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INTRODUCTION

Dear Medicare Patient:

The Center for Medicare Advocacy has produced this packet to help you understand Medicare coverage and how to file an appeal if appropriate.

Medicare is the national health insurance program to which many disabled individuals and most older people are entitled under the Social Security Act. All too often, Medicare claims are erroneously denied. It is your right to appeal an unfair denial; we urge you to do so.

If you have any questions you can contact the Center for Medicare Advocacy at (860) 456-7790.
HOW TO USE THIS PACKET

We’ve organized this packet so that it provides you with the information needed to successfully appeal a skilled nursing facility (nursing home) decision to discontinue Medicare Part A skilled nursing coverage. We suggest you take the following steps:

1. Read the Quick Screen and the General Description of a Skilled Nursing Facility Expedited Appeal included in this packet.

2. Once you receive the notice letting you know that Medicare coverage will end, call the 1-800 number provided on the notice by noon of the next calendar day. It’s very important that you do not miss this step.

3. Ask the nursing home for a copy of the patient’s medical records. Review the records for helpful information and share that information with the patient’s community physicians.

4. Gather support from the patient’s community physicians regarding the medical necessity of the daily skilled nursing home care.

5. If you have questions, contact the Center for Medicare Advocacy at 860-456-7790.
Q U I C K S C R E E N

WHEN SHOULD MEDICARE COVERAGE BE AVAILABLE
FOR SKILLED NURSING FACILITY (SNF) CARE

A Medicare SNF claim suitable for appeal should meet the following criteria:

1. The patient must have been hospitalized for at least three days (not including day of discharge), and, in most cases, must have been admitted to the SNF within 30 days of hospital discharge.

2. A physician must certify that the patient needs SNF care.

3. The beneficiary must require "skilled nursing or skilled rehabilitation services, or both, on a daily basis." Skilled nursing and skilled rehabilitation services are those which require the skills of technical or professional personnel such as registered nurses, licensed practical nurses, physical therapists, and occupational therapists. In order to be deemed skilled the service must be so inherently complex that it can be safely and effectively performed only by, or under the supervision of, professional or technical personnel.

4. The skilled nursing facility must be a Medicare-certified facility.

OTHER IMPORTANT POINTS:

1. The restoration potential of a patient is not the deciding factor in determining whether skilled services are needed. Skilled services to maintain a patient’s condition can be covered.

2. The management of a plan involving only a variety of "custodial" personal care services is skilled when, in light of the patient's condition, the aggregate of those services requires the involvement of skilled personnel.

3. The requirement that a patient receive "daily" skilled services will be met if skilled rehabilitation services are provided five days per week.
4. Examples of skilled services:
   a. Overall management and evaluation of care plan;
   b. Observation and assessment of the patient's changing condition;
   c. Levin tube and gastrostomy feedings;
   d. Ongoing assessment of rehabilitation needs and potential;
   e. Therapeutic exercises or activities;
   f. Gait evaluation and training.

5. The doctor is the patient's most important ally. If it appears that Medicare coverage will be denied, ask the doctor to help demonstrate that the standards described above are met.

6. If the nursing home issues a notice saying Medicare coverage is not available and the patient seems to satisfy the criteria above, ask the nursing home to submit a claim for a formal Medicare coverage determination. The nursing home must submit a claim if the patient or representative requests; the patient is not required to pay until he/she receives a formal determination from Medicare.

7. If the nursing home proposes to totally terminate all Medicare covered services or to discharge the patient from the skilled nursing facility, they must issue a written notice offering you a “fast-track” or “expedited” review of their proposed action. This review will be conducted by a “qualified independent contractor” [in Connecticut, the entity is known as Qualidigm]. The patient or his/her helper can request the “fast-track” or “expedited” review, by following the instructions on the notice given to the patient or his/her helper by the skilled nursing facility.

8. Don't be satisfied with a Medicare determination unreasonably limiting coverage; appeal for the benefits the patient deserves.
A BRIEF SUMMARY OF MEDICARE COVERAGE FOR SKILLED NURSING FACILITY CARE AND THE IMPROVEMENT MYTH

Medicare is the national health insurance program to which all Social Security recipients who are either at least 65 years old or are permanently disabled are entitled. In addition, individuals receiving Railroad Retirement benefits and individuals with End Stage Renal Disease (ESRD) or Amyotrophic Lateral Sclerosis (ALS) are eligible to receive Medicare benefits. Medicare was established in 1965 by Title 18 of the Social Security Act. 42 USC§1395 et seq.

Private Medicare plans are known as "Medicare Advantage" (MA) plans. Although the Medicare Advantage system is different from the original Medicare program, Medicare Advantage plan benefits are required to be identical to, or more generous than, those in the original program.

THE MEDICARE “IMPROVEMENT MYTH”

There is a long standing myth that Medicare coverage is not available for beneficiaries who have an underlying condition from which they will not improve. This is not true. In fact, the notion of "improvement" is only mentioned once in the Medicare Act – and it is not about coverage for nursing home care.

As an overarching principle, the Medicare Act states that no payment will be made except for items and services that are "reasonable and necessary for the diagnosis or treatment of an illness or injury, or to improve the functioning of a malformed body member.” 42 USC §1395y(a)(1)(A). While it is not clear what a "malformed body member" is, clearly this language does not limit Medicare coverage only to services, diagnoses or treatments that will improve illness or injury. Yet, in practice, beneficiaries are often denied coverage on the grounds that they are not likely to improve, or are "stable", or "chronic," or require "maintenance services only." These are not legitimate reasons for Medicare denials.

This issue was finally resolved in federal court in Jimmo vs. Sebelius, (D. VT, 1/24/2013). In Jimmo the judge approved a Settlement stating that Medicare coverage for nursing home care does not depend on the individual’s potential for improvement, but rather on his or her need for skilled care – which can be to maintain or slow deterioration of the individual’s condition.
MEDICARE COVERAGE FOR NURSING HOME (SKILLED NURSING FACILITY) CARE

Medicare provides limited coverage for nursing home care for a limited period of time. For Medicare coverage purposes, nursing homes are referred to as skilled nursing facilities (abbreviated as SNF). The SNF benefit is available for a short time at best – for up to 100 days during each spell of illness. 42 USC §1395d(a)(2)(A).

If Medicare coverage requirements are met, the patient is entitled to full coverage of the first 20 days of SNF care. From the 21st through the 100th day, Medicare pays for all covered services except for a daily coinsurance amount. Beneficiaries in traditional Medicare are not entitled to any Medicare SNF coverage unless they were hospitalized for at least three days prior to the SNF admission and, usually, they must be admitted to the SNF within 30 days of the hospital discharge. 42 USC §1395x(i). Further, SNF patients must require daily skilled nursing or rehabilitation to qualify for Medicare coverage. 42 USC §1395f(a)(2)(B).

There are certain requirements that must be met for an individual to receive Medicare skilled nursing facility coverage. These requirements include:

1. A physician must certify that the patient needs skilled nursing facility care; and

2. The beneficiary must generally be admitted to the SNF within 30 days of a 3-day qualifying hospital stay; and

3. The beneficiary must require daily skilled nursing or rehabilitation; and

4. The care needed by the patient must, as a practical matter, only be available in a skilled nursing facility on an inpatient basis; and

5. The skilled nursing facility must be a Medicare-certified provider.

See: 42 USC §1395f(a)(2)(B); 42 USC §1395x(h) - (i).

If coverage is available, the benefit for SNF care is intended to cover all the services generally available in a SNF, including:

- Nursing care provided by registered professional nurses,
- Bed and board,
- Physical therapy,
- Occupational therapy,
- Speech therapy,
- Medical social services,
- Drugs, biologicals
- Supplies,
- Equipment, and
- Other services necessary to the health of the patient.

42 USC §1395x(h).
Examples of services recognized as skilled by the Medicare SNF benefit include the following:

- Overall management and evaluation of care plan;
- Observation and assessment of the patient's changing condition;
- Patient education services;
- Levin tube and gastrostomy feedings;
- Ongoing assessment of rehabilitation needs and potential;
- Therapeutic exercises or activities;
- Gait evaluation and training.

42 CFR §409.33

Unfortunately, Medicare coverage is often denied to individuals who qualify under the law. In particular, beneficiaries are often denied coverage because they have certain chronic conditions such as Alzheimer's disease, Parkinson's disease, and multiple sclerosis, or because they need nursing or therapy "only" to maintain their condition. Again, these are not legitimate reasons for Medicare denials.

The question to ask is does the patient meet the qualifying criteria listed above and need skilled nursing and/or therapy on a daily basis – not does the patient have a particular disease or will she recover.

**IMPORTANT ADVOCACY TIPS**

1. The restoration potential of a patient is not the deciding factor in determining whether skilled services are needed.
   42 USC §409.32(c); CMS Policy Manual 100-02, Chapter 8, §30.2.2.

2. Medicare recognizes that skilled care can be required to maintain an individual’s condition or functioning, or to slow or prevent deterioration.
   42 CFR §409.32(c)
   - Including physical therapy to maintain the individual’s condition or function. 42 CFR §409.33(c)(5)

3. The doctor is the patient's most important ally. Ask the doctor to help demonstrate that the standards described above are met. In particular, ask the individual’s doctor to state in writing why skilled services are required.

4. The management of a plan involving only a variety of "custodial" personal care services is skilled when, in light of the patient's condition, the aggregate of those services requires the involvement of skilled personnel.

5. The requirement that a patient receive "daily" skilled services will be met if skilled rehabilitation services (physical, speech or occupational therapy) are provided five days per week.
If a nursing home or Medicare Advantage plan says Medicare coverage is not available and the patient seems to satisfy the criteria above, ask the nursing home to submit a claim for a formal Medicare coverage determination. The nursing home must submit a claim if the patient or representative requests; the patient is not required to pay until he/she receives a formal determination from Medicare.

**CONCLUSION**

Medicare coverage for nursing home care is limited – it is only available for 100 days per benefit period and only if the individual needs skilled care. However, under the law, *Medicare coverage is not limited to services that will improve the individual's condition*. Coverage can be available for items and services needed to maintain the person's condition or to arrest or retard further deterioration.

Medicare coverage is often erroneously denied for individuals with chronic conditions, for people who are not improving, or who are in need of services to maintain their condition. *It is not necessary for the individual’s underlying condition to improve to qualify for Medicare coverage!* The Medicare program has an appeal system to contest such denials. Beneficiaries and their advocates should use this system to appeal Medicare determinations that unfairly deny or limit coverage.

For more information about Medicare coverage, appeals, and related topics visit the Center for Medicare Advocacy's web site at [www.medicareadvocacy.org](http://www.medicareadvocacy.org).
MEDICARE EXPEDITED APPEAL
General Description of a Skilled Nursing Facility (SNF) Appeal

**Typical Scenario:** You are a Medicare beneficiary who is receiving medical care in a nursing home (skilled nursing facility). Medicare Part A is paying for this care because you receive it on a daily basis and because it must be provided by a skilled professional (a nurse or a physical, occupational or speech therapist). You are told that the care will be discontinued because you have “plateaued,” returned to “baseline,” are “maintenance only,” or require only “custodial care.” Once the care is stopped, your stay at the nursing home (including room and board) will no longer be paid for by Medicare. You are not ready to go home and you believe you will benefit from more daily skilled care.

**Action Steps:** Medicare is an insurance program; it only pays for care that has been provided, it does not pay for care that should have been provided. In other words, once your care is discontinued, it will be essentially impossible to remedy the problem with a Medicare appeal. So the first order of business is to keep the care in place. The best way to keep care in place is an expedited (fast) appeal with support from your community physician (regular doctor). Review the Quick Screen for SNF care, included in this packet, to see if your care seems to qualify for Medicare coverage. Remember that skilled care can be covered when it is necessary to maintain or improve your condition, not just when improvement is expected.

1. **How to Do an Expedited Appeal**

Beneficiaries in traditional Medicare have a legal right to an expedited appeal when nursing homes plan to discharge them or discontinue daily skilled care. This right is often triggered when the nursing home plans to stop providing physical, occupational, or speech therapy five days a week. However, it is also triggered when the facility believes that the patient no longer requires skilled nursing care seven days a week.

The Medicare rules require that the nursing home gives you (or your representative) a standardized notice at least two days prior to the last day of covered care. This standardized notice is called a “Notice of Medicare Provider Non-Coverage.” It is also referred to as a “generic notice.” The notice must include the date that coverage of care ends, the date you will become financially responsible for a continued stay at the nursing home, and a description of your right to an expedited determination. To prevent the discontinuation of Medicare covered care, take the following action steps.
Step One

Read the standardized (generic) notice. It will contain the telephone number for your state’s Quality Improvement Organization (QIO). To start the expedited appeal, you or your representative must contact the QIO by no later than noon of the calendar day following receipt of the standardized notice. You can do this in writing or by telephone. Once the contact is made, the nursing home should give you a more specific notice which will include a detailed explanation as to why it believes the Medicare covered care should end a description of any applicable Medicare coverage rules and information about how to obtain them, and other facts specific to your case.

After you contact the QIO, it is supposed to make its decision about Medicare coverage within 72 hours. Prior to making a decision, the QIO must review your medical records, give the nursing home an opportunity to explain why it believes the discontinuation of care is appropriate, and get your opinion. Legally, the nursing home must prove its decision to discharge you from covered care is correct. However, you should be prepared to explain to the QIO why it is you continue to need ongoing care. For instance, you may continue to need daily physical therapy because your home has stairs and you have not yet regained the strength and coordination necessary to climb stairs.

Step Two

While the QIO is gathering information for its decision, gather support for your case. It would be helpful to have one or more of your community physicians contact the nursing home physician. A community physician may be able to explain to the facility’s physician why your care continues to be medically reasonable and necessary. Additionally, ask your community physician to submit a written statement to the QIO explaining why you continue to need daily skilled medical care and ask that he or she make him or herself available to the QIO by telephone to answer questions.

Step Three

You have a legal right to review your medical record. At your request or the request of your representative, the facility must give you a copy of or access to any documentation it sends to the QIO, including records of any information provided by telephone. The facility may, however, charge you the cost of copying and sending documents. Some states, including Connecticut and Massachusetts, prohibit providers from billing patients for copies of their medical records when they are appealing Medicare denials of coverage. The facility must honor your request by no later than close of business of the first day after the material is requested. This information can be very helpful in supporting the medical need for the continuation of your care and in assisting your community physician with understanding your current medical condition. If you get these records, be sure to give a copy to your community physician.

If the QIO agrees with you, you will continue to get your daily Medicare covered care. However, if the QIO agrees with the nursing home, you will be financially responsible for your continued stay at the nursing home. You do, however, have the right to another appeal, an “expedited reconsideration.” Expedited reconsiderations are performed by an organization called the Qualified Independent Contractor (QIC). If the QIO decided that Medicare coverage should end, it should give you the telephone number for the QIC.
Step Four

If the QIO ruled against you and you wish to continue your appeal, you or your representative must call the QIC no later than noon of the calendar day following notification by the QIO of its decision.

Ordinarily, the QIC must tell you its decision within 72 hours of receipt of your call and any medical or other records needed for an expedited reconsideration. You have the right to extend this period to up to 14 days so that you can gather medical records and prepare your argument.

Step Five

If you did not get your medical records during the QIO review, you can get them at this stage. You can request them from the QIO who must send you a copy of or give you access to any documentation it sent to the QIC. The QIO may charge for the cost of duplicating documents and for the cost of delivery. The QIO must comply with your request no later than close of business of the first day after your request for the documents. If you were not able to submit support from your community physician to the QIO, at this second stage of the appeal process, it is a good idea to use the 14 day extension to get and submit that support. If you get your medical records, be sure and share them with your doctor.

If the QIC agrees with you, you will continue to get your daily care and it will be covered by Medicare. In the event that the QIC believes that your care is no longer medically reasonable and necessary, then you have the right to an Administrative Law Judge (ALJ) hearing. The QIC should send you a written copy of its decision with information about how to request an ALJ hearing.

Step Six

ALJ hearings and decisions are not expedited. This means that you may have to wait a long time (several months) before you can have a hearing. You must request the hearing within 60 days of notice from the QIC that it has denied Medicare coverage for your care. The ALJ is supposed to issue a decision within 90 days of receipt of the request for hearing. Unfortunately, if you started your appeal to keep nursing or therapy services in place, and the care has already stopped, this level of appeal has little value. This is because it will probably be several months before the judge hears your case and issues a decision and because even if the judge agrees with you that care should not have been discontinued, you may have gone a long time without covered services. Additionally, there will probably be legal hurdles preventing the ALJ from authorizing additional coverage of your care.

If you request an ALJ hearing, and continue to get care at the nursing home, you are financially responsible for the ongoing care until the ALJ writes a favorable decision. If the ALJ issues an unfavorable decision, you will remain financially responsible for the continued care. The ALJ’s decision will tell you how to file the last administrative appeal with the Medicare Appeals Council.
2. Other Ways to Get Medicare Covered Care

**In the Nursing Home**

In the event that you are not successful with your expedited appeal, it is still possible to get more Medicare covered therapy or nursing so long as the daily skilled care is started again within thirty days of your last Medicare covered day and you still have days available within the benefit period (there are up to 100 skilled nursing facility days per benefit period). So be sure to have your community physician, if willing, educate the nursing home’s physician as to why you still need daily therapy or nursing. You might also ask your community physician to talk to the nursing home physician about ordering another form of therapy, for instance occupational therapy on a daily basis. Occupational therapists work with patients on many of the skills necessary for independent living. Daily occupational therapy or a combination of physical and occupational therapy can trigger further Part A skilled nursing facility coverage.

If the nursing home physician will not order daily therapy, he or she might order therapy intermittently (less than 5 days a week). If you get therapy less than five days a week, Medicare Part B will pay for the care, but not your room and board at the nursing home.

Alternatively, if, after receiving the QIC’s decision you plan to stay in the nursing home and you are receiving daily *skilled* nursing care or seven days a week of nursing and therapy combined, you definitely *should* exercise your right to a standard Medicare appeal. Note that Medicare will only cover nursing care in a nursing home if you need it seven days a week and if it is skilled care. Skilled care is care that is so *inherently complex* that it must be done by a skilled professional. Unfortunately, Medicare does not cover care in a nursing home when it is only a “custodial.” Examples of custodial care include the administration of medications or assisting a patient with bathing or toileting. To begin a standard appeal, you need to have the nursing home submit a demand bill. Call the Center for Medicare Advocacy regarding how to make this request.

**At Home**

If you feel you are safe to return home, you might speak to the nursing home physician or your community physician about ordering home health care services. Among other services, physical therapy, occupational therapy, skilled nursing, and home health aide care are all available under the Medicare home health benefit. With this additional care in the home, you may still reach your full potential and begin living independently once again.

3. Conclusion

The best way to keep skilled care in place is to exercise your expedited appeal rights. You are most likely to succeed if you have the support of your community physician. Should you have questions about this process, please call the Center for Medicare Advocacy’s Connecticut office at (800) 262-4414 or our office in Washington, D.C. at (202) 293-5760.
Posthospital SNF care, including SNF-type care furnished in a hospital or CAH that has a swing-bed approval, is covered only if the beneficiary meets the requirements of this section and only for days when he or she needs and receives care of the level described in § 409.31. A beneficiary in an SNF is also considered to meet the level of care requirements of § 409.31 up to and including the assessment reference date for the 5-day assessment prescribed in § 413.343(b) of this chapter, when assigned to one of the Resource Utilization Groups that is designated (in the annual publication of Federal prospective payment rates described in § 413.345 of this chapter) as representing the required level of care. For the purposes of this section, the assessment reference date is defined in accordance with § 483.315(d) of this chapter, and must occur no later than the eighth day of posthospital SNF care.

(a) Pre-admission requirements. The beneficiary must--

1 Have been hospitalized in a participating or qualified hospital or participating CAH, for medically necessary inpatient hospital or inpatient CAH care, for at least 3 consecutive calendar days, not counting the date of discharge; and

2 Have been discharged from the hospital or CAH in or after the month he or she attained age 65, or in a month for which he or she was entitled to hospital insurance benefits on the basis of disability or end-stage renal disease, in accordance with part 406 of this chapter.

(b) Date of admission requirements. [FN1]

Before December 5, 1980, the law required that admission and receipt of care be within 14 days after discharge from the hospital or CAH and permitted admission up to 28 days after discharge if a SNF bed was not available in the geographic area in which the patient lived, or at the time it would be medically appropriate to begin an active course of treatment, if SNF care would not be medically appropriate within 14 days after discharge.

(1) Except as specified in paragraph (b)(2) of this section, the beneficiary must be in need of posthospital SNF care, be admitted to the facility, and receive the needed care within 30 calendar days after the date of discharge from a hospital or CAH.

(2) The following exceptions apply--

(i) A beneficiary for whom posthospital SNF care would not be medically appropriate within 30 days after discharge from the hospital or CAH, or a beneficiary enrolled in a Medicare+Choice (M+C) plan, may be admitted at the time it would be medically appropriate to begin an active course of treatment.
(ii) If, upon admission to the SNF, the beneficiary was enrolled in an M+C plan, as defined in § 422.4 of this chapter, offering the benefits described in § 422.101(c) of this chapter, the beneficiary will be considered to have met the requirements described in paragraphs (a) and (b) of this section, and also in § 409.31(b)(2), for the duration of the SNF stay.

§ 409.31 Level of care requirement.

(a) Definition. As used in this section, skilled nursing and skilled rehabilitation services means services that:

(1) Are ordered by a physician;

(2) Require the skills of technical or professional personnel such as registered nurses, licensed practical (vocational) nurses, physical therapists, occupational therapists, and speech pathologists or audiologists; and

(3) Are furnished directly by, or under the supervision of, such personnel.

(b) Specific conditions for meeting level of care requirements.

(1) The beneficiary must require skilled nursing or skilled rehabilitation services, or both, on a daily basis.

(2) Those services must be furnished for a condition--

(i) For which the beneficiary received inpatient hospital or inpatient CAH services; or

(ii) Which arose while the beneficiary was receiving care in a SNF or swing-bed hospital for a condition for which he or she received inpatient hospital or inpatient CAH services; or

(iii) For which, for an M+C enrollee described in § 409.20(c)(4), a physician has determined that a direct admission to a SNF without an inpatient hospital or inpatient CAH stay would be medically appropriate.

(3) The daily skilled services must be ones that, as a practical matter, can only be provided in a SNF, on an inpatient basis.

§ 409.32 Criteria for skilled services and the need for skilled services.

(a) To be considered a skilled service, the service must be so inherently complex that it can be safely and effectively performed only by, or under the supervision of, professional or technical personnel.

(b) A condition that does not ordinarily require skilled services may require them because of special medical complications. Under those circumstances, a service that is usually nonskilled (such as those listed in § 409.33(d)) may be considered skilled because it must be performed or supervised by skilled nursing or rehabilitation personnel. For example, a plaster cast on a leg does not usually require skilled care. However, if the patient has a preexisting acute skin
condition or needs traction, skilled personnel may be needed to adjust traction or watch for complications. In situations of this type, the complications, and the skilled services they require, must be documented by physicians' orders and nursing or therapy notes.

(c) The restoration potential of a patient is not the deciding factor in determining whether skilled services are needed. Even if full recovery or medical improvement is not possible, a patient may need skilled services to prevent further deterioration or preserve current capabilities. For example, a terminal cancer patient may need some of the skilled services described in § 409.33.

§ 409.33 Examples of skilled nursing and rehabilitation services.

(a) Services that could qualify as either skilled nursing or skilled rehabilitation services--

(1) Overall management and evaluation of care plan.

(i) When overall management and evaluation of care plan constitute skilled services. The development, management, and evaluation of a patient care plan based on the physician's orders constitute skilled services when, because of the patient's physical or mental condition, those activities require the involvement of technical or professional personnel in order to meet the patient's needs, promote recovery, and ensure medical safety. Those activities include the management of a plan involving a variety of personal care services only when, in light of the patient's condition, the aggregate of those services requires the involvement of technical or professional personnel.

(ii) Example. An aged patient with a history of diabetes mellitus and angina pectoris who is recovering from an open reduction of a fracture of the neck of the femur requires, among other services, careful skin care, appropriate oral medications, a diabetic diet, an exercise program to preserve muscle tone and body condition, and observation to detect signs of deterioration in his or her condition or complications resulting from restricted, but increasing, mobility. Although any of the required services could be performed by a properly instructed person, such a person would not have the ability to understand the relationship between the services and evaluate the ultimate effect of one service on the other. Since the nature of the patient's condition, age, and immobility create a high potential for serious complications, such an understanding is essential to ensure the patient's recovery and safety. Under these circumstances, the management of the plan of care would require the skills of a nurse even though the individual services are not skilled. Skilled planning and management activities are not always specifically identified in the patient's clinical record. Therefore, if the patient's overall condition supports a finding that recovery and safety can be ensured only if the total care is planned, managed, and evaluated by technical or professional personnel, it is appropriate to infer that skilled services are being provided.

(2) Observation and assessment of the patient's changing condition—

(i) When observation and assessment constitute skilled services. Observation and assessment constitute skilled services when the skills of a technical or professional person are required to identify and evaluate the patient's need for modification of treatment or for additional medical procedures until his or her condition is stabilized.
(ii) Examples. A patient with congestive heart failure may require continuous close observation to detect signs of decompensation, abnormal fluid balance, or adverse effects resulting from prescribed medication(s) that serve as indicators for adjusting therapeutic measures. Similarly, surgical patients transferred from a hospital to an SNF while in the complicated, unstabilized postoperative period, for example, after hip prosthesis or cataract surgery, may need continued close skilled monitoring for postoperative complications and adverse reaction. Patients, who in addition to their physical problems, exhibit acute psychological symptoms such as depression, anxiety, or agitation, may also require skilled observation and assessment by technical or professional personnel to ensure their safety or the safety of others, that is, to observe for indications of suicidal or hostile behavior. The need for services of this type must be documented by physicians’ orders or nursing or therapy notes.

(3) Patient education services--

(i) When patient education services constitute skilled services. Patient education services are skilled services if the use of technical or professional personnel is necessary to teach a patient self-maintenance.

(ii) Examples. A patient who has had a recent leg amputation needs skilled rehabilitation services provided by technical or professional personnel to provide gait training and to teach prosthesis care. Similarly, a patient newly diagnosed with diabetes requires instruction from technical or professional personnel to learn the self-administration of insulin or foot-care precautions.

(b) Services that qualify as skilled nursing services.

(1) Intravenous or intramuscular injections and intravenous feeding.

(2) Enteral feeding that comprises at least 26 per cent of daily calorie requirements and provides at least 501 milliliters of fluid per day.

(3) Nasopharyngeal and tracheostomy aspiration;

(4) Insertion and sterile irrigation and replacement of suprapubic catheters;

(5) Application of dressings involving prescription medications and aseptic techniques;

(6) Treatment of extensive decubitus ulcers or other widespread skin disorder;

(7) Heat treatments which have been specifically ordered by a physician as part of active treatment and which require observation by nurses to adequately evaluate the patient’s progress;

(8) Initial phases of a regimen involving administration of medical gases;

(9) Rehabilitation nursing procedures, including the related teaching and adaptive aspects of nursing that are part of active treatment, e.g., the institution and supervision of bowel and bladder training programs.
(c) Services which would qualify as skilled rehabilitation services.

(1) Ongoing assessment of rehabilitation needs and potential: Services concurrent with the management of a patient care plan, including tests and measurements of range of motion, strength, balance, coordination, endurance, functional ability, activities of daily living, perceptual deficits, speech and language or hearing disorders;

(2) Therapeutic exercises or activities: Therapeutic exercises or activities which, because of the type of exercises employed or the condition of the patient, must be performed by or under the supervision of a qualified physical therapist or occupational therapist to ensure the safety of the patient and the effectiveness of the treatment;

(3) Gait evaluation and training: Gait evaluation and training furnished to restore function in a patient whose ability to walk has been impaired by neurological, muscular, or skeletal abnormality;

(4) Range of motion exercises: Range of motion exercises which are part of the active treatment of a specific disease state which has resulted in a loss of, or restriction of, mobility (as evidenced by a therapist's notes showing the degree of motion lost and the degree to be restored);

(5) Maintenance therapy: Maintenance therapy, when the specialized knowledge and judgment of a qualified therapist is required to design and establish a maintenance program based on an initial evaluation and periodic reassessment of the patient's needs, and consistent with the patient's capacity and tolerance. For example, a patient with Parkinson's disease who has not been under a rehabilitation regimen may require the services of a qualified therapist to determine what type of exercises will contribute the most to the maintenance of his present level of functioning.

(6) Ultrasound, short-wave, and microwave therapy treatment by a qualified physical therapist;

(7) Hot pack, hydrocollator, infrared treatments, paraffin baths, and whirlpool; Hot pack hydrocollator, infrared treatments, paraffin baths, and whirlpool in particular cases where the patient's condition is complicated by circulatory deficiency, areas of desensitization, open wounds, fractures, or other complications, and the skills, knowledge, and judgment of a qualified physical therapist are required; and

(8) Services of a speech pathologist or audiologist when necessary for the restoration of function in speech or hearing.

(d) Personal care services. Personal care services which do not require the skills of qualified technical or professional personnel are not skilled services except under the circumstances specified in § 409.32(b). Personal care services include, but are not limited to, the following:

(1) Administration of routine oral medications, eye drops, and ointments;

(2) General maintenance care of colostomy and ileostomy;
(3) Routine services to maintain satisfactory functioning of indwelling bladder catheters;

(4) Changes of dressings for noninfected postoperative or chronic conditions;

(5) Prophylactic and palliative skin care, including bathing and application of creams, or treatment of minor skin problems;

(6) Routine care of the incontinent patient, including use of diapers and protective sheets;

(7) General maintenance care in connection with a plaster cast;

(8) Routine care in connection with braces and similar devices;

(9) Use of heat as a palliative and comfort measure, such as whirlpool and hydrocollator;

(10) Routine administration of medical gases after a regimen of therapy has been established;

(11) Assistance in dressing, eating, and going to the toilet;

(12) Periodic turning and positioning in bed; and

(13) General supervision of exercises which have been taught to the patient; including the actual carrying out of maintenance programs, i.e., the performance of the repetitive exercises required to maintain function do not require the skills of a therapist and would not constitute skilled rehabilitation services (see paragraph (c) of this section). Similarly, repetitious exercises to improve gait, maintain strength, or endurance; passive exercises to maintain range of motion in paralyzed extremities, which are not related to a specific loss of function; and assistive walking do not constitute skilled rehabilitation services.

§ 409.34 Criteria for “daily basis”.

(a) To meet the daily basis requirement specified in § 409.31(b)(1), the following frequency is required:

(1) Skilled nursing services or skilled rehabilitation services must be needed and provided 7 days a week; or

(2) As an exception, if skilled rehabilitation services are not available 7 days a week those services must be needed and provided at least 5 days a week.

(b) A break of one or two days in the furnishing of rehabilitation services will not preclude coverage if discharge would not be practical for the one or two days during which, for instance, the physician has suspended the therapy sessions because the patient exhibited extreme fatigue.
§ 409.35 Criteria for “practical matter”.

(a) General considerations. In making a “practical matter” determination, as required by § 409.31(b)(3), consideration must be given to the patient's condition and to the availability and feasibility of using more economical alternative facilities and services. However, in making that determination, the availability of Medicare payment for those services may not be a factor. Example: The beneficiary can obtain daily physical therapy from a physical therapist in independent practice. However, Medicare pays only the appropriate portion (after deduction of applicable deductible and coinsurance amounts) of the first $500 of services furnished by such a practitioner in a year. This limitation on payment may not be a basis for finding that the needed care can only be provided in a SNF.

(b) Examples of circumstances that meet practical matter criteria--

(1) Beneficiary's condition. Inpatient care would be required “as a practical matter” if transporting the beneficiary to and from the nearest facility that furnishes the required daily skilled services would be an excessive physical hardship.

(2) Economy and efficiency. Even if the beneficiary's condition does not preclude transportation, inpatient care might be more efficient and less costly if, for instance, the only alternative is daily transportation by ambulance.

You can access these regulations at various websites, including: www.law.cornell.edu
§ 405.1200 Notifying beneficiaries of provider service terminations.

(a) Applicability and scope.

(1) For purposes of §§ 405.1200 through 405.1204, the term, provider, is defined as a home health agency (HHA), skilled nursing facility (SNF), comprehensive outpatient rehabilitation facility (CORF), or hospice.

(2) For purposes of §§ 405.1200 through 405.1204, a termination of Medicare-covered service is a discharge of a beneficiary from a residential provider of services, or a complete cessation of coverage at the end of a course of treatment prescribed in a discrete increment, regardless of whether the beneficiary agrees that the services should end. A termination does not include a reduction in services. A termination also does not include the termination of one type of service by the provider if the beneficiary continues to receive other Medicare-covered services from the provider.

(b) Advance written notice of service terminations. Before any termination of services, the provider of the service must deliver valid written notice to the beneficiary of the provider's decision to terminate services. The provider must use a standardized notice, as specified by CMS, in accordance with the following procedures:

(1) Timing of notice. A provider must notify the beneficiary of the decision to terminate covered services no later than 2 days before the proposed end of the services. If the beneficiary's services are expected to be fewer than 2 days in duration, the provider must notify the beneficiary at the time of admission to the provider. If, in a non-residential setting, the span of time between services exceeds 2 days, the notice must be given no later than the next to last time services are furnished.

(2) Content of the notice. The standardized termination notice must include the following information:

(i) The date that coverage of services ends;

(ii) The date that the beneficiary's financial liability for continued services begins;

(iii) A description of the beneficiary's right to an expedited determination under § 405.1202, including information about how to request an expedited determination and about a beneficiary's right to submit evidence showing that services must continue;

(iv) A beneficiary's right to receive the detailed information specified under § 405.1202(f); and

(v) Any other information required by CMS.
(3) When delivery of the notice is valid. Delivery of the termination notice is valid if--

(i) The beneficiary (or the beneficiary's authorized representative) has signed and dated the notice to indicate that he or she has received the notice and can comprehend its contents; and

(ii) The notice is delivered in accordance with paragraph (b)(1) of this section and contains all the elements described in paragraph (b)(2) of this section.

(4) If a beneficiary refuses to sign the notice. The provider may annotate its notice to indicate the refusal, and the date of refusal is considered the date of receipt of the notice.

(5) Financial liability for failure to deliver valid notice. A provider is financially liable for continued services until 2 days after the beneficiary receives valid notice as specified under paragraph (b)(3) of this section, or until the service termination date specified on the notice, whichever is later. A beneficiary may waive continuation of services if he or she agrees with being discharged sooner than the planned service termination date.

§ 405.1202 Expedited determination procedures.

(a) Beneficiary's right to an expedited determination by the QIO. A beneficiary has a right to an expedited determination by a QIO under the following circumstances:

(1) For services furnished by a non-residential provider, the beneficiary disagrees with the provider of those services that services should be terminated, and a physician certifies that failure to continue the provision of the service(s) may place the beneficiary's health at significant risk.

(2) For services furnished by a residential provider or a hospice, the beneficiary disagrees with the provider's decision to discharge the beneficiary.

(b) Requesting an expedited determination.

(1) A beneficiary who wishes to exercise the right to an expedited determination must submit a request for a determination to the QIO in the State in which the beneficiary is receiving those provider services, in writing or by telephone, by no later than noon of the calendar day following receipt of the provider's notice of termination. If the QIO is unable to accept the beneficiary's request, the beneficiary must submit the request by noon of the next day the QIO is available to accept a request.

(2) The beneficiary, or his or her representative, must be available to answer questions or to supply information that the QIO may request to conduct its review.

(3) The beneficiary may, but is not required to, submit evidence to be considered by a QIO in making its decision.

(4) If a beneficiary makes an untimely request for an expedited determination by a QIO, the QIO will accept the request and make a determination as soon as possible, but the 72–hour time frame
under paragraph (e)(6) and the financial liability protection under paragraph (g) of this section do not apply.

(c) Coverage of provider services. Coverage of provider services continues until the date and time designated on the termination notice, unless the QIO reverses the provider's service termination decision. If the QIO's decision is delayed because the provider did not timely supply necessary information or records, the provider may be liable for the costs of any additional coverage, as determined by the QIO in accordance with paragraph (e)(7) of this section. If the QIO finds that the beneficiary did not receive valid notice, coverage of provider services continues until at least 2 days after valid notice has been received. Continuation of coverage is not required if the QIO determines that coverage could pose a threat to the beneficiary's health or safety.

(d) Burden of proof. When a beneficiary requests an expedited determination by a QIO, the burden of proof rests with the provider to demonstrate that termination of coverage is the correct decision, either on the basis of medical necessity, or based on other Medicare coverage policies.

1 In order for the QIO to determine whether the provider has met the burden of proof, the provider should supply any and all information that a QIO requires to sustain the provider's termination decision, consistent with paragraph (f) of this section.

2 The beneficiary may submit evidence to be considered by a QIO in making its decision.

(e) Procedures the QIO must follow.

1 On the day the QIO receives the request for an expedited determination under paragraph (b) of this section, it must immediately notify the provider of those services that a request for an expedited determination has been made.

2 The QIO determines whether the provider delivered valid notice of the termination decision consistent with § 405.1200(b) and paragraph (f) of this section.

3 The QIO examines the medical and other records that pertain to the services in dispute. If applicable, the QIO determines whether a physician has certified that failure to continue the provision of services may place the beneficiary's health at significant risk.

4 The QIO must solicit the views of the beneficiary who requested the expedited determination.

5 The QIO must provide an opportunity for the provider/practitioner to explain why the termination or discharge is appropriate.

6 No later than 72 hours after receipt of the request for an expedited determination, the QIO must notify the beneficiary, beneficiary's physician, and the provider of services of its determination whether termination of Medicare coverage is the correct decision, either on the basis of medical necessity or based on other Medicare coverage policies.
(7) If the QIO does not receive the information needed to sustain a provider's decision to terminate services, it may make its determination based on the evidence at hand, or it may defer a decision until it receives the necessary information. If this delay results in extended Medicare coverage of an individual's provider services, the provider may be held financially liable for these services, as determined by the QIO.

(8) The QIO's initial notification may be by telephone, followed by a written notice including the following information:

(i) The rationale for the determination;

(ii) An explanation of the Medicare payment consequences of the determination and the date a beneficiary becomes fully liable for the services; and

(iii) Information about the beneficiary's right to a reconsideration of the QIO's determination, including how to request a reconsideration and the time period for doing so.

(f) Responsibilities of providers.

(1) When a QIO notifies a provider that a beneficiary has requested an expedited determination, the provider must send a detailed notice to the beneficiary by close of business of the day of the QIO's notification. The detailed termination notice must include the following information:

(i) A specific and detailed explanation why services are either no longer reasonable and necessary or are no longer covered;

(ii) A description of any applicable Medicare coverage rule, instruction, or other Medicare policy, including citations to the applicable Medicare policy rules or information about how the beneficiary may obtain a copy of the Medicare policy;

(iii) Facts specific to the beneficiary and relevant to the coverage determination that are sufficient to advise the beneficiary of the applicability of the coverage rule or policy to the beneficiary's case; and

(iv) Any other information required by CMS.

(2) Upon notification by the QIO of the request for an expedited determination, the provider must supply all information that the QIO needs to make its expedited determination, including a copy of the notices required under § 405.1200(b) and under paragraph (f)(1) of this section. The provider must furnish this information as soon as possible, but no later than by close of business of the day the QIO notifies the provider of the request for an expedited determination. At the discretion of the QIO, the provider may make the information available by phone or in writing (with a written record of any information not transmitted initially in writing).

(3) At a beneficiary's request, the provider must furnish the beneficiary with a copy of, or access to, any documentation that it sends to the QIO including records of any information provided by telephone. The provider may charge the beneficiary a reasonable amount to cover the costs of
duplicating the documentation and/or delivering it to the beneficiary. The provider must accommodate such a request by no later than close of business of the first day after the material is requested.

(g) Coverage during QIO review. When a beneficiary requests an expedited determination in accordance with the procedures required by this section, the provider may not bill the beneficiary for any disputed services until the expedited determination process (and reconsideration process, if applicable) has been completed.

§ 405.1204 Expedited reconsiderations.

(a) Beneficiary's right to an expedited reconsideration. A beneficiary who is dissatisfied with a QIO's expedited determination may request an expedited reconsideration by the appropriate QIC.

(b) Requesting an expedited reconsideration.

(1) A beneficiary who wishes to obtain an expedited reconsideration must submit a request for the reconsideration to the appropriate QIC, in writing or by telephone, by no later than noon of the calendar day following initial notification (whether by telephone or in writing) receipt of the QIO's determination. If the QIC is unable to accept the beneficiary's request, the beneficiary must submit the request by noon of the next day the QIC is available to accept a request.

(2) The beneficiary, or his or her representative, must be available to answer questions or supply information that the QIC may request to conduct its reconsideration.

(3) The beneficiary may, but is not required to, submit evidence to be considered by a QIC in making its decision.

(4) A beneficiary who does not file a timely request for an expedited QIC reconsideration subsequently may request a reconsideration under the standard claims appeal process, but the coverage protections described in paragraph (f) of this section would not extend through this reconsideration, nor would the timeframes or the escalation process described in paragraphs (c)(3) and (c)(5) of this section, respectively.

(c) Procedures the QIC must follow.

(1) On the day the QIC receives the request for an expedited determination under paragraph (b) of this section, the QIC must immediately notify the QIO that made the expedited determination and the provider of services of the request for an expedited reconsideration.

(2) The QIC must offer the beneficiary and the provider an opportunity to provide further information.

(3) Unless the beneficiary requests an extension in accordance with paragraph (c)(6) of this section, no later than 72 hours after receipt of the request for an expedited reconsideration, and any medical or other records needed for such reconsideration, the QIC must notify the QIO, the beneficiary, the beneficiary's physician, and the provider of services, of its decision on the reconsideration request.
(4) The QIC's initial notification may be done by telephone, followed by a written notice including:

(i) The rationale for the reconsideration decision;

(ii) An explanation of the Medicare payment consequences of the determination and the beneficiary's date of liability; and

(iii) Information about the beneficiary's right to appeal the QIC's reconsideration decision to an ALJ, including how to request an appeal and the time period for doing so.

(5) Unless the beneficiary requests an extension in accordance with paragraph (c)(6) of this section, if the QIC does not issue a decision within 72 hours of receipt of the request, the QIC must notify the beneficiary of his or her right to have the case escalated to the ALJ hearing level if the amount remaining in controversy after the QIO determination is $100 or more.

(6) A beneficiary requesting an expedited reconsideration under this section may request (either in writing or orally) that the QIC grant such additional time as the beneficiary specifies (not to exceed 14 days) for the reconsideration. If an extension is granted, the deadlines in paragraph (c)(3) of this section do not apply.

(d) Responsibilities of the QIO.

(1) When a QIC notifies a QIO that a beneficiary has requested an expedited reconsideration, the QIO must supply all information that the QIC needs to make its expedited reconsideration as soon as possible, but no later than by close of business of the day that the QIC notifies the QIO of the request for an expedited reconsideration.

(2) At a beneficiary's request, the QIO must furnish the beneficiary with a copy of, or access to, any documentation that it sends to the QIC. The QIO may charge the beneficiary a reasonable amount to cover the costs of duplicating the documentation and/or delivering it to the beneficiary. The QIO must accommodate the request by no later than close of business of the first day after the material is requested.

(e) Responsibilities of the provider. A provider may, but is not required to, submit evidence to be considered by a QIC in making its decision. If a provider fails to comply with a QIC's request for additional information beyond that furnished to the QIO for purposes of the expedited determination, the QIC makes its reconsideration decision based on the information available.

(f) Coverage during QIC reconsideration process. When a beneficiary requests an expedited reconsideration in accordance with the deadline specified in (b)(1) of this section, the provider may not bill the beneficiary for any disputed services until the QIC makes its determination.

You can access these regulations at various websites, including: www.law.cornell.edu
Manual Provisions for SNF Care

The Internet-only Manuals (IOMs) are a replica of the Center for Medicare & Medicaid Services’ (CMS) official record copy. They are CMS' program issuances, day-to-day operating instructions, policies, and procedures that are based on statutes, regulations, guidelines, models, and directives. The CMS program components, providers, contractors, Medicare Advantage organizations, and state survey agencies use the IOMs to administer Medicare.

The skilled nursing facility manual can be found at: www.cms.gov/manuals/iom/List.asp. On this page, click the Internet-Only Manuals button on the left hand side of the screen. Then open publication 100-2. This is the Medicare Benefit Claims Manual. From here, open Chapter 8. This chapter is entitled, Coverage of Extended Care (SNF) Services Under Hospital Insurance.

Information in this chapter may be useful for preparing a successful appeal. However, be aware that any language requiring improvement for coverage is legally incorrect and will soon be changed. This is because of the federal court case, Jimmo v. Sebelius, (D.VT 1/24/2013). In Jimmo, the judge approved a settlement stating that Medicare coverage for nursing home care does not depend on the individual’s potential for improvement, but rather on his or her need for skilled care – which can be to maintain or slow deterioration of the individual’s condition.

Because of the Jimmo settlement, CMS will revise the Medicare Benefit Policy Manual to correct all suggestions that Medicare coverage is dependent on a beneficiary “improving.” New policy provisions will state that skilled nursing and therapy services necessary to maintain a person’s condition can be covered by Medicare.

Specifically, the proposed settlement requires that CMS make manual revisions clarifying that in skilled nursing facility, home health, and outpatient therapy settings, “coverage of therapy to perform a maintenance program does not turn on the presence or absence of a beneficiary’s potential for improvement from the therapy, but rather on the beneficiary’s need for skilled care.” The proposed settlement also requires CMS to make manual revisions clarifying that Medicare coverage of skilled nursing facility and home health care “does not turn on the presence or absence of an individual’s potential for improvement from the nursing care, but rather on the beneficiary’s need for skilled care.”

For more information on the settlement, visit www.medicareadvocacy.org.
GLOSSARY OF TERMS

BENEFICIARY

An individual enrolled in the Medicare program.

CLAIMANT

An individual requesting reimbursement from Medicare for expenses incurred for medical care (or the individual requesting payment on behalf of a Medicare enrollee).

CO-INSURANCE

The amount a beneficiary must pay as his or her share of the cost of a given service. For example, a beneficiary must pay part of the cost of days 21 through 100 in a skilled nursing facility. There is also a co-insurance (20% of the reasonable charge) which must be paid for Part A or B services.

CMS (Centers for Medicare and Medicaid Services)

The federal agency which administers the Medicare program: part of the United States Department of Health and Human Services.

DEDUCTIBLE

The amount which a beneficiary must pay before Medicare (or other insurance program) will begin to cover the bill. Each calendar year a deductible must be paid before Medicare will cover hospital care under Part A, or physician visits and other services under Medicare Part B.

HEALTH INSURANCE CLAIM NUMBER

The Social Security number under which you receive benefits. This number is the number on your health insurance (Medicare) card.
INPATIENT

An individual admitted to a hospital, skilled nursing facility, or other health care institution for treatment

MEDICARE CLAIM DETERMINATION

The written notice of denial of Medicare coverage issued by the intermediary.

MEDICARE CONTRACTOR

An agent of the federal government, often an insurance company, which makes Part A Medicare claim determinations for skilled nursing facility and home health coverage, and issues payments to providers.

MEDIGAP

Private insurance which covers the "gaps" in Medicare (such as deductibles and co-insurance amounts). Significantly, these policies generally do not pay when Medicare refuses coverage.

SKILLED CARE

Care which requires the skill of technical or professional personnel in order to ensure its safety and effectiveness, and is furnished directly by, or under the supervision of, such personnel. (Nurses and physical or occupational therapists are examples of professional personnel.)

SKILLED NURSING FACILITY (SNF)

A skilled nursing facility, or "SNF," is a nursing home which delivers a relatively substantial degree of skilled nursing and rehabilitative care, and personal care. In order to receive Medicare coverage for nursing home care, a patient must receive daily skilled care in a Medicare-certified skilled nursing facility.

SPELL OF ILLNESS (BENEFIT PERIOD)

The name of the benefit period for Medicare Part A. The "spell of illness" begins on the first day a patient receives Medicare-covered inpatient hospital care and ends when the patient has spent 60 consecutive days outside the institution, or remains in the institution but does not receive Medicare-coverable care for 60 consecutive days.