

*Questions & Answers*  
*CMS*  
*Division of Nursing Homes*  
*Survey and Certification*

**Hurricane Irene  
SNF/NF and MDS Related Questions**

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## Contents

Main Topic	Questions
A. Evacuation to Alternate SNF or Hospital	1. When a SNF evacuates its residents to another SNF or hospital as part of an emergency plan, who should bill for the services?
	2. What is the process for evacuation of SNF residents to hospitals?
B. MDS Assessment and Records	1. What are the requirements for filling out an MDS assessment for evacuated residents?
	2. If the MDS assessments are being completed by the receiving facility consistent with the schedule (so there are no late or missed assessments), will this prevent the “evacuating” facility payment from defaulting to the lowest rate?
	3. Is there information in the <i>Long-Term Care Facility Resident Assessment Instrument User’s Manual, MDS 3.0</i> regarding natural disasters?
	4. MDS Medical Record Information
	5. Electronic Submission of MDS
C. MDS and Payment	1. Do CMS policies about the MDS and payment include Medicare Part A residents?
	2. Where should we direct payment questions regarding SNFs?
D. 1135 Waiver Process	1. What is the process for requesting an 1135(b) waiver?
E. CMS Emergency Links and FAQs	.

## **Hurricane Irene SNF/NF and MDS Related Questions**

### **A. Evacuation to Alternate SNF or Hospital**

#### **A.1 When a SNF evacuates its residents to another SNF or hospital as part of an emergency plan, who should bill for the services?**

If the evacuation is for less than 30 days, a SNF can temporarily transfer its residents to another facility and thus be providing its services “under arrangements.” The transferring SNF need not issue a formal discharge in this situation, as it is still considered the provider and should normally bill Medicare for each day of care. The transferring SNF is then responsible for reimbursing the other provider that accepted its residents during the emergency period. For specific instructions on the procedures to be followed, please review the detailed survey and certification instructions at: [http://www.cms.hhs.gov/SurveyCertEmergPrep/04\\_Resources.asp#TopOfPage](http://www.cms.hhs.gov/SurveyCertEmergPrep/04_Resources.asp#TopOfPage)

We have defined “temporary” as 30 days or less. During this period, the transferring SNF continues to bill Medicare. The transferring SNF is responsible for completing the necessary MDS assessments (either directly or by delegating the function to the receiving facility). The receiving SNF need only complete the clinical assessment portion of the MDS for each evacuated resident, and may do this on a paper MDS form if the electronic MDS is not available. The receiving SNF may then send the paper MDS assessment back to the transferring/evacuating facility. The original transferring/evacuating SNF may transmit the updated MDS at a later date, once the emergency is resolved as long as the MDS was completed timely and within the appropriate observation period.

Alternatively, if there is a “missed MDS assessment” during the emergency, the facilities may agree to accept the default PPS rate for the resident during that time period.

This process does not require the issuance of the 1135(b) waiver.

#### **A.2 What is the process for evacuation of SNF residents to hospitals?**

In situations where the SNF makes arrangements to temporarily evacuate Medicare Part A residents to a hospital, the transferring SNF is responsible for paying the receiving facility. Thus, the transferring SNF is still considered the provider and would be providing services to its residents “under arrangement” in this situation. If the resident/patient does not meet the hospital level of care, there is no mechanism for Medicare to pay the hospital directly.

We have defined “temporary” as 30 days or less. During this period, the transferring SNF continues to bill Medicare. The transferring SNF is responsible for completing the necessary MDS assessments. The transferring SNF may transmit the updated MDS at a later date, once the emergency is resolved as long as the MDS was completed timely and within the appropriate observation period.

This process does not require the issuance of the 1135(b) waiver.

## **B. MDS Assessment and Records**

### **B.1 What are the requirements for filling out an MDS assessment for evacuated residents?**

Under normal circumstances, **or absent implementation of an 1135(b) waiver**, a provider is required to complete a Minimum Data Set (MDS) assessment of a resident within 14 days of admission to the facility or when there has been a significant change in the resident's condition. If 1135(b) waiver authority exists (having been issued by the HHS Secretary following a Presidential Declaration under either the National Emergencies Act or Stafford Act and determination of a Public Health Emergency under Section 319 of the Public Health Services Act the guidance below will apply during the 1135(b) waiver period:

In the case of evacuations, the evacuating facility should determine by day 15 whether or not residents will be able to return to the evacuating facility within 30 days from the date of the evacuation.

If and when the residents return to the evacuating facility within 30 days, the MDS cycle will continue as though the residents were never transferred. This decision places minimal disruption on the staffs' daily routine in caring for all residents. The evacuating facility would then complete the MDS according to the *Long-Term Care Facility Resident Assessment Instrument User's Manual, MDS 3.0* once the residents return to its facility.

When the evacuating facility determines that the residents will not return to the facility within the 30-day time frame, the facility should discharge the resident by completing a discharge assessment whenever possible. The receiving facility will admit the resident (if the actual emergency has resolved, they may also offer alternative choices of other available facilities). Once admitted, the receiving facility will complete an admission MDS (and/or a 5-day MDS) as per the federal participation requirements. The MDS cycle will begin as of the admission date. The discharge/admission date must occur within the previously mentioned 30-day time frame.

If and when the resident returns to the evacuating facility after the 30-day time frame, the receiving facility will discharge the resident and complete a discharge assessment. The evacuating facility will re-admit the resident. The MDS cycle will be established based on the admission assessment.

When residents are transferred to the receiving facility with an anticipated return to the evacuating facility within the 30-day time frame, the evacuating facility may bill Medicare for the services that were provided at the receiving facility. The evacuating facility is responsible for payment to the receiving facility for the services that the receiving facility provides to the evacuated residents. In these cases, the fiscal intermediary will process these claims using the evacuating facility's provider number as if the patients had not been transferred (i.e., are being provided services "under arrangement"). Specific methods for transfer of funds from one facility to another are not determined by Medicare or the fiscal intermediary; these financial arrangements should be made by the facilities among each other.

When a provider is having a problem meeting these requirements, they should contact their State Agency to discuss the situation and receive guidance about any extensions in meeting the required MDS assessment time frames.

**B.2 If the MDS assessments are being completed by the receiving facility consistent with the schedule (so there are no late or missed assessments), will this prevent the "evacuating" facility payment from defaulting to the lowest rate?**

If the MDS assessments are completed timely, the receiving facility may submit them electronically to CMS and follow its normal billing procedures to submit claims to CMS using the RUG-IV group generated from the MDS. The RUG IV rates are based on each resident's clinical condition and are generally much higher than the default rate. All other rules such as the 100-day limitation on SNF benefits still apply.

If the receiving facility does not have access to the resident's demographic or other information needed to complete the MDS electronically, or if connectivity has been damaged and the receiving facility is unable to transmit the MDS, the receiving facility may complete the MDS on a paper form. The receiving facility may then send the paperwork back to the evacuating facility and the evacuating facility may complete and transmit the MDS information. Once the timely MDS has been submitted and accepted, the SNF may bill at the appropriate RUG rate. If electronic submission will be delayed, facilities should contact the State Survey Agency to notify them that the transmission will not arrive on time.

### **B.3 Is there information in the *Long-Term Care Facility Resident Assessment Instrument User's Manual, MDS 3.0* regarding natural disasters?**

The following information is found in Chapter 2, section 2.3 on page 2-5 of the MDS 3.0 RAI Manual (Version 1.07):

- When there has been a transfer of residents as a result of a natural disaster(s) (e.g., flood, earthquake, fire) with an **anticipated return** to the facility, the evacuating facility should contact their Regional Office, State agency, and Medicare contractor for guidance.
- When there has been a transfer as a result of a natural disaster(s) (e.g., flood, earthquake, fire) and it has been determined that the resident will not return to the evacuating facility, the evacuating provider will discharge the resident **return not anticipated** and the receiving facility will admit the resident, with the MDS cycle beginning as of the admission date to the receiving facility. For questions related to this type of situation, providers should contact their State Agency, Regional Office, and Medicare contractor for guidance.

### **B.4 MDS Medical Record Information**

Skilled nursing facility residents in the public health emergency area may be evacuated to other nursing homes without their medical history. The Minimum Data Set (MDS) may be the primary source of medical record information for many of these residents. Providers accepting such residents may submit requests for consideration to obtain information available on the residents' MDS record by contacting the QIES Help Desk at 888-477-7876.

### **B.5 Electronic Submission of MDS**

During a disaster, the electronic MDS submission may not be possible by the evacuated facilities. If the MDS database is lost or destroyed, facilities may contact the QIES Help Desk at 888-477-7876 for assistance. Note: CMS is unable to restore data unless the provider previously submitted the data to the Federal data submission system.

## **C. MDS and Payment**

### **C.1 Do CMS policies about the MDS and payment include Medicare Part A residents?**

This policy applies ONLY to Medicare Part A residents. The State Medicaid department should be contacted to find out how they will reimburse receiving facilities for Medicaid patients. Similarly, if any residents are covered under another insurer, the receiving facility needs to get instructions from that third party payer on the procedures to follow.

### **C2. Where should we direct payment questions regarding SNFs?**

Medicare FFS emergency policies and procedures are located at:

[http://www.cms.gov/Emergency/Downloads/Consolidated\\_Medicare\\_FFS\\_Emergency\\_QsAs.pdf](http://www.cms.gov/Emergency/Downloads/Consolidated_Medicare_FFS_Emergency_QsAs.pdf)  
<http://www.cms.gov/Emergency/downloads/MedicareFFS-EmergencyQsAs1135Waiver.pdf>

See CMS Response to the North Dakota and Minnesota Storms/Flooding Emergencies – Medicare Fee-For-Service, Question and Answer link:

<http://www.cms.gov/Emergency/Downloads/NorthDakotaMinnesotaEmergencyMedicareFFSPolicy.pdf>, Skilled Nursing Facility (SNF), beginning on page 11.

In addition, facilities should contact their State Survey Agency or Regional Office for information.

## **D. 1135(b) Waiver Process**

### **D.1 What is the process for requesting an 1135(b) waiver?**

Before section 1135(b) waiver authority can be invoked, there must be two separate federal declarations of emergency or disaster:

First, a Presidential Declaration under either the National Emergencies Act or Stafford Act and a second, a Secretarial Declaration of a Public Health Emergency (PHE) under Section 319 of Public Health Services Act.

The Secretary may then choose to authorize waivers/modifications of one or more of the requirements described in section 1135(b) of the Social Security Act.

Once an 1135(b) waiver is authorized, health care providers can submit requests to operate under that authority or for other relief that may be possible outside that authority to the CMS Regional Office with a copy to the State Survey Agency. Requests may be made by sending an email to the CMS Regional Office in your service area. Email addresses are listed below. Information on your facility and justification for requesting the waiver will be required.

[ROATLHSQ@cms.hhs.gov](mailto:ROATLHSQ@cms.hhs.gov) (Atlanta RO): Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, Tennessee

[RODALDSC@cms.hhs.gov](mailto:RODALDSC@cms.hhs.gov) (Dallas RO): Arkansas, Louisiana, New Mexico, Oklahoma, Texas

[ROPHIDSC@cms.hhs.gov](mailto:ROPHIDSC@cms.hhs.gov) (Northeast Consortium): Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, West Virginia, New York, New Jersey, Puerto Rico, Virgin Islands, Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont

[ROCHISC@cms.hhs.gov](mailto:ROCHISC@cms.hhs.gov) (Midwest Consortium): Illinois, Indiana, Michigan, Minnesota, Ohio, Wisconsin, Iowa, Kansas, Missouri, Nebraska

[ROSFOSO@cms.hhs.gov](mailto:ROSFOSO@cms.hhs.gov) (Western Consortium): Colorado, Montana, North Dakota, South Dakota, Utah, Wyoming, Alaska, Idaho, Oregon, Washington, Arizona, California, Hawaii, Nevada, Pacific Territories.

## **E. CMS Emergency Links and FAQs**

### **-All Hazards FAQ:**

<http://www.cms.gov/SurveyCertEmergPrep/downloads/AllHazardsFAQs.pdf>

### **-General information on Emergencies and Emergency Specific FAQs:**

<http://www.cms.hhs.gov/SurveyCertEmergPrep/>

### **-FFS Emergency FAQs and other recent disaster specific FAQs (includes FFS waivers with and without 1135 waiver policy, recent hurricanes)**

<http://www.cms.gov/Emergency/>