventive services. Also, some services can be captured under Medicare Part A, but they cannot be provided within the SNF, such as hospice. Furthermore, other services may also be billed separately by the vendor that services the resident off the SNF campus, but this is not part of the CB protocol for the SNF.