During recent weeks, the Centers for Medicare & Medicaid Services (CMS) has been announcing revisions to its regulatory requirements on a near-daily basis, in an attempt to ease administrative and logistical burdens on providers amid the ongoing COVID-19 pandemic. As such, articles published on one day may later be found to contain outdated information just several days later. RACmonitor.com and ICD10monitor.com are committed to providing comprehensive coverage of these changes as they continue to be made, so please stay tuned as new developments unfold.

The medical treatment of COVID-19 is unlike that of any other disease. The coding and billing rules are unlike those for any other disease. And the discharge challenges are unlike that of any other disease. This is especially evident with the difficulties hospitals are currently experiencing getting patients who require care in a skilled nursing facility (SNF) transferred to a SNF. This is understandable; the first outbreak of COVID-19 was in a SNF in Washington State. Several recent articles in the lay media also highlight the large number of deaths from COVID-19 in SNFs.

When the pandemic began, SNFs developed their own screening criteria for new admissions, often requiring multiple negative COVID-19 tests. This was a high hurdle, especially at a time when tests were nearly unavailable. The U.S. Centers for Disease Control and Prevention (CDC) and Centers for Medicare & Medicaid Services (CMS) have intensified their efforts for both protecting current SNF residents and guiding SNFs in developing rational admission policies. They have also assisted SNFs in creating dedicated COVID-19 wings and SNFs to cohort patients and dedicate staff.

Despite this, many hospitals continue to have trouble placing patients in SNFs, even those without COVID-19. CMS noted in one of its earliest transmittals on the virus that if a hospital inpatient no longer requires hospital care, but an accepting SNF cannot be found, the additional days would be considered medically necessary, and could
be included on the claim for calculation of any outlier payment. While this helps ease some of the uncertainty, the inpatient outlier payment does not kick in until costs exceed the DRG by over $26,000.

In addition, many Medicare patients are hospitalized as outpatients and require SNF care. With the three-day inpatient admission requirement for Part A SNF eligibility waived, these patients are now eligible to be transferred to a SNF from the ED or observation, but often, no accepting SNF can be found. These patients will remain as outpatients, with little or no additional revenue to the hospital for the care they provide, while waiting for a SNF. Fortunately, there are solutions.

If a hospital is fortunate enough to have swing beds, it is simply a matter of discharging the patient from the acute hospital and admitting them as a swing-bed patient. While there was initial confusion about the eligibility of swing beds to use the three-day inpatient stay waiver, CMS has clarified that a three-day inpatient stay is not necessary for use of a swing bed.

For non-swing bed hospitals, every hospital should be in contact with their local SNFs to see what requirements they have set for admissions. If your area has COVID-19 cases, contact your state health department to find out if they are working with the local SNFs to provide capacity for new patients, both COVID-19 and non-COVID-19 patients. The health department should have the resources and the influence to get action that a hospital alone may not have. There are other options to consider as well.

The waivers issued by CMS also include a provision that allows a “facility without walls,” as described in this document. Using this flexibility, a SNF may contract with a hospital to provide care for their COVID-19 patients while they remain in the hospital. The SNF then bills CMS for the care under Part A, and then pays the hospital a negotiated rate. This is commonly known as an “under arrangement” agreement, and is often used in SNFs for services such as physical and occupational therapy. With this agreement, the SNF is responsible for the regulatory requirements, such as the Minimum Data Set (MDS), but the hospital can provide the skilled care the patient requires in an environment with the staffing and resources needed to safely care for COVID-19 patients. The limitation is that as written, this option is limited to COVID-19 patients, and would not apply to non-COVID-19 patients with “ordinary” medical issues that require skilled care.

The other option would be for a hospital to request an individual waiver from CMS to use acute-care beds as swing beds. This would allow the hospital to get the full reimbursement from CMS and admit any patient, but would also require the hospital to meet all the regulatory requirements of swing beds, many of which they have no experience fulfilling. It is unknown which, if any, of these requirements CMS would waive, if they were to grant such a waiver. A third option would be a novel solution from CMS that incorporates elements from all of these other solutions. CMS could allow hospitals to “discharge”
the patient from the acute-care stay and then “admit” them to the same bed and pay them at a “SNF rate,” without requiring the administrative hurdles for swing or SNF beds, such as the MDS. They could do this by allowing the hospital to bill with the swing bed type of bill 181 or another designated bill type and apply the DR condition code to inform the Medicare Administrative Contractor (MAC) that the claim should be paid at the specified rate. CMS is aware of the problems and actively seeking solutions.

With each day of this pandemic comes new challenges. Ensuring that patients get the care they need while providers get the reimbursement to cover that care should be a goal that everyone can support. With cooperation and ingenuity, these goals both can be met.