3-Day Stay and Benefit-Period Waivers for Medicare Part A SNF PPS

Fast Facts

- These waivers will continue to apply until at least January 20, 2021.
- During the COVID-19 public health emergency (PHE), a SNF has the option to apply the 3-Day Prior Hospitalization waiver in order to furnish Medicare Part A services without a qualifying hospital stay (QHS), or to extend Part A services beyond 100-days (Benefit-Period waiver) if certain conditions are met.
- A COVID-19 diagnosis is not required for a beneficiary to qualify for either the QHS waiver or the Benefit-Period waiver.
- If a SNF applies the QHS waiver during the PHE,
    - Medicare beneficiaries can be admitted to a SNF for Part A benefits directly from their home, a physician's office, emergency room, hospital observation stay, or hospital inpatient stay of less than 3 days only if they develop a need for a SNF level of skilled care.
    - Medicare beneficiaries residing in a nursing facility but not receiving a SNF level of skilled care can be covered under Part A benefits only if they develop a need for a SNF level of skilled care.
    - There does not need to be a 60-day break in spell-of-illness.
- If a beneficiary's plan of care was disrupted by the COVID-19 PHE in a manner that prevented or delayed the completion of the plan by the end of the beneficiary's 100-day SNF benefit period, a SNF has the option to apply a Benefit-Period waiver which will qualify the beneficiary for up to one additional 100-day benefit period without interruption in order to complete the plan of care.
- The presence of a confirmed diagnosis of COVID-19 in a beneficiary, confirmed or suspected beneficiary exposure to someone with COVID-19, or the presence of symptoms that are suspected to be COVID-19 does not automatically qualify a beneficiary for SNF Part A coverage. That's because SNF coverage isn't based on particular diagnoses or medical conditions, but rather on whether the beneficiary meets the statutorily-prescribed SNF level of care definition of needing and receiving skilled services on a daily basis which, as a practical matter, can only be provided in a SNF on an inpatient basis.
- Claim coding and documentation requirements are different for the 3-Day Prior Hospitalization waiver and the Benefit-Period waiver.
- SNF Providers must fully document in medical records that care meets the waiver requirements; as these claims may be subject to post payment review.
- MACs must temporarily suspend and manually process benefit period waiver claims but are instructed to make every effort to ensure timely payment before the end of the 14-day payment floor. Providers should allow sufficient time before inquiring about these claims.

Background

In certain circumstances, the Secretary of the Department of Health and Human Services (HHS) using section 1135 of the Social Security Act (SSA) can temporarily modify or waive certain Medicare, Medicaid, CHIP, or HIPAA requirements, called 1135 waivers. There are different kinds of 1135 waivers, including Medicare blanket waivers. When there's an emergency, sections 1135 or 1812(f) of the SSA allow the Secretary to issue blanket waivers to help beneficiaries access care. When a blanket waiver is issued, providers don't have to apply for an individual 1135 waiver for the duration of the PHE.

In response to the declaration of the COVID-19 national public health emergency (PHE), effective March 1, 2020, the Centers for Medicare and Medicaid Services (CMS) has issued a blanket waiver of the 3-Day Prior Hospitalization requirement to qualify for SNF care under Medicare Part A as follows:

> ***3- Day Prior Hospitalization:*** *Using the waiver authority under Section 1812(f) of the Social Security Act, CMS is temporarily waiving the requirement for a 3-day prior hospitalization for coverage of a skilled nursing facility (SNF) stay. This waiver provides temporary emergency coverage of SNF services without a qualifying hospital stay. In addition, for certain beneficiaries who exhausted their SNF benefits, it authorizes renewed SNF coverage without first having to start and complete a 60-day "wellness period" (that is, the 60-day period of non-inpatient status that is normally required in order to end the current benefit period and renew SNF benefits). This waiver will apply only for those beneficiaries who have been delayed or prevented by the emergency itself from commencing or completing the 60-day "wellness period" that would have occurred under normal circumstances. By contrast, if the patient has a continued skilled care need (such as a feeding tube) that is unrelated to the COVID-19 emergency, then the beneficiary cannot renew his or her SNF benefits under the Section 1812(f) waiver, as it is this continued skilled care in the SNF rather than the emergency that is preventing the beneficiary from beginning the 60-day "wellness period."*

This means that a Medicare beneficiary can receive Medicare Part A SNF coverage without a qualifying 3-day hospital inpatient stay if they develop a need for a SNF level of care and could be admitted directly from the community, a doctor's office, an emergency room, from a hospital observation stay, or from a hospital inpatient stay that is less than 3-days. It also means that a SNF long-term resident could qualify for SNF benefits, or "skill-in-place", or potentially could qualify for Medicare coverage beyond 100 days, but only if all other Medicare SNF coverage requirements are met.

These waivers have been renewed by the Secretary of Health and Human Services multiple times, most recently on October 2, 2020. Therefore, these waivers will continue to apply until at least January 20, 2021, unless the Secretary signs another extension of the PHE.

This fact sheet will highlight those requirements in the context of the COVID-19 3-Day prior hospitalization and benefit period waivers.

Medicare Part A SNF Skilled Coverage Requirements

With the exception of the waived 3-day qualifying hospital stay requirement, all other SNF coverage requirements continue to apply. These requirements are described in the Medicare Benefit Policy Manual, Chapter 8, Section 30. Below is a summary in the context of the COVID-19 PHE waivers:

During the PHE, SNF Medicare Part A care is covered if all of the following four factors (with exception of hospital stay) 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; 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; *[AHCA Interpretation Note: Or – if during the PHE - for a condition that arose elsewhere].*
- The patient requires these skilled services on a daily basis; and
- As a practical matter, considering economy and efficiency, the daily skilled services can be provided only on an inpatient basis in a SNF.
- 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.

If any one of these four factors is not met (excluding 3-Day stay requirement), a stay in a SNF, even though it might include the delivery of some skilled services, is not covered. For example, payment for a SNF level of care could not be made if a patient needs an intermittent rather than daily skilled service.

CMS 3-Day Stay and Spell of Illness Waivers Guidance in COVID-19 Billing FAQs

Section Y of the extensive CMS *COVID-19 Frequently Asked Questions (FAQs) on Medicare Fee-for-Service (FFS) Billing* resource contains the following specific guidance related to applying the SNF QHS or Benefit-Period waivers.

1. Question: Does the section 1812(f) waiver for the 3-day qualifying hospital stay apply only to those beneficiaries who are actually diagnosed with COVID-19, or does the waiver apply to all SNF-level beneficiaries under Medicare Part A?

Answer: The qualifying hospital stay waiver applies to all SNF-level beneficiaries under Medicare Part A, regardless of whether the care the beneficiary requires has a direct relationship to COVID-19. See [this page].
New: 4/10/20

2. Question: Can a Medicare Part A beneficiary who has exhausted his or her SNF benefits, but continues to need and receive skilled care in the SNF (e.g., for a qualifying feeding tube), renew SNF benefits under the section 1812(f) waiver regardless of whether or not the SNF or hospital was affected by the COVID-19 emergency?

Answer: If the patient has a continued skilled care need (such as a feeding tube) that is unrelated to the COVID-19 emergency, then the beneficiary cannot renew his or her SNF benefits under the section 1812(f) waiver as it is this continued skilled care in the SNF rather than the emergency that is preventing the beneficiary from beginning the 60 day "wellness period." [See this page].
New: 4/10/20

4. Question: Does waiving (pursuant to section 1812(f) of the Act) the requirement for a 3-day prior hospitalization for coverage of a SNF stay apply to swing-bed services furnished by CAHs and rural (non-CAH) swing-bed hospitals?

Answer: Yes, under the section 1812(f) waiver, CAHs and rural (non-CAH) swing-bed hospitals may furnish extended care services to a SNF-level patient even if the patient has not had a 3-day prior hospitalization in that or any other facility. The Social Security Act permits certain CAHs and rural (non-CAH) swing-bed hospitals to enter into a swing-bed agreement, under which the hospital can use its beds, as needed, to provide either acute or SNF care. Rural (non-CAH) hospitals are paid under the SNF PPS for their SNF-level swing-bed services. By contrast, CAH swing-bed services are not subject to the SNF PPS. Instead, Medicare pays CAHs based on 101 percent of reasonable cost for their swing-bed services. For additional information on swing-beds, see [this page].
New: 4/10/20

6. Question: Can a positive COVID-19 test qualify a beneficiary (including a beneficiary who is currently receiving non-skilled services in a nursing home?) for a covered Medicare Part A skilled nursing facility (SNF) stay?

Answer: A COVID-19 diagnosis would not in and of itself automatically serve to qualify a beneficiary for coverage under the Medicare Part A SNF benefit. That's because SNF coverage isn't based on particular diagnoses or medical conditions, but rather on whether the beneficiary meets the statutorily-prescribed SNF level of care definition of needing and receiving skilled services on a daily basis which, as a practical matter, can only be provided in a SNF on an inpatient basis.
New: 6/19/20

CMS 3-Day Stay Waiver Claims Processing Guidance

CMS developed and has been updating an extensive MLN Matters Article Number SE20011 titled Medicare Fee-For-Service (FFS) Response to the Public Health Emergency on the Coronavirus (COVID-19) that contains the following detailed claims processing guidance related to the SNF QHS and Benefit-Period waivers.

Skilled Nursing Facility (SNF) Benefit Period Waiver - Provider Information

CMS recognizes that disruptions arising from a PHE can affect coverage under the SNF benefit:

- Prevent a beneficiary from having the 3-day inpatient qualifying hospital stay (QHS)
- Disrupt the process of ending the beneficiary's current benefit period and renewing their benefits.

Emergency waivers of QHS and benefit period requirements under §1812(f) of the Social Security Act help restore SNF coverage that beneficiaries affected by the emergency would be entitled to under normal circumstances.

Using the authority under section 1812(f) of the Social Security Act, CMS is waiving the requirement for a 3-day prior hospitalization for coverage of a SNF stay, which provides temporary emergency coverage of SNF services s (including SNF-level swing-bed services in rural hospitals and Critical Access Hospitals (CAHs)) without a QHS, for those people who experience dislocations, or are otherwise affected by COVID-19. In addition, for certain beneficiaries who recently exhausted their SNF benefits, the waiver authorizes a one-time renewal of benefits for an additional 100 days of Part A SNF coverage without first having to start a new benefit period (this waiver will apply only for those beneficiaries who have been delayed or prevented by the emergency itself from commencing or completing the process of ending their current benefit period and renewing their SNF benefits that would have occurred under normal circumstances).

For the QHS waiver:

- All beneficiaries qualify, regardless of whether they have SNF benefit days remaining
- The beneficiary's status of being "affected by the emergency" exists nationwide under the current PHE. (You do not need to verify individual cases.)

In contrast, for the Benefit Period Waiver:

- Beneficiaries who exhaust their SNF benefits can receive a renewal of SNF benefits under the waiver except in one particular scenario: that is, those beneficiaries who are receiving ongoing skilled care in a SNF that is unrelated to the emergency, as discussed below. To qualify for the benefit period waiver, a beneficiary's continued receipt of skilled care in the SNF must in some way be related to the PHE. One example would be when a beneficiary who had been receiving daily skilled therapy, then develops COVID-19 and requires a respirator and a feeding tube. We would also note that beneficiaries who do not themselves have a COVID-19 diagnosis may nevertheless be affected by the PHE; for example, when disruptions from the PHE cause delays in obtaining treatment for another condition.
- Would not apply to those beneficiaries who are receiving ongoing skilled care in the SNF that is *unrelated to the emergency* - a scenario that would have the effect of prolonging

the current benefit period and precluding a benefit period renewal even under normal circumstances. For example, if the patient has a continued skilled care need (such as a feeding tube) that is unrelated to the COVID-19 emergency, then the beneficiary cannot renew his or her SNF benefits under the section 1812(f) waiver as it is this continued skilled care in the SNF rather than the emergency that is preventing the beneficiary from beginning the 60 day "wellness period."

- In making such determinations, 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.
- **Providers should use the above criteria in determining when to document on the claim that the patient meets the requirement for the waiver.**

In this situation, we would also ask 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. Additionally, we also recognize that during the COVID-19 PHE, some SNF providers may have not yet submitted the PPS assessments for the benefit period waiver. In these limited circumstances, providers 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.

Billing Instructions

The following guidance provides specific instructions for using the QHS and benefit period waivers, as well as how this affects claims processing and SNF patient assessments.
To bill for the QHS waiver, include the DR condition code.

To bill for the benefit period waiver:

- Submit a final discharge claim on day 101 with patient status 01, discharge to home
- Readmit the beneficiary 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.

For SNF benefit period waiver claims, include the following:

- 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.

If you previously submitted a claim for a benefit period waiver that rejected for exhausted benefits, take either of the following actions:

1. If you billed the discharge and readmission correctly:

    - Cancel the rejected claim to remove it from claims history. DO NOT submit an adjustment to the rejected claim.
    - Once the cancel has finalized, resubmit the initial claim.
    - If you submit a claim without COVID100 in the remarks, we cannot process it for an additional 100 benefit days.

2. If you did not previously bill for a discharge on the last covered day to start a new admission with the benefit period waiver days:

    - Cancel the paid claim that includes the last covered coinsurance benefit day.
    - Once the cancel is processed, resubmit as a final bill with patient status equal to 01.
    - Cancel the initial benefit period waiver claim that rejected for exhausted benefits. You can submit this concurrently with the cancel of the paid claim.
    - Once the rejected claim is cancelled, submit an initial bill for the benefit period waiver following the same instructions as #1 above.

Please note, as previously stated, ongoing skilled care in the SNF that is unrelated to the PHE does not qualify for the benefit period waiver. You must determine if the waiver applies in accordance with the criteria set forth above. If so:

- Fully document in medical records that care meets the waiver requirements; this may be subject to post payment review.
- Track benefit days used in the benefit period waiver spell and only submit claims with covered days 101 - 200.
- Once the additional 100 days have been exhausted, follow existing processes to continue to bill Medicare no-pay claims until you discharge the beneficiary.
- Identify no-pay claims as relating to the benefit period waiver by using condition code DR and including “BENEFITS EXHAUST” in the remarks field.

MACs must manually process claims to pay the benefit period waiver but will make every effort to ensure timely payment. Please allow sufficient time before inquiring about claims in process.

Note: You must abide by all other SNF billing guidelines