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MDS Alert

Medicare Coverage: Break The Spell Of Illness Without Bending The Rules

Residents may be out of Medicare days but not out of luck, if you know how they can earn another benefit period.

Everyone needs a break, especially a resident who's used up his 100 days of SNF Medicare coverage and may require skilled care in the future.

The basics: Residents who remain in your nursing facility after they exhaust their SNF benefit can "earn" another 100 days if they have an uninterrupted 60-day break in their "spell of illness" requiring skilled care. That means you can save the day by knowing what counts as a 60-day break - and what your facility can do to help residents sidestep some of the traps that prevent them from getting a new benefit period.

The good news: Despite misconceptions to the contrary, a resident in a Medicare-certified bed in a facility that's 100 percent certified can accrue a 60-day break in the spell of illness - if he or she is not receiving a skilled level of care that meets Medicare criteria, says **Diane Atchinson, RN-CS, MSN, ANP**, president of **DPA Associates** in Kansas City, MO. "If the facility has a distinct part, however, move the person who is no longer receiving Medicare or a skilled level of care to a noncertified bed when one becomes available," she suggests.

Forget this myth: A resident who's exhausted his benefits and still requires skilled care can't earn another 100-day benefit by moving from a certified to a noncertified bed. "It's the resident's need and the services being provided that are key to whether he gets a break in the spell of illness - not the type of bed he's in (certified or not)," emphasizes **Diane Martinez, RN, LNHA**, a consultant with **Parente Randolph** in Harrisburg, PA.

Avoid, Double-Check Hospitalizations

Say a resident who's exhausted his SNF benefits has been sailing along without any skilled services for 50 days, but then he develops a sudden bout of gastroenteritis and requires 48 hours of inpatient hospitalization to receive IV fluids. The resident returns to the nursing facility and receives custodial care for another 10 days before he's hospitalized over a three-midnight stay to treat a small stroke. You might assume that you can reskill him for rehab under Part A when he returns to the facility - but not so fast.

The resident hasn't really had a 60-day break in the spell of illness, thanks to that two-day hospitalization for gastroenteritis. "A resident cannot accrue a 60-day break in the spell of illness if he is hospitalized as an inpatient for even one day during what would otherwise count as a 60-day break in the spell of illness," cautions **Helen Merlo, RN**, also with Parente Randolph. "That's where we see a lot of SNFs go wrong in assuming a resident has had a break in the skilled need," she says.

Take This Proactive Strategy

To avert unnecessary hospitalizations that prevent residents from earning another 100-day benefit period, look at your hospitalization patterns and protocols for referring patients to the hospital.

"Most admissions to the hospital from SNFs are for emergency evaluations," Merlo notes, "so the SNF should definitely look at why residents are being transferred to the hospital." So ask yourself these key questions, Merlo advises: "Is the SNF unable to provide necessary care that one would expect a SNF to manage, such as an acute respiratory condition?

Or is the facility's quality of care causing residents to suffer negative outcomes requiring inpatient hospitalization?"

If the answer is yes in either case, it might be time to suggest some changes for quality assurance purposes, as well as to keep residents from missing out on a new benefit period.

Remember: Only an inpatient hospital stay interrupts the break in the spell of illness. So a trip to the ER or an overnight stay in the hospital observation unit won't count in that regard, if the hospital billed the stay as an outpatient service. "Check to see how the hospital billed the stay - and its impact on the break in the spell of illness - by contacting the hospital or by checking the Common Working File," Merlo advises. "Hospitals typically bill weekly, so if the hospital filed a clean claim that was paid quickly, the SNF could potentially have that information in a couple of weeks, although that's not always the case."

What To Do About Tube Feedings, O2 Therapy

Figuring out whether a resident qualifies for a break in the spell of illness can get tricky when he continues to receive tube feedings or oxygen after he exhausts his 100 days of Medicare SNF coverage.

For example, a resident who requires a feeding tube (usually gastrostomy) won't qualify for a break as long as she receives enough nutrition and fluid to trigger on the MDS [26 percent to 50 percent of calories and 501cc's or more of fluid daily, or 51 percent of caloric intake], cautions **Roberta Reed, MSN, RN**, a consultant with **Howard Wershbale & Co.** in Cleveland, OH. "That's true even though the facility may view the feeding as routine and customary care," she notes.

Yet that same logic doesn't apply to oxygen therapy, which is considered skilled when the resident receiving it requires daily nursing assessment and monitoring of the underlying condition and oxygenation levels. But oxygen becomes a customary and routine service for a medically stable resident who requires it on a chronic basis, Reed says. Thus a resident with COPD, for example, who continually requires oxygen administration could qualify for a 60-day break in the spell of illness, if he doesn't receive any skilled care (based on Medicare criteria) during that time period, Reed says.

In the case of the resident receiving tube feedings, "facilities can try to wean the person to under the threshold for nutritional and fluid intake so he receives the majority of his intake by mouth," says Reed. "This can help the resident earn another 100-day benefit should he need it."

Get Rehab in the Picture

Since dysphagia following a stroke is one of the most common reasons for enteral nutrition, ask the therapy department to evaluate a resident to see if he might improve his swallowing ability with Part B rehab, Reed advises. "Facilities will usually refer the resident for an evaluation if she declines in functional status, but not when the person improves to the extent that she might be able to receive therapy," Reed observes. That's especially important if the therapy was stopped due to the resident's lack of progress or inability to participate (due to cognitive impairment, for example, which has now improved).

Provision of rehab therapy also helps a resident's Medicaid case-mix score in states with RUG or other case-mix based payment, Reed notes. "You can do the quarterly early to capture the therapy even if the resident doesn't have a significant change in status," she adds.