

OVERCOMING BARRIERS TO MEDICARE COVERAGE OF SKILLED NURSING FACILITY CARE

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INTRODUCTION

- Most nursing home advocates work on quality of care and quality of life issues
- This session is about Medicare coverage of care in a skilled nursing facility (SNF)
 - Introduction to Medicare coverage rules
 - Two barriers to coverage
 - Observation services
 - The myth of “medical improvement”

MEDICARE

- Medicare pays increasing portion of nursing home bills
 - 2008: Medicare represents 19% of national nursing home payments (\$25.7 billion); Medicaid, 41% (\$56.3 billion)
 - 2000: Medicare paid 11.0% of national nursing home payments (\$10.1 billion); Medicaid, 44% (\$42.0 billion)

<http://www.cms.hhs.gov/NationalHealthExpendData/downloads/tables.pdf> (Table 9)

MEDICARE RESOURCES

- Medicare statute, 42 U.S.C. §1395
 - §1395d(a)(2)(A) [extended care services]
 - §1395x(h) [definition of extended care services]
 - §1395f(a)(2)(B) [conditions of payment for extended care services]
- Medicare regulations, 42 C.F.R. §409.30-.36
- Medicare Benefit Policy Manual, CMS Pub. 100-02, Chapter 8,
<http://www.cms.hhs.gov/manuals/Downloads/bp102c08.pdf>

MEDICARE COVERAGE OF SNF CARE

- **Basic Requirements, 42 C.F.R. §409.30**
 - 3-day qualifying hospital stay for medically necessary inpatient hospital care
 - Admission to SNF within 30 days of hospital discharge
 - Physician certification of resident's need for SNF care
 - Resident requires daily skilled nursing or rehabilitation services
 - Medicare-certified facility; Medicare-certified bed
 - As a practical matter, inpatient care is needed, 42 C.F.R. §409.31(b)(3)

MEDICARE COVERAGE OF SNF CARE

- **Three-day qualifying hospital stay**
 - “The beneficiary must have been hospitalized..., for medically necessary inpatient hospital care...for at least 3 consecutive calendar days, not counting the day of discharge,” 42 C.F.R. §409.30(a)(1)

MEDICARE COVERAGE OF SNF CARE

- **Admission within 30 days of hospital discharge**
 - “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 the hospital.” 42 C.F.R. §409.30(b)(1)
 - “A beneficiary for whom posthospital SNF care would not be medically appropriate within 30 days after discharge from the hospital...may be admitted at the time it would be medically appropriate to begin an active course of treatment.” 42 C.F.R. §409.30(b)(2)(i)
 - Medicare Advantage exception to 3-day hospital rule. 42 C.F.R. §409.20(c)(4)

LEVEL OF CARE REQUIREMENT

- Care must
 - be reasonable and necessary, 42 U.S.C. §1395y(a)(1)(A)
 - be ordered by a physician, 42 C.F.R. §409.31(a)(i)
 - “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.” 42 C.F.R. §409.31(a)(2)

LEVEL OF CARE

- Beneficiary admitted from hospital is presumed to meet level of care requirements for first five days of SNF stay if correctly assigned to a Resource Utilization Group (RUG) that is annually designated as meeting the SNF level of care. 42 C.F.R. §409.30; Medicare Benefit Policy Manual, Ch. 8, §30.1

SKILLED CARE

- Skilled care must be provided daily, 42 C.F.R. §§409.31(b)(1), 409.34
 - Nursing, 7 days a week
 - Therapy, 5 days a week
 - Combination of nursing and therapy, 7 days a week
 - Break of 1-2 days “will not preclude coverage” if, for example, resident cannot participate in therapy because of “extreme fatigue.” 42 C.F.R. §409.34(b)

DAILY SKILLED SERVICES

- Daily skilled nursing or rehabilitation services must be provided for
 - a condition for which the beneficiary received inpatient hospital services, 42 C.F.R. §409.31(b)(2)(i); *or*
 - a condition which arose while the beneficiary was receiving care in a SNF, 42 C.F.R. §409.31(b)(2)(ii)

CRITERIA FOR SKILLED SERVICES

- 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.” 42 C.F.R. §409.32(a)

CRITERIA FOR SKILLED SERVICES

- “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 . . . may be considered skilled because it must be performed or supervised by skilled nursing or rehabilitation personnel.” 42 C.F.R. §409.32(b)

CRITERIA FOR SKILLED SERVICES

- **Skilled services, 42 C.F.R. §409.32(b)**
 - Example: “A plaster cast on a leg does not usually require skilled care. However, if the resident 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.”

CRITERIA FOR SKILLED SERVICES

- More examples and detail in Medicare Benefit Policy Manual, CMS Pub. 100-02, Chapter 8
 - Skilled service, CMS Pub. 100-02, Ch. 8, §30.2.2
 - “Although the act of turning a patient normally is not a skilled service, for some patients the skills of a nurse may be necessary to assure proper body alignment in order to avoid contractures and deformities.”

SKILLED NURSING SERVICES

- **Skilled nursing and rehabilitation services, 42 C.F.R. §409.33(a), include**
 - Overall management and evaluation of care plan
 - Observation and assessment of changing condition
 - Resident education services

SKILLED NURSING

- **Overall management and evaluation of care plan, 42 C.F.R. §409.33(a)(1)**
 - “The development, management, and evaluation of a patient care plan...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 resident’s needs, promote recovery, and ensure medical safety.”

SKILLED NURSING

- **Overall management and evaluation of care plan, 42 C.F.R. §409.33(a)(1)(ii)**
 - Example: “An aged patient with a history of diabetes 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, and exercise program to preserve muscle tone and body condition, and observation to detect signs of deterioration...or complications resulting from restricted but increasing, mobility. Although any of the 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.”

SKILLED NURSING

- Overall management and evaluation of care plan, 42 C.F.R. §409.33(a)(1)(ii)
 - “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 resident’s clinical record.”

SKILLED NURSING

- Overall management and evaluation of care plan, 42 C.F.R. §409.33(a)(1)(ii)
 - “[I]f the resident’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.”

OBSERVATION AND ASSESSMENT

- Observation and assessment of changing condition, 42 C.F.R. §409.33(a)(2)(i)
 - “the skills of a technical or professional person are required to identify and evaluate the resident’s need for modification of treatment or for additional medical procedures until his or her condition is stabilized.”
 - Example: “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).” 42 C.F.R. §409.33(a)(2)(ii)

OBSERVATION AND ASSESSMENT

- Observation and assessment of a changing condition, 42 C.F.R. §409.33(a)(2)(ii)
 - Example: “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.”

OBSERVATION AND ASSESSMENT

- More details and examples in Medicare Benefit Policy Manual
 - Observation and assessment of a changing condition, CMS Pub. 100-02, Ch. 8, §30.2.3.2
 - “A frail 85-year-old man was hospitalized for pneumonia. The infection was resolved, but the resident, who had previously maintained adequate nutrition, will not eat or eats poorly. The resident is transferred to a SNF for monitoring of fluid and nutrient intake, assessment of the need for tube feeding. Observation and monitoring by skilled nursing personnel of the resident’s oral intake is required to prevent dehydration.”

SKILLED NURSING

- **Patient education services, 42 C.F.R. §409.33(a)(i)**
 - Patient education services are skilled “if the use of technical or professional personnel is necessary to teach a resident self-maintenance.”
 - Example: “A patient, newly diagnosed with diabetes requires instruction from technical or professional personnel to learn the self administration of insulin or foot-care precautions.” 42 C.F.R. §409.33(a)(ii)

SKILLED NURSING

- More details and examples in Medicare Benefit Policy Manual
 - **Patient education services**, CMS Pub. 100-02, Ch. 8, §30.2.3.3.
 - Teaching self-administration of injectable medications or a complex range of medications
 - Teaching self-administration of medical gases to a resident
 - Gait training and teaching of prosthesis care for a resident who has had a recent leg amputation
 - Teaching residents how to care for a recent colostomy or ileostomy

EXAMPLES OF SKILLED NURSING SERVICES

- **Requirement for skilled care is met for a beneficiary receiving one or more of the following services:**
 - Intravenous or intramuscular injections
 - Intravenous feeding
 - Enteral feeding that is at least 26% of daily caloric requirements and provides at least 501 ml fluids/day
 - Insertion and sterile irrigation of suprapubic catheters
 - Application of dressings involving prescription medications and aseptic techniques
 - Treatment of extensive decubitus ulcers and other widespread skin disorders

42 C.F.R. §409.33(b)(1)-(9)

NOTICE ISSUES

- Medicare must make a determination of non-coverage from which beneficiary may appeal; a health care provider's statement that Medicare will not pay for care (at admission or continued stay) does not get the beneficiary into the Medicare appeals system.

NOTICE ISSUES

ADMISSION

- Notice of Exclusion from Medicare Benefits, SNF NEMB,
<http://www.cms.hhs.gov/BNI/Downloads/CMS20014.pdf>
 - Technical denials of coverage on admission, including lack of qualifying three-day inpatient hospital stay
 - Use of SNF NEMB is discretionary for facility

NOTICE ISSUES CONTINUED STAY

- Advanced beneficiary notice of non-coverage (SNFABN), <http://www.cms.hhs.gov/BNI/Downloads/CMS10055.pdf>, or one of five denial letters, <http://www.cms.hhs.gov/BNI/Downloads/SNF%20DENIAL%20LETTERS.pdf>, is **required** to inform the beneficiary of the date on which the beneficiary will be held financially liable for the SNF bill.

42 U.S.C. §1395pp; 42 C.F.R. §411.404

NOTICE

- Beneficiary is not liable (responsible for paying) if beneficiary “did not know, and could not reasonably have been expected to know . . .” that services would not be covered.

APPEALS

- Many layers of appeal of denials of coverage at admission or during a SNF stay
 - Redetermination by Medicare contractor
 - Reconsideration by Qualified Independent Contractor (QIC)
 - Hearing before Administrative Law Judge (ALJ)
 - Medicare Appeals Council
 - Judicial Review
- Appeals, by themselves, are a topic for a webinar
 - *See Center's Self-Help Packet,*
<http://www.medicareadvocacy.org/InfoByTopic/SkilledNursingFacility/SNFSelfHelpPacket.2010.pdf>

TWO OBSTACLES TO MEDICARE COVERAGE OF SNF CARE

- Observation services, which prevent coverage at admission to SNF
- The myth of medical improvement, which prevents continued Medicare coverage when the resident is not “improving”

3-DAY QUALIFYING HOSPITAL STAY

- “The beneficiary must have been hospitalized . . . for medically necessary inpatient hospital care . . . for at least 3 consecutive calendar days, not counting the day of discharge.” 42 C.F.R. §409.30(a)(1)

OBSERVATION SERVICES

- New phenomenon: beneficiary is in a hospital bed, receiving medical and nursing care, tests, treatments, drugs, food, supplies, etc., BUT is receiving “observation services” and is called an outpatient (Medicare Part B), not an inpatient (Medicare Part A)
- Observation services are not defined in the Medicare statute or regulation.

OBSERVATION SERVICES

- Defined in CMS's manuals as "a well-defined set of specific, clinically appropriate services, which include ongoing short term treatment, assessment, and reassessment, that are furnished while a decision is being made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital." Medicare Benefit Policy Manual, CMS Pub. No. 100-02, Ch. 6, §20.6. Same language in Medicare Claims Processing Manual, CMS Pub. No.100-04, Ch. 4, §290.1.

OBSERVATION SERVICES

- Time spent in observation status in the emergency room prior to (or instead of) an inpatient admission does not count toward the 3-day qualifying inpatient stay. Medicare Benefit Policy Manual, CMS Pub. No. 100-02, Ch. 8, §20.1.
 - *Landers v. Leavitt*, 545 F.3d 98 (2nd Cir. 2008), *cert. denied*, 129 S.Ct. 2878 (2009)
 - *Jenkel v. Shalala*, 845 F. Supp. 69 (D. Conn. 1994)

OBSERVATION SERVICES

- Manuals say observation should not exceed 24-48 hours
- Now, increasingly, Medicare beneficiaries' **entire** stay in an acute care hospital is called observation services
 - Cases of multiple days and weeks in the hospital, all in observation

OBSERVATION SERVICES

- Consequences for beneficiaries whose entire time in hospital is considered to be observation
 - Denied Part A coverage for hospital stay
 - Denied Part A coverage for prescription drugs received while in hospital
 - Denied Part A coverage for SNF stay

OBSERVATION SERVICES

- Even if admitted as an inpatient by a patient's attending physician, the hospital's utilization review committee may retroactively reverse the admission determination to outpatient observation services
 - Condition Code 44, Transmittal 299 (Sep. 2004), now at Medicare Claims Processing Manual, CMS Pub. No. 100-04, Ch. 1, §50.3, <http://www.cms.hhs.gov/manuals/downloads/clm104c01.pdf> (scroll down to §50.3 at p. 138)

OBSERVATION SERVICES

- Hospitals generally appear to be using InterQual criteria (McKesson Corp.) to make coverage decisions
 - Proprietary process
 - Proprietary criteria, with screens for diagnoses
 - Severity of illness
 - Intensity of service

OBSERVATION SERVICES NOTICE ISSUES

- Notice issues unclear
 - CMS Manual says beneficiary must be notified by hospital if hospital retroactively changes status from inpatient to outpatient
 - Few beneficiaries are receiving notices; notices do not give appeal rights

OBSERVATION SERVICES

- New CMS brochure, “Are You a Hospital Inpatient or Outpatient?”, CMS Product No. 11435 (Dec. 2009),
<http://www.medicare.gov/Publications/Pubs/pdf/11435.pdf>
 - Misstates CMS Manuals by suggesting that beneficiary’s physician approved observation
 - Tells beneficiaries to ask if they are outpatients or inpatients
 - Does not identify any rights to appeal

OBSERVATION SERVICES

- SNF may give beneficiary SNF Notice of Exclusion from Medicare Benefits (SNF NEMB) for lack of 3-day hospital stay, but use of SNF NEMB is discretionary for SNFs.

<http://www.cms.hhs.gov/BNI/Downloads/CMS20014.pdf>

WHAT TO DO

- Appeal from notices that are received
- If no specific notice from hospital or SNF, appeal from Medicare Summary Notice (quarterly notice of all Medicare services received)
- Continue through appeal levels; cases have been won at higher appeal levels

WHAT TO DO

- Ask hospital for
 - written notice;
 - reason patient received observation services;
 - copy of documents the hospital relied on to make determination of observation
- Request complete hospital records
- Ask SNF for NEMB
- Request complete SNF records

FACT-BASED DECISIONS

- Whether a Medicare beneficiary is an inpatient should be a decision that is based on the facts

FAVORABLE DECISIONS

- ALJ Appeal No. 1-517883673 (Jan. 8, 2010), http://www.medicareadvocacy.org/InfoByTopic/ObservationStatus/Decisions/VT_ALJ_01.10.pdf
 - Patient required monitoring, assessment, intravenous fluids (including intravenous morphine)
 - ALJ overruled Maximus Federal Services and held entire 5-day hospital stay was covered
 - ALJ relied on Medicare Benefit Policy Manual, CMS Pub. No. 100-02, Ch. 1, §6; and QIO Manual, CMS Pub. No. 100-10, Ch. 4, §4110, describing complex medical judgment that considers patient's medical history, current medical needs, severity of signs and symptoms

FAVORABLE DECISIONS

- Medicare Appeal No. 1-496442359 (Nov. 10, 2009),
http://www.medicareadvocacy.org/InfoByTopic/ObservationStatus/Decisions/MN_Maximus_11.09.pdf
 - Patient, who had been fully oriented at his assisted living facility, went to hospital with delirium, “an acutely life-threatening condition”
 - Maximus relied on Medicare Benefit Policy Manual, Pub. 100-02, Ch. 1, §10, and Program Integrity Manual, Pub. 100-08, Ch. 8, §6.5.2, to authorize inpatient coverage for entire 5-day period

FAVORABLE DECISION

- ALJ Appeal No. 1-380068132 (April 9, 2009), http://www.medicareadvocacy.org/InfoByTopic/ObservationStatus/Decisions/WI_ALJ_04.09.09.pdf
 - ALJ addressed denial of 30-day SNF stay for lack of 3-day hospital stay, when resident had been in hospital for 13 days
 - ALJ found resident met hospital stay and needed and received Medicare-covered care in SNF

FAVORABLE DECISIONS

- ALJ Appeal No. 1-424979831 (Dec. 9, 2009), http://www.medicareadvocacy.org/InfoByTopic/ObservationStatus/Decisions/CA_ALJ_inpatient_InterQual_12.09.pdf
 - Not observation case, but denial of continued hospital care
 - ALJ found inputs in InterQual were subjective and “inconsistent with the known medical treatment” provided to patient

OBSERVATION SERVICES

■ Resources

- CMA, “Observation Services: What Can Beneficiaries and Advocates Do?” (Weekly Alert, Feb. 18, 2010), http://medicareadvocacy.org/InfoByTopic/ObservationStatus/10_02.18.ObservationDecisions.htm
- CMA, “When Is a Hospital Stay Not a Hospital Stay? When the Patient Is in ‘Observation Status,’” (Weekly Alert, Dec. 11, 2008), http://medicareadvocacy.org/InfoByTopic/SkilledNursingFacility/SNF_08_12.11.ObservationStatus.htm

THE MYTH OF IMPROVEMENT

- Medicare coverage of care and services in a SNF does not depend on the resident's "improving"

THE MYTH OF IMPROVEMENT

- Restoration potential is not a valid reason for denial of coverage
 - “Even if full recovery or medical improvement is not possible, a resident may need skilled services to prevent further deterioration or preserve current capabilities.”
42 C.F.R. §409.32(c)
 - Example: “A terminal cancer patient may need some of the skilled services described in §409.33.” 42 C.F.R. §409.32(c)

MAINTENANCE-LEVEL REHABILITATION

- Maintenance rehabilitation therapy is a Medicare-covered service
 - “. . . when the specialized knowledge of a qualified therapist is required to design and establish a maintenance program based on an initial evaluation and periodic assessment of a resident’s needs. . . .” 42 C.F.R §409.33(c)(5)

INDIVIDUALIZED ASSESSMENT

- Medicare should not use “rules of thumb,” such as
 - Lack of restoration potential, CMS Pub. No. 100-02, Ch. 8, 30.2.2 (“When rehabilitation services are the primary services, the key issue is whether the skills of a therapist are needed. The deciding factor is not the patient’s potential for recovery, but whether the services needed require the skills of a therapist or whether they can be provided by nonskilled personnel.”)

INDIVIDUALIZED ASSESSMENT

- *Fox v. Bowen*, 656 F. Supp. 1236 (D. Conn. 1987)
 - Need for skilled nursing must be based solely upon beneficiary's unique condition and individual needs
 - Court rejected “informal presumptions” or “rules of thumb” that denied coverage to beneficiaries who were not in weight-bearing stage of rehabilitation, amputees who did not have prostheses, beneficiaries who could ambulate 50 feet with supervision
 - Court held that the Secretary's practice of denying Medicare coverage violated the Due Process Clause of the Fifth Amendment

FAVORABLE DECISIONS

- ALJ Appeal No. 1-517589113 (Jan. 25, 2010)
 - ALJ reverses QIO decision, which affirmed Medicare Advantage Plan's termination of Medicare beneficiary's SNF coverage, based on alleged stabilization of therapeutic regimen and no need for additional skilled nursing care, <http://www.medicareadvocacy.org/ALJDecisions/1-517589113.pdf>
 - ALJ finds coverage for resident with "very complex medical history." Additional therapy needed for resident to reach therapy goals, to prevent deterioration, and to preserve function. When resident's medical condition destabilized, she needed skilled nursing observation and monitoring of her high-risk MRSA infection and "complicating underlying condition."

MEDICARE RESOURCES

- Medicare statute, 42 U.S.C. §1395
 - §1395d(a)(2)(A) [extended care services]
 - §1395x(h) [definition of extended care services]
 - §1395f(a)(2)(B) [conditions of payment for extended care services]
- Medicare regulations, 42 C.F.R. §409.30-.36
- Medicare Benefit Policy Manual, CMS Pub. 100-02, Chapter 8,
<http://www.cms.hhs.gov/manuals/Downloads/bp102c08.pdf>

RESOURCES

- Gill Deford, Margaret Murphy, Judith Stein, “How the ‘Improvement Standard’ Improperly Denies Coverage to Medicare Patients with Chronic Conditions,” *Clearinghouse Review* (Jan.-Feb. 2010), <http://medicareadvocacy.org/Projects/Improvement/PublishedArticle.pdf>
- Center for Medicare Advocacy, “Medicare Skilled Nursing Facility Self Help Packet,” <http://www.medicareadvocacy.org/InfoByTopic/SkilledNursingFacility/SNFSelfHelpPacket.2010.pdf> (which includes the regulations and sections of the Medicare Beneficiary Policy Manual, Pub. No. 100-02, Ch. 8)
- Center for Medicare Advocacy, Searchable Database of ALJ Decisions, <http://www.medicareadvocacy.org/ALJDecisions/ALJSearch.asp>

FOR MORE INFORMATION

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