SNF RESOURCE: CMS Waiver Skilling Guide

Under Section 1812(f) of the Social Security Act, CMS is waiving the requirement for 3-day prior hospitalization for coverage of a skilled nursing facility (SNF) stay effective 3/1/20

This translates to

- No hospital transfer necessary at all
- Skill directly from the community: LTC, AL, IL, Home
- No 60 day break required for resident who exhausted and still requires daily skilled care

WAIVER STATEMENT	ELIGIBILITY CONSIDERATIONS
Resident is displaced or evacuated as a result of the emergency.	• Lack of caregiver due to quarantine or suspected COVID-19 case. • Resident transfer from SNF to SNF or home to SNF.
Hospital stay shortened/avoided to make acute beds available for more critical individuals	• ER transfer directly to SNF. • Community admission directly to the SNF. • Initiation of Part A benefits without transfer to the acute hospital. • COVID-19 may be suspected, diagnosed or not present in the resident. • The community may have mild, moderate or severe exposure/cases. • Avoiding sending fragile residents to the community or the acute setting is the goal.

When a resident needs daily skilled care as a direct result of emergency itself (skill in place)	• Long term care residents who demonstrate the need for daily skilled care can access benefits and avoid hospital transfers.
	• Residents who are amidst a 60 day wellness period do not need to wait to initiate a new spell of illness, including benefits exhaust situations when symptoms and skilled need are identified.
	• Residents may or may not be placed in isolation. All related symptoms are qualifying including fever, cough, swallow issues, sore throat, difficulty breathing or other respiratory symptoms.
	• Physician and clinician documentation is required to describe the avoidance of hospital transfers in consideration of the national emergency and the resident's need for daily skilled interventions.
	• Clinical Grand Rounds process to identify – complete this daily with Nursing, MDS and Rehab. Discuss ALL LTC residents each month.
	• Morning clinical meeting: A MUST HAVE! Decisions to skill determined in the morning clinical meeting.
	• Medicare Part A vs. Part B services
	  o What are the barriers and how many days/week does the resident need therapy?
	  o Does the service rise to a daily skilled profile if the resident had gone to the acute setting?
	  o List the medical and functional barriers, then the skilled assessments, observations and treatments to determine if the resident should transition to Medicare Part A.

Conditions identified as requiring skilled interventions in the SNF do **NOT** need to be COVID or suspected COVID. Medical complexities can be any variation of conditions and services that require the skills, knowledge and judgement of the licensed professionals in the SNF setting.

Skilled Criteria Has NOT Changed

Must require and receive daily skilled services

7 days per week nursing

(and/or)
Therapy 5 - 7 days per week

Coverage Categories
- Skilled therapy
- Skilled nursing
- Observation & Assessment
- Coordination of Care Plan
- Teaching and training

***Per MBPM Ch. 8**

Essential List of Documents

- MD Certification
- MD note/orders to initiate skilled care under Medicare Part A benefits
  Due to declared emergency/disaster
- Initial assessments nursing and Rehab that outline skilled need / deficits
- 5 Day MDS ARD set within 8 day window
- MARs/TARs with daily administration and delivery of treatments
- Beneficiary notices prior to discontinuing Medicare benefits
- UB-04 lists Condition Code "DR" in FL 18-28 AND include "**declared emergency/disaster**" in the remarks section

SKILL IN PLACE FOR LTC RESIDENTS
• Long term care residents need to be monitored daily and discussed in Morning Clinical Meeting • Watch for clinical indicators listed below
• Should or would this resident go to the hospital? o If you would send the resident but due to the emergency, you will treat at your site instead – this could qualify the resident to access their Medicare Part A benefits. • Identify with the team what the daily skilled observations are, skilled assessments and treatments. o Fever, breath sounds, cough, sore throat, elevated BP. achy, decline, in cognition. See below for more details.
• Is your resident receiving Medicare Part B therapy services: o Each case is reviewed individually. o As noted above, review for the daily skilled care provided to determine if Medicare Part A benefits are indicated, i.e. nursing (7 days) and/or therapy 5-7x/week, at risk for further medical decline of cardiac, respiratory, infectious process, exacerbation of underlying co-morbidities (Parkinson's, MS, hemiparesis) o Conversion from Medicare Part B should include documentation stating the case is skilled related to the declared emergency • Consider the Medicaid CMI impact that this can have. Maintain MDS assessments to remain OBRA compliant.

Documentation Tips for Nursing, Rehab, Case Management/MDS, SS

Assessments completed, Observations made, Actions taken (per shift)

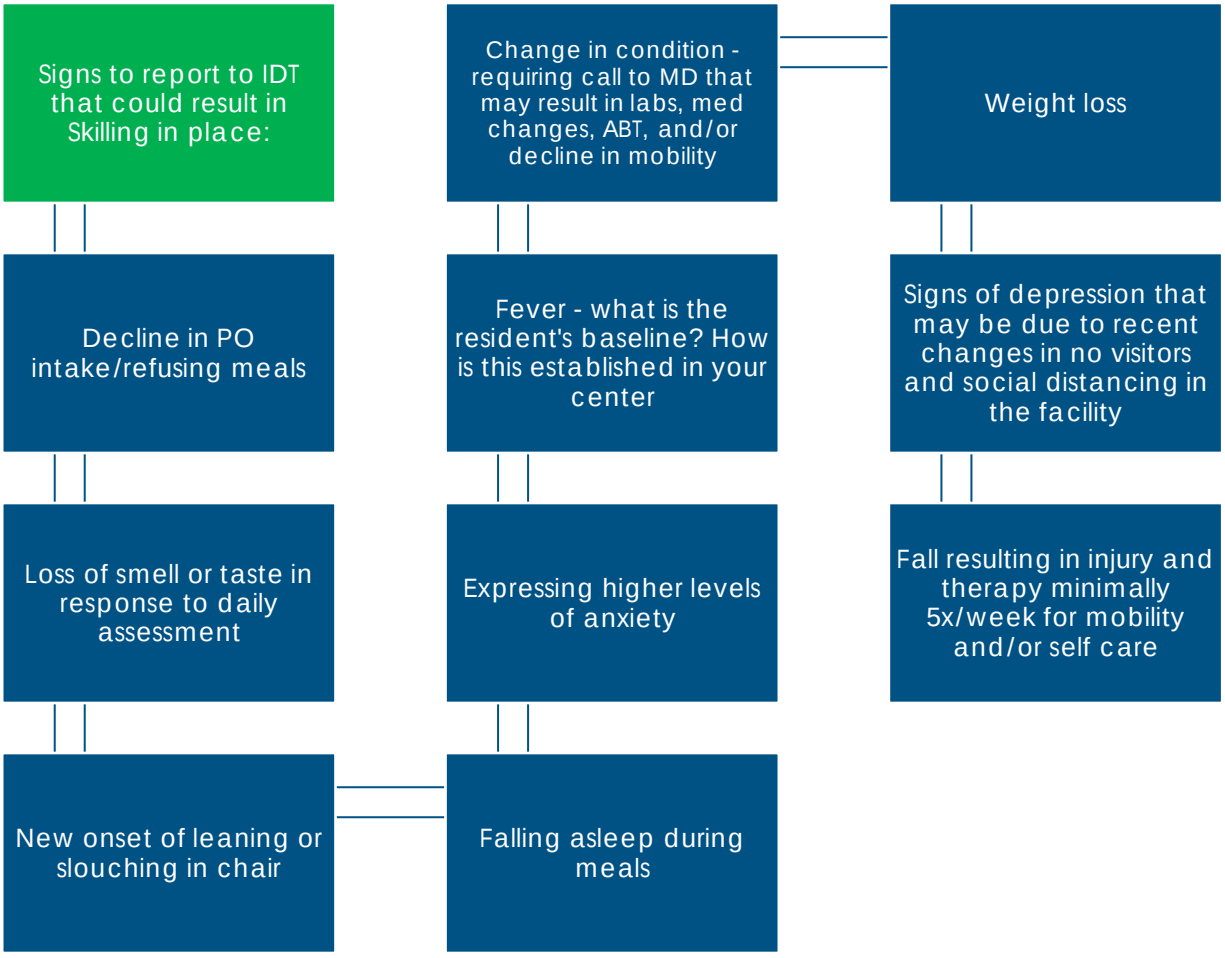
Medications and Treatment provided

Case management notes outlining the daily skilled care and emergency management systems spurring a skilled episode of care

State the risk a hospital transfer will pose to the resident in the SNF Medicare initiation/admission orders related to the COVID concerns

Documentation must support a significant change in condition requiring daily skilled care from licensed nursing and/or therapy professionals

Physician orders for Isolation and documentation of the specific infection with description of all services delivered in the room



Medical barriers to consider that support skill in place – placing the resident at risk for hospital transfers and risk of infection:

- History of CHF, COPD, recent pneumonia, etc…
- Fever
- Recent weight loss
- Hemiparesis
- Wounds
- Dysphagia
- Dementia
- Change in cognition
- Hyper/hypoglycemia
- Tremors
- Sore throat, wet or dry cough

(Not an exhaustive list)