MEDICARE SKILLED NURSING FACILITY SELF HELP PACKET

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INTRODUCTION

Dear Medicare Patient:

The Center for Medicare Advocacy, in conjunction with the State of Connecticut Department of Social Services has produced this packet of materials to help you understand Medicare coverage and to file an appeal if it is necessary.

Medicare is the national health insurance program to which individuals 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.

The materials enclosed include a Request for Redetermination form which has accompanying instructions for completing and filing. In order to appeal your Medicare denial, you must file the Request for Redetermination with the Medicare contractor. You will receive a Redetermination decision usually within one to three months after submitting the request.

Please do not hesitate to contact The Center for Medicare Advocacy at (800)262-4414 or (860)456-7790 if you have any questions.

HOW TO USE THIS PACKET

We've organized this packet so that it provides you with the information and forms necessary to enable you to evaluate your case and file a "Request for Redetermination," the first level of administrative appeal. We suggest you take the following steps:

1. Read the "Brief Summary." This summary will give you the background necessary to understand your case.

2. If your case has merit (that is, the coverage denial you have received is erroneous), you should complete the "Request for Redetermination" form, following the Instructions.

3. Send a copy of your "Request for Redetermination" to your Medicare contractor. Keep a copy of the form for your own records.

4. If you have questions when you receive the "Redetermination" decision, feel free to telephone the Center for Medicare Advocacy. The toll free number in Connecticut is 800-262-4414.

A BRIEF SUMMARY OF MEDICARE COVERGE 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.*

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

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of SNF care. From the 21st through the 100th day, Medicare pays for all covered services except for a daily coinsurance amount ($137.50 in 2010). Beneficiaries 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:

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- 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 s/he 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)

   - <u>*Including*</u> *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.

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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.

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Medicare Overview

Generally, coverage is available (except for hospice care) only when services are medically reasonable and necessary for treatment or diagnosis of illness or injury.

PART A

Coverage:

- Inpatient Hospital Services
- Inpatient Hospital Rehabilitation Services
- Inpatient Skilled Nursing Facility Services
- Home Health Services
- Hospice Services

PART B

Coverage:

- Physicians' Services
- Some Outpatient Services & Therapy
- Prosthetic Devices
- Ambulance Services
- Preventive Screenings such as: prostate cancer, bone mass, glaucoma
- Some Nutrition Therapy Services
- Flu and Pneumonia Vaccines
- Some Therapeutic Shoes

Appeals Process

1. Redetermination (by Quality Improvement Organization [QIO] or Medicare Contractor)

2. Reconsideration (by Qualified Independent Contractors (QIC)

3. Administrative Law Judge Hearing (U.S. Dept. of Health & Human Services) [If at least $130 in controversy]*[$200 for Hospital Case]

4. Medicare Appeals Council (MAC) (U.S. Dept. of Health and Human Services) [If at least $130 in controversy]* [$200 for Hospital Case]

5. Judicial Review (U.S. Dept. of Health and Human Services) [If at least $1,260 in controversy]* [$200 for Hospital Case]

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* The amount in controversy is increased by the percentage increase in the medical care component price index.

MEDICARE PREMIUMS AND DEDUCTIBLES FOR 2010

Hospital Deductible: $1,100.00 / Benefit period

Hospital Coinsurance:

- Days 0-60: $0
- Days 61-90: $275 / Day
- Days 91-150: $550 / Day

Skilled Nursing Facility Coinsurance:

- Days 0-20: $0
- Days 21-100: $137.50 / Day

Part A Premium (For voluntary enrollees only)

- With 30-39 quarters of Social Security coverage: $254 / Month
- With 29 or fewer quarters of Social Security coverage: $461 / Month

Part B

- Deductible: $155 / Year
- Standard Premium: $110.50 / Month*

PART B INCOME-RELATED PREMIUM

Beneficiaries who file an individual tax return with income:	Beneficiaries who file a joint tax return with income:	Income-related monthly adjustment amount	Total monthly premium amount
Less than or equal to $85,000	Less than or equal to $170,000	$0	$110.50*
Greater than $85,000 and less than or equal to $107,000	Greater than $170,000 and less than or equal to $214,000	$44.20	$154.70
Greater than $107,000 and less than or equal to $160,000	Greater than $214,000 and less than or equal to $320,000	$110.50	$221.00
Greater than $160,000 and less than or equal to $214,000	Greater than $320,000 and less than or equal to $428,000	$176.80	$287.30
Greater than $214,000	Greater than $428,000	$243.10	$353.60

PART B PREMIUM (cont.)

In addition, the monthly Part B premium rates to be paid by beneficiaries who are married, but file a separate return from their spouse and lived with their spouse at some time during the taxable year are:

Beneficiaries who are married but file a separate tax return from their spouse:	Income-related monthly adjustment amount	Total monthly premium amount
Less than or equal to $85,000	$0.00	$110.50*
Greater than $85,000 and less than or equal to $129,000	$176.80	$287.30
Greater than $129,000	$243.10	$353.60

*The majority of beneficiaries will not see an increase in their Part B monthly premium from the 2009 amount ($96.40) thanks to the "hold harmless" provision of the Social Security Act (42 U.S.C. §1395r(f)). See the discussion of the hold harmless provision that is included in the following weekly alert: http://www.medicareadvocacy.org/PartB 09 08.27.PremiumsandCOLA.htm.

STANDARD PART D COST-SHARING FOR 2010

Deductible: $310.00
Initial Coverage Limit: $2,830.00
Out-of-pocket Threshold: $4,550.00
Total Covered Part D Drugs to Get to Catastrophic Limit: $6,440
Catastrophic cost-sharing: Generic/ Preferred Drug: $2.50
Other Drugs: $6.30

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REQUIRED NOTICES FROM SKILLED NURSING FACILITY AND HOW TO HAVE A BILL SUBMITTED TO MEDICARE

Nursing homes make the first decision as to whether or not the care they provide will be covered by the Medicare program. If a nursing home decides, either upon admission or at a later time, that the services it provides will not be covered by Medicare, it is required by law to give the beneficiary or his/her representative a formal written notice to that effect. This is in the form of a generic notice. You must disagree with the decision and inform the SNF that you wish to appeal. You will then be given a more detailed notice.

As a result of a lawsuit, Sarrassat v. Bowen, these written notices must be uniform in content. The notice must explain why the care being provided will not be covered by Medicare. It must also explain that in order to appeal this decision there must be a request that a bill be submitted to Medicare for the non-covered services. The second page of the notice has boxes which can be checked to indicate whether or not bill submission is requested. It is important to remember that if you do not object to the first notification that care is ending and no bill is submitted to Medicare there can be no appeal.

The submission of a bill will result in a formal written determination by Medicare as to whether or not the care is covered. A Medicare beneficiary cannot be required to pay the nursing home for services until this formal determination has been issued. This determination notice will be sent to the beneficiary and/or the representative and can be appealed by a request for "redetermination".

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MEDICARE PART A APPEALS

(Includes claims for Hospital, Skilled Nursing Facility, Home Health, & Hospice)

Stage of Appeal:	**Redetermination Request**	**Reconsideration Request**	**Administrative Law Judge (ALJ) Hearing Request**	**Request for Medicare Appeals Council**	**Request For Judicial Review**
Time Deadline for Filing Appeal:	Within 120 Days of receipt of “Initial Determination”	Within 180 Days of receipt of “Redetermination”	Within 60 Days of receipt of "Reconsideration Determination"	Within 60 Days of receipt of ALJ "Hearing Decision"	Within 60 Days of receipt of "MAC Decision"
Amount of Claim:	No Minimum	No Minimum	$130 Minimum* $200 for Hospital case	$130 Minimum * $200 for Hospital case	$1,260 Minimum* $2000 for Hospital case
File Appeal Request With:	Medicare Contractor (Fiscal intermediary)	Qualified Independent Contractor (QIC)	Qualified Independent Contractor (QIC)	U.S. Dept. of Health and Human Services	United States District Court
Appeal Reviewed & Decided By:	Medicare Contractor	Qualified Independent Contractor (QIC)	Administrative Law Judge from US Dept. of Health and Human Services	U.S. Dept. of Health and Human Services Medicare Council	United States District Court

*****The amount in controversy is increased annually by the percentage increase in the medical care component price index.

** This chart does not describe the “fast-track” or “expedited appeals” process which is available when all Medicare covered services are being terminated or the patient is being completely discharged from care. Please contact the Center for Medicare Advocacy with questions about the “fast-track” or “expedited appeals” process

INSTRUCTIONS FOR COMPLETING REDETERMINATION REQUEST FORM

Although most sections of the form are self-explanatory, a few sections may not be so clear. Below are instructions for completing those sections as well as instructions for submitting your Request for Redetermination. Remember to refer to the included Glossary of Terms if need be.

#2. Medicare Number- This number can be found in the upper right section of the "Medicare Summary Notice." You can also use the Social Security number under which you receive benefits. Your Medicare Number can also be found on your Medicare card.

#5. My reasons are: - Fill in the following: "The services provided are coverable under the Medicare Act." If you missed the 120 day appeal deadline, you will need to establish "good cause" for late filing of your Request Redetermination. Here are some acceptable "good cause" reasons.

#6. Date of the initial determination notice-The date can be found on the "Medicare Summary Notice" in a box in the upper Right hand corner.

If you received your initial determination notice more than 120 days ago, include your reason for late filing from the options below:

a. During the time in question, the patient suffered from (list illnesses), and thus was unable to attend to matters of personal business. Waiver is sought pursuant to 42 CFR §405.942(b)(i).

b. During the time in question, the patient had a death or serious illness in his/her immediate family. Waiver is sought pursuant to 42 CFR §405.942(b)(3)(iii).

c. Important records were destroyed or damaged by fire or other accidental cause. Waiver is sought pursuant to 42 CFR §405.942(b)(3)(iii).

d. The Medicare contractor did not give the patient correct or complete information about when or how to request a Redetermination. Waiver is sought pursuant to 42 CFR §405.942(b)(3)(iv).

e. The patient did not receive the initial determination. Waiver is sought pursuant to 42 CFR §405.942(b)(3)(v).

f. The patient sent the request to a government agency in good faith within the time limit but the request did not reach the appropriate contractor until after the time period had passed. Waiver is sought pursuant to 42 CFR §405.942(b)(3)(vi.)

If you are representing the beneficiary, have him/her sign the Appointment of Representative form included in this packet and attach a copy with the Request for Redetermination.

When completed, keep a copy for your records and deliver/mail* the original to the Medicare contractor. Attach a copy of the Medicare denial notice being appealed, and if appropriate, copies of your Appointment Representative form.

REMEMBER: KEEP THE ORGINAL OR A COPY OF ALL PAPERS YOU SUBMIT.

*Name and Address of the Medicare Contractor can be found on the "Medicare Summary Notice".

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE REDETERMINATION REQUEST FORM

1. Beneficiary's Name: ____________________

2. Medicare Number: ____________________

3. Description of Item or Service in Question: ____________________

4. Date the Service or Item was Received: ____________________

5. I do not agree with the determination of my claim. MY REASONS ARE:

____

____

____

6. Date of the initial determination notice ____________________
(If you received your initial determination notice more than 120 days ago, include your reason for not making this request earlier.)

____

____

____

7. Additional Information Medicare Should Consider: ____________________

____

____

____

8. Requester's Name: ____________________

9. Requester's Relationship to the Beneficiary: ____________________

10. Requester's Address: ____________________

____

11. Requester's Telephone Number: ____________________

12. Requester's Signature: ____________________

13. Date Signed: ____________________

14. ☐ I have evidence to submit. (Attach such evidence to this form.)
☐ I do not have evidence to submit.

NOTICE: Anyone who misrepresents or falsifies essential information requested by this form may upon conviction be subject to fine or imprisonment under Federal Law.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Form Approved
OMB no. 0938-0950

APPOINTMENT OF REPRESENTATIVE

NAME OF BENEFICIARY	MEDICARE NUMBER

SECTION I: APPOINTMENT OF REPRESENTATIVE

To be completed by the beneficiary:

I appoint this individual: ______________________________ to act as my representative in connection with my claim or asserted right under Title XVIII of the Social Security Act (the "Act") and related provisions of Title XI of the Act. I authorize this individual to make any request; to present or to elicit evidence; to obtain appeals information; and to receive any notice in connection with my appeal, wholly in my stead. I understand that personal medical information related to my appeal may be disclosed to the representative indicated below.

SIGNATURE OF BENEFICIARY		DATE
STREET ADDRESS		PHONE NUMBER (AREA CODE)
CITY	STATE	ZIP

SECTION II: ACCEPTANCE OF APPOINTMENT

To be completed by the representative:

I, ______________________________, hereby accept the above appointment. I certify that I have not been disqualified, suspended, or prohibited from practice before the Department of Health and Human Services; that I am not, as a current or former employee of the United States, disqualified from acting as the beneficiary's representative; and that I recognize that any fee may be subject to review and approval by the Secretary.

I am a / an ____
(PROFESSIONAL STATUS OR RELATIONSHIP TO THE PARTY, E.G. ATTORNEY, RELATIVE, ETC.)

SIGNATURE		DATE
STREET ADDRESS		PHONE NUMBER (AREA CODE)
CITY	STATE	ZIP

SECTION III: WAIVER OF FEE FOR REPRESENTATION

Instructions: This form should be filled out if the representative waives a fee for such representation. (Note that providers or suppliers may not charge a fee for representation and thus, all providers or suppliers that furnished the items or services at issue **must** complete this section.)

I waive my right to charge and collect a fee for representing ______________________________ before the Secretary of the Department of Health and Human Services.

SIGNATURE	DATE

SECTION IV: WAIVER OF PAYMENT FOR ITEMS OR SERVICES AT ISSUE

Instructions: Providers or suppliers that furnished the items or services at issue must complete this section if the appeal involves a question of liability under section 1879(a)(2) of the Act. (Section 1879(a)(2) generally addresses whether a provider/supplier or beneficiary did not know, and could not reasonably be expected to know, that the items or services at issue would not be covered by Medicare.)

I waive my right to collect payment from the beneficiary for furnished items or services at issue involving 1879(a)(2) of the Act.

SIGNATURE	DATE

CHARGING OF FEES FOR REPRESENTING BENEFICIARIES BEFORE THE SECRETARY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

An attorney, or other representative for a beneficiary, who wishes to charge a fee for services rendered in connection with an appeal before the Department of Health and Human Services (DHHS) at the Administrative Law Judge (ALJ) or Medicare Appeals Council (MAC) level is required by law to obtain approval of the fee in accordance with 42 CFR §405.910(f). A claim that has been remanded by a court to the Secretary for further administrative proceedings is considered to be before the Secretary after the remand by the court.

The form, "Petition to Obtain Representative Fee" elicits the information required for a fee petition. It should be completed by the representative and filed with DHHS. Where a representative has rendered services in a claim before DHHS, the regulations require that the amount of the fee to be charged, if any, for services performed before the Secretary of DHHS be specified. If any fee is to be charged for such services, a petition for approval of that amount must be submitted.

An approval of a fee is not required where the appellant is a provider or supplier or where the fee is for services (1) rendered in an official capacity such as that of legal guardian, committee, or similar court-appointed office and the court has approved the fee in question; (2) in representing the beneficiary before the federal district court of above, or (3) in representing the beneficiary in appeals below the ALJ level. If the representative wishes to waive a fee, he or she may do so. Section III on the front of this form can be used for that purpose. In some instances, as indicated on the form, the fee must be waived for representation.

AUTHORIZATION OF FEE

The requirement for the approval of fees ensures that representative will receive fair value for the services performed before DHHS on behalf of a claimant while at the same time giving a measure of security to the beneficiaries. In approving a requested fee, the ALJ or MAC considers the nature and type of services performed, the complexity of the case, the level of skill and competence required in rendition of the services, the amount of time spent on the case, the results achieved, the level of administrative review to which the representative carried the appeal and the amount of the fee requested by the representative.

CONFLICT OF INTEREST

Sections 203, 205 and 207 of Title XVIII of the United States Code make it a criminal offense for certain officers, employees and former officers and employees of the United States to render certain services in matters affecting the Government or to aid or assist in the prosecution of claims against the United States. Individuals with a conflict of interest are excluded from being representatives of beneficiaries before DHHS.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0950. The time required to prepare and distribute this collection is 15 minutes per notice, including the time to select the preprinted form, complete it and deliver it to the beneficiary. If you have comments concerning the accuracy of the time estimates or suggestions for improving this form, please write to CMS, PRA Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

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 Unites 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.

Federal Regulations
Requirements for Medicare Coverage for Skilled Nursing Facility Care

42 CFR 409.30 - 409.36

Subpart D—Requirements for Coverage of Posthospital SNF Care

§409.30 Basic requirements.

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.*[1] (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.

[48 FR 12541, Mar. 25, 1983, as amended at 51 FR 41338, Nov. 14, 1986; 58 FR 30666, 30667, May 26, 1993; 62 FR 46025, Aug. 29, 1997; 63 FR 26307, May 12, 1998; 64 FR 41681, July 30, 1999; 68 FR 50584, Aug. 22, 2003; 72 FR 43436, Aug. 3, 2007]

§ 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.

[48 FR 12541, Mar. 25, 1983, as amended at 58 FR 30666, May 26, 1993; 68 FR 50854, Aug. 22, 2003; 70 FR 45055, Aug. 4, 2005]

§ 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

[1] 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.

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.

[48 FR 12541, Mar. 25, 1983, as amended at 59 FR 65493, Dec. 20, 1994]

§ 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.

[48 FR 12541, Mar. 25, 1983, as amended at 63 FR 26307, May 12, 1998; 64 FR 41681, July 30, 1999]

§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.

[48 FR 12541, Mar. 25, 1983, as amended at 50 FR 33033, Aug. 16, 1985]

§ 409.36 Effect of discharge from posthospital SNF care.

If a beneficiary is discharged from a facility after receiving posthospital SNF care, he or she is not entitled to additional services of this kind in the same benefit period unless—

(a) He or she is readmitted to the same or another facility within 30 calendar days following the day of discharge (or, before December 5, 1980, within 14 calendar days after discharge); or

(b) He or she is again hospitalized for at least 3 consecutive calendar days.

Subpart E—Home Health Services Under Hospital Insurance

§ 409.40 Basis, purpose, and scope.

This subpart implements sections 1814(a)(2)(C), 1835(a)(2)(A), and 1861(m) of the Act with respect to the requirements that must be met for Medicare payment to be made for home health services furnished to eligible beneficiaries.

[59 FR 65493, Dec. 20, 1994]

§ 409.41 Requirement for payment.

In order for home health services to qualify for payment under the Medicare program the following requirements must be met:

(a) The services must be furnished to an eligible beneficiary by, or under arrangements with, an HHA that—

(1) Meets the conditions of participation for HHAs at part 484 of this chapter; and

(2) Has in effect a Medicare provider agreement as described in part 489, subparts A, B, C, D, and E of this chapter.

(b) The physician certification and recertification requirements for home health services described in § 424.22.

(c) All requirements contained in §§ 409.42 through 409.47.

[59 FR 65494, Dec. 20, 1994]

§ 409.42 Beneficiary qualifications for coverage of services.

To qualify for Medicare coverage of home health services, a beneficiary must meet each of the following requirements:

(a) *Confined to the home.* The beneficiary must be confined to the home or in an institution that is not a hospital, SNF or nursing facility as defined in section 1861(e)(1), 1819(a)(1) or 1919(a)(1) of the Act, respectively.

(b) *Under the care of a physician.* The beneficiary must be under the care of a physician who establishes the plan of care. A doctor of podiatric medicine may establish a plan of care only if that is consistent with the functions he or she is authorized to perform under State law.

(c) *In need of skilled services.* The beneficiary must need at least one of the following skilled services as certified by a physician in accordance with the physician certification and recertification requirements for home health services under § 424.22 of this chapter.

(1) Intermittent skilled nursing services that meet the criteria for skilled services and the need for skilled services found in § 409.32. (Also see § 409.33(a) and (b) for a description of examples of skilled nursing and rehabilitation services.)

(2) Physical therapy services that meet the requirements of § 409.44(c).

(3) Speech-language pathology services that meet the requirements of § 409.44(c).

(4) Continuing occupational therapy services that meet the requirements of

IMPORTANT SELECTIONS FROM THE MEDICARE BENEFIT POLICY MANUAL

Chapter 8—Coverage of Extended Care (SNF) Services Under Hospital Insurance

30 - Skilled Nursing Facility Level of Care - General

(Rev. 1, 10-01-03)

Care in a SNF is covered if all of the following four factors are met:

- The patient requires skilled nursing services or skilled rehabilitation services, i.e., services that must be performed by or under the supervision of professional or technical personnel (see §§30.2 - 30.4); are ordered by a physician and the services are rendered for a condition for which the patient received inpatient hospital services or for a condition that arose while receiving care in a SNF for a condition for which he received inpatient hospital services;

- The patient requires these skilled services on a daily basis (see §30.6); and

- As a practical matter, considering economy and efficiency, the daily skilled services can be provided only on an inpatient basis in a SNF. (See §30.7.)

- The services must be reasonable and necessary for the treatment of a patient's illness or injury, i.e., be consistent with the nature and severity of the individual's illness or injury, the individual's particular medical needs, and accepted standards of medical practice. The services must also be reasonable in terms of duration and quantity.

If any one of these four factors is not met, a stay in a SNF, even though it might include the delivery of some skilled services, is not covered. For example, payment for a SNF level of care could not be made if a patient needs an intermittent rather than daily skilled service.

In reviewing SNF services to determine whether the level of care requirements are met, the intermediary first considers whether a patient needs skilled care. If a need for a skilled service does not exist, then the "daily" and "practical matter" requirements are not addressed.

Eligibility for SNF Medicare A coverage has not changed with the inception of PPS. However, the skilled criteria and the medical review process have changed slightly. For Medicare to render payment for skilled services provided to a beneficiary during a SNF Part A stay, the facility must complete an MDS.

EXAMPLE: Even though the irrigation of a suprapubic catheter may be a skilled nursing service, daily irrigation may not be "reasonable and necessary" for the treatment of a patient's illness or injury.

30.1 – Administrative Level of Care Presumption

(Rev. 57, Issued: 11-08-06, Effective: 07-27-66, Implementation: 12-14-06)

Under the SNF PPS, beneficiaries who are admitted (or readmitted) directly to a SNF after a qualifying hospital stay are considered to meet the level of care requirements of 42

CFR 409.31 up to and including the assessment reference date (ARD) for the 5-day assessment prescribed in 42 CFR 413.343(b), when correctly assigned to one of the Resource Utilization Groups (RUGs) that is designated (in the annual publication of Federal prospective payment rates described in 42 CFR 413.345) as representing the required level of care. If the beneficiary is not admitted (or readmitted) directly to a SNF after a qualifying hospital stay, the administrative level of care presumption does not apply.

For purposes of this presumption, the assessment reference date is defined in accordance with 42 CFR 483.315(d), and must occur no later than the eighth day of posthospital SNF care. Consequently, if the ARD for the 5-day assessment* prescribed in 42 CFR 413.343(b) is set on day 9, or later, the administrative level of care presumption does not apply. The coverage that arises from this presumption remains in effect for as long thereafter as it continues to be supported by the facts of the beneficiary's condition and care needs. However, this administrative presumption does not apply to any of the subsequent assessments.

To be correctly assigned, the data coded on the Resident Assessment Instrument (RAI) must be accurate and meet the definitions described in the Long Term Care Facility RAI User's Manual. The beneficiary must receive services in the SNF that are reasonable and necessary. Services provided to the beneficiary during the hospital stay are reviewed to ensure proper coding of the most recent version of the RAI. The two examples illustrated below demonstrate a correct assignment and an incorrect assignment.

<u>Incorrect Assignment</u>: IV med provided in hospital coded on MDS, but IV was for a surgical procedure only – as a consequence, the MDS is not accurate and the presumption does not apply (<u>see</u> Chapter 3, Section P of the RAI).

<u>Correct Assignment</u>: Beneficiary is receiving oxygen therapy as well as rehab service. The respiratory therapy services are found reasonable and necessary; however, the rehab services are found not reasonable and necessary, resulting in a revised RUG. Beneficiary was and is now correctly assigned – presumption applies.

A beneficiary who groups into other than one of the RUGs designated as representing the required level of care on the 5-day assessment prescribed in 42 CFR 413.343(b) is not automatically classified as meeting or not meeting the SNF level of care definition. Instead, the beneficiary must receive an individual level of care determination using existing administrative criteria and procedures.

*Includes Medicare Readmission/Return Assessment.

The following scenarios further clarify that a beneficiary's correct classification to one of the RUGs that is designated (in the annual publication of Federal prospective payment rates described in 42 CFR 413.345) as representing the required level of care triggers the

coverage presumption under the initial 5-day, Medicare-required assessment only when that assessment occurs directly following the beneficiary's hospital discharge.

1. Routine SNF Admission Directly From Qualifying Hospital Stay

If the beneficiary is admitted to the SNF immediately following a 3-day qualifying hospital stay, there is a presumption that he or she meets the Medicare level of care criteria when correctly assigned to one of the RUGs that is designated (in the annual publication of Federal prospective payment rates described in 42 CFR 413.345) as representing the required level of care. The presumption lasts through the assessment reference date of the 5-day assessment, which must occur no later than the eighth day of the stay.

2. Admission to SNF does not immediately follow discharge from the qualifying hospital stay, but occurs within 30 days (as required under the "30 day transfer" rule)
If the beneficiary is discharged from the hospital to a setting other than the SNF, the presumption of coverage does not apply, even if the beneficiary's SNF admission occurs within 30 days of discharge from the qualifying hospital stay. Accordingly, coverage would be determined based on a review of the medical evidence in the file.

3. SNF Resident is Re-Hospitalized and Then Returns Directly to the SNF

If a beneficiary who has been in a covered Part A stay requires readmission to a hospital, and subsequently returns directly to the SNF for continuing care, there is a presumption that he or she meets the level of care criteria upon readmission to the SNF when correctly assigned to one of the RUGs that is designated (in the annual publication of Federal prospective payment rates described in 42 CFR 413.345) as representing the required level of care. A new Medicare 5-day assessment is required and the presumption of coverage lasts through the assessment reference date of that assessment, which must occur no later than the eighth day of the stay.

4. Routine SNF Admission Directly From Qualifying Hospital Stay, but Initial Portion of SNF Stay Covered by Another Insurer (Medicare as Secondary Payer)

When a beneficiary goes directly from a qualifying hospital stay to the SNF, but the initial portion of the SNF stay is covered by another insurer that is primary to Medicare, Medicare coverage would not start until coverage by the primary insurer ends. Accordingly, the Medicare required schedule of assessments is not required to begin until the first day of Medicare coverage. If a beneficiary met the level of care criteria for Medicare coverage during the first 8 days of the stay following a qualifying hospital stay, and the other insurer covered this part of the stay, there is no presumption. If Medicare becomes primary before the eighth day of the stay following a qualifying hospital stay, the presumption would apply through the assessment reference date on the 5-day assessment or, if earlier, the eighth day of the stay.

5. Readmission to SNF Within 30 Days After Discharge From Initial SNF Stay – No Intervening Hospitalization

As noted in scenario 1, if a beneficiary is initially admitted to the SNF directly from the hospital for a covered Part A stay, the presumption for that stay is applicable when the beneficiary is correctly assigned to one of the RUGs that is designated (in the annual publication of Federal prospective payment rates described in 42 CFR 413.345) as representing the required level of care. However, if that beneficiary is discharged (NOT to an acute care facility) and then subsequently readmitted, there is no presumption applicable to the second SNF admission. (If the beneficiary is transferred to a hospital, and returns directly to the SNF, see scenario 3 above).

6. Initial, Non-Medicare SNF Stay Followed by Qualifying Hospitalization and Readmission to SNF for Medicare Stay

Dually eligible (Medicare/Medicaid) beneficiaries whose initial stay in the SNF is either Medicaid-covered or private pay, are eligible for the Medicare presumption of coverage when readmitted to the SNF following a qualifying hospitalization, when correctly assigned to one of the RUGs that is designated (in the annual publication of Federal prospective payment rates described in 42 CFR 413.345) as representing the required level of care. (Of course, in order to qualify for Medicare coverage upon readmission, the beneficiary must be placed in the portion of the institution that is actually certified by Medicare as a SNF.)

No presumption of coverage applies when Medicare is the secondary payer for days 1 through 8 of the covered stay where Medicare becomes primary after day 8 due to a reversal or denial by the secondary insurer.

7. Transfer From One SNF to Another

There is no presumption of coverage in cases involving the transfer of a beneficiary from one SNF to another or from SNF-level care in a swing bed to a SNF. The presumption only applies to the SNF stay that immediately follows the qualifying hospital stay when the beneficiary is correctly assigned to one of the RUGs that is designated (in the annual publication of Federal prospective payment rates described in 42 CFR 413.345) as representing the required level of care. Therefore, in cases involving transfer of a beneficiary from a swing-bed hospital to a SNF, the presumption only applies if the beneficiary was receiving acute care (rather than SNF-level care) immediately prior to discharge from the swing-bed hospital.

<u>Federal Register Notices Designating RUGs Representing Required Level of Care</u>

FR Vol. 70, No. 149/August 4, 2005 Pg. 45045

30.2 - Skilled Nursing and Skilled Rehabilitation Services

(Rev. 1, 10-01-03)

A3-3132.1, SNF-214.1

30.2.1 - Skilled Services Defined
(Rev. 37, Issued: 08-12-05; Effective/Implementation: 09-12-05)

Skilled nursing and/or skilled rehabilitation services are those services, furnished pursuant to physician orders, that:

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

- Must be provided directly by or under the general supervision of these skilled nursing or skilled rehabilitation personnel to assure the safety of the patient and to achieve the medically desired result.

NOTE: "General supervision" requires initial direction and periodic inspection of the actual activity. However, the supervisor need not always be physically present or on the premises when the assistant is performing services.

30.2.2 - Principles for Determining Whether a Service is Skilled
(Rev. 1, 10-01-03)

A3-3132.1.B, SNF-214.1.B

- If the inherent complexity of a service prescribed for a patient is such that it can be performed safely and/or effectively only by or under the general supervision of skilled nursing or skilled rehabilitation personnel, the service is a skilled service; e.g., the administration of intravenous feedings and intramuscular injections; the insertion of suprapubic catheters; and ultrasound, shortwave, and microwave therapy treatments.

- The intermediary considers the nature of the service and the skills required for safe and effective delivery of that service in deciding whether a service is a skilled service. While a patient's particular medical condition is a valid factor in deciding if skilled services are needed, a patient's diagnosis or prognosis should never be the sole factor in deciding that a service is not skilled.

  EXAMPLE: 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. (See §30.5.)

- A service that is ordinarily considered nonskilled could be considered a skilled service in cases in which, because of special medical complications, skilled

nursing or skilled rehabilitation personnel are required to perform or supervise it or to observe the patient. In these cases, the complications and special services involved must be documented by physicians' orders and nursing or therapy notes.

EXAMPLE:

Whirlpool baths do not ordinarily require the skills of a qualified physical therapist. However, the skills, knowledge, and judgment of a qualified physical therapist might be required where the patient's condition is complicated by circulatory deficiency, areas of desensitization, or open wounds.

- In determining whether services rendered in a SNF constitute covered care, it is necessary to determine whether individual services are skilled, and whether, in light of the patient's total condition, skilled management of the services provided is needed even though many or all of the specific services were unskilled.

EXAMPLE:

An 81-year-old woman who is aphasic and confused, suffers from hemiplegia, congestive heart failure, and atrial fibrillation, has suffered a cerebrovascular accident, is incontinent, has a Stage 1 decubitus ulcer, and is unable to communicate and make her needs known. Even though no specific service provided is skilled, the patient's condition requires daily skilled nursing involvement to manage a plan for the total care needed, to observe the patient's progress, and to evaluate the need for changes in the treatment plan.

- The importance of a particular service to an individual patient, or the frequency with which it must be performed, does not, by itself, make it a skilled service.

EXAMPLE:

A primary need of a nonambulatory patient may be frequent changes of position in order to avoid development of decubitus ulcers. However, since such changing of position does not ordinarily require skilled nursing or skilled rehabilitation personnel, it would not constitute a skilled service, even though such services are obviously necessary.

- The possibility of adverse effects from the improper performance of an otherwise unskilled service does not make it a skilled service unless there is documentation to support the need for skilled nursing or skilled rehabilitation personnel. 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. In all such cases, the reasons why skilled nursing or skilled rehabilitation personnel are essential must be documented in the patient's record.

30.2.3 - Specific Examples of Some Skilled Nursing or Skilled Rehabilitation Services

(Rev. 1, 10-01-03)

A3-3132.1.C, SNF-214.1.C

30.2.3.1 - Management and Evaluation of a Patient Care Plan
(Rev. 1, 10-01-03)

A3-3132.1.C.1, SNF-214.1.C.1

The development, management, and evaluation of a patient care plan, based on the physician's orders, constitute skilled nursing services when, in terms of the patient's physical or mental condition, these services require the involvement of skilled nursing personnel to meet the patient's medical needs, promote recovery, and ensure medical safety. However, the planning and management of a treatment plan that does not involve the furnishing of skilled services may not require skilled nursing personnel; e.g., a care plan for a patient with organic brain syndrome who requires only oral medication and a protective environment. The sum total of nonskilled services would only add up to the need for skilled management and evaluation when the condition of the beneficiary is such that there is an expectation that a change in condition is likely without that intervention.

EXAMPLE 1:

An aged patient with a history of diabetes mellitus and angina pectoris is recovering from an open reduction of the neck of the femur. He requires, among other services, careful skin care, appropriate oral medications, a diabetic diet, a therapeutic exercise program to preserve muscle tone and body condition, and observation to notice signs of deterioration in his condition or complications resulting from his restricted (but increasing) mobility. Although any of the required services could be performed by a properly instructed person, that person would not have the capability to understand the relationship among the services and their effect on each other. Since the nature of the patient's condition, his age and his immobility create a high potential for serious complications, such an understanding is essential to assure the patient's recovery and safety. The management of this plan of care requires skilled nursing personnel until the patient's treatment regimen is essentially stabilized, even though the individual services involved are supportive in nature and do not require skilled nursing personnel.

EXAMPLE 2:

An aged patient is recovering from pneumonia, is lethargic, is disoriented, has residual chest congestion, is confined to bed as a result of his debilitated condition, and requires restraints at times. To decrease the chest congestion, the physician has prescribed frequent changes in position, coughing, and deep breathing. While the residual chest congestion alone would not represent a high risk factor, the patient's immobility and confusion represent complicating factors which, when coupled with the chest congestion, could create high probability of a relapse. In this situation, skilled overseeing of the

nonskilled services would be reasonable and necessary, pending the elimination of the chest congestion, to assure the patient's medical safety.

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 assured only if the total care, skilled or not, is planned and managed by skilled nursing personnel, the intermediary assumes that skilled management is being provided even though it is not readily discernible from the record. It makes this assumption only if the record as a whole clearly establishes that there was a likely potential for serious complications without skilled management.

30.2.3.2 - Observation and Assessment of Patient's Condition
(Rev. 1, 10-01-03)

A3-3132.1.C.2, SNF-214.1.C.2

Observation and assessment are skilled services when the likelihood of change in a patient's condition requires skilled nursing or skilled rehabilitation personnel to identify and evaluate the patient's need for possible modification of treatment or initiation of additional medical procedures, until the patient's treatment regimen is essentially stabilized.

EXAMPLE 1:

A patient with arteriosclerotic heart disease with congestive heart failure requires close observation by skilled nursing personnel for signs of decompensation, abnormal fluid balance, or adverse effects resulting from prescribed medication. Skilled observation is needed to determine whether the digitalis dosage should be reviewed or whether other therapeutic measures should be considered, until the patient's treatment regimen is essentially stabilized.

EXAMPLE 2:

A patient has undergone peripheral vascular disease treatment including revascularization procedures (bypass) with open or necrotic areas of skin on the involved extremity. Skilled observation and monitoring of the vascular supply of the legs is required.

EXAMPLE 3:

A patient has undergone hip surgery and has been transferred to a SNF. Skilled observation and monitoring of the patient for possible adverse reaction to the operative procedure, development of phlebitis, skin breakdown, or need for the administration of subcutaneous Heparin, is both reasonable and necessary.

EXAMPLE 4:

A patient has been hospitalized following a heart attack, and following treatment but before mobilization, is transferred to the SNF. Because it is unknown whether exertion will exacerbate the heart disease, skilled observation is reasonable and necessary as mobilization is initiated, until the patient's treatment regimen is essentially stabilized.

EXAMPLE 5:

A frail 85-year-old man was hospitalized for pneumonia. The infection was resolved, but the patient, who had previously maintained adequate nutrition, will not eat or eats poorly. The patient is transferred to a SNF for monitoring of fluid and nutrient intake, assessment of the need for tube feeding and forced feeding if required. Observation and monitoring by skilled nursing personnel of the patient's oral intake is required to prevent dehydration.

If a patient was admitted for skilled observation but did not develop a further acute episode or complication, the skilled observation services still are covered so long as there was a reasonable probability for such a complication or further acute episode. "Reasonable probability" means that a potential complication or further acute episode was a likely possibility.

Skilled observation and assessment may also be required for patients whose primary condition and needs are psychiatric in nature or for patients who, in addition to their physical problems, have a secondary psychiatric diagnosis. These patients may exhibit acute psychological symptoms such as depression, anxiety or agitation, which require skilled observation and assessment such as observing for indications of suicidal or hostile behavior. However, these conditions often require considerably more specialized, sophisticated nursing techniques and physician attention than is available in most participating SNFs. (SNFs that are primarily engaged in treating psychiatric disorders are precluded by law from participating in Medicare.) Therefore, these cases must be carefully documented.

30.2.3.3 - Teaching and Training Activities
(Rev. 1, 10-01-03)

A3-3132.1.C.3, SNF-214.1.C.3

Teaching and training activities, which require skilled nursing or skilled rehabilitation personnel to teach a patient how to manage their treatment regimen, would constitute skilled services. Some examples are:

- Teaching self-administration of injectable medications or a complex range of medications;

- Teaching a newly diagnosed diabetic to administer insulin injections, to prepare and follow a diabetic diet, and to observe foot-care precautions;

- Teaching self-administration of medical gases to a patient;
- Gait training and teaching of prosthesis care for a patient who has had a recent leg amputation;
- Teaching patients how to care for a recent colostomy or ileostomy;
- Teaching patients how to perform self-catheterization and self-administration of gastrostomy feedings;
- Teaching patients how to care for and maintain central venous lines, such as Hickman catheters;
- Teaching patients the use and care of braces, splints and orthotics, and any associated skin care; and
- Teaching patients the proper care of any specialized dressings or skin treatments.

30.2.4 - Questionable Situations
(Rev. 1, 10-01-03)

A3-3132.1.D, SNF-214.1.D

There must be specific evidence that daily skilled nursing or skilled rehabilitation services are required and received if:

- The primary service needed is oral medication; or
- The patient is capable of independent ambulation, dressing, feeding, and hygiene.

30.3 - Direct Skilled Nursing Services to Patients
(Rev. 1, 10-01-03)

A3-3132.2, SNF-214.2

Some examples of direct skilled nursing services are:

- Intravenous or intramuscular injections and intravenous feeding;
- Enteral feeding that comprises at least 26 percent of daily calorie requirements and provides at least 501 milliliters of fluid per day;
- Naso-pharyngeal and tracheotomy aspiration;
- Insertion, sterile irrigation, and replacement of suprapubic catheters;

- Application of dressings involving prescription medications and aseptic techniques (see §30.5 for exception);

- Treatment of decubitus ulcers, of a severity rated at Stage 3 or worse, or a widespread skin disorder (see §30.5 for exception);

- Heat treatments which have been specifically ordered by a physician as part of active treatment and which require observation by skilled nursing personnel to evaluate the patient's progress adequately (see §30.5 for exception);

- Rehabilitation nursing procedures, including the related teaching and adaptive aspects of nursing, that are part of active treatment and require the presence of skilled nursing personnel; e.g., the institution and supervision of bowel and bladder training programs;

- Initial phases of a regimen involving administration of medical gases such as bronchodilator therapy; and

- Care of a colostomy during the early post-operative period in the presence of associated complications. The need for skilled nursing care during this period must be justified and documented in the patient's medical record.

30.4 - Direct Skilled Rehabilitation Services to Patients
(Rev. 1, 10-01-03)

A3-3132.1.C, SNF-214.1.C

30.4.1 – Skilled Physical Therapy
(Rev. 1, 10-01-03)

A3-3132.3A, SNF-214.3.A

30.4.1.1 - General
(Rev. 73, Issued: 06-29-07, Effective: 07-30-99, Implementation: 10-01-07)

Skilled physical therapy services must meet all of the following conditions:

- The services must be directly and specifically related to an active written treatment plan that is based upon an initial evaluation performed by a qualified physical therapist after admission to the SNF and prior to the start of physical therapy services in the SNF that is approved by the physician after any needed consultation with the qualified physical therapist. In those cases where a beneficiary is discharged during the SNF stay and later readmitted, an initial evaluation must be performed upon readmission to the SNF, prior to the start of physical therapy services in the SNF;

- The services must be of a level of complexity and sophistication, or the condition of the patient must be of a nature that requires the judgment, knowledge, and skills of a qualified physical therapist;

- The services must be provided with the expectation, based on the assessment made by the physician of the patient's restoration potential, that the condition of the patient will improve materially in a reasonable and generally predictable period of time, or the services must be necessary for the establishment of a safe and effective maintenance program;

- The services must be considered under accepted standards of medical practice to be specific and effective treatment for the patient's condition; and,

- The services must be reasonable and necessary for the treatment of the patient's condition; this includes the requirement that the amount, frequency, and duration of the services must be reasonable.

EXAMPLE 1:

An 80-year old, previously ambulatory, post-surgical patient has been bed-bound for 1 week, and, as a result, had developed muscle atrophy, orthostatic hypotension, joint stiffness and lower extremity edema. To the extent that the patient requires a brief period of daily skilled physical therapy to restore lost functions, those services are reasonable and necessary.

EXAMPLE 2:

A patient with congestive heart failure also has diabetes and previously had both legs amputated above the knees. Consequently, the patient does not have a reasonable potential to achieve ambulation, but still requires daily skilled physical therapy to learn bed mobility and transferring skills, as well as functional activities at the wheelchair level. If the patient has a reasonable potential for achieving those functions in a reasonable period of time in view of the patient's total condition, the physical therapy services are reasonable and necessary.

If the expected results are insignificant in relation to the extent and duration of physical therapy services that would be required to achieve those results, the physical therapy would not be reasonable and necessary, and thus would not be covered skilled physical therapy services.

Many SNF inpatients do not require skilled physical therapy services but do require services, which are routine in nature. Those services can be performed by supportive personnel; e.g., aides or nursing personnel, without the supervision of a physical therapist. Such services, as well as services involving activities for the general good and welfare of the patient (e.g., general exercises to promote overall fitness and flexibility and

activities to provide diversion or general motivation) do not constitute skilled physical therapy.

30.4.1.2 - Application of Guidelines

(Rev. 1, 10-01-03)

A3-3132.3.A.2, SNF-214.3.A.2

Some of the more common skilled physical therapy modalities and procedures are:

A. Assessment

The skills of a physical therapist are required for the ongoing assessment of a patient's rehabilitation needs and potential. Skilled rehabilitation services concurrent with the management of a patient's care plan include tests and measurements of range of motion, strength, balance, coordination, endurance, and functional ability.

B. Therapeutic Exercises

Therapeutic exercises, which must be performed by or under the supervision of the qualified physical therapist, due either to the type of exercise employed or to the condition of the patient.

C. Gait Training

Gait evaluation and training furnished to a patient whose ability to walk has been impaired by neurological, muscular, or skeletal abnormality often require the skills of a qualified physical therapist.

Repetitious exercises to improve gait, or to maintain strength and endurance, and assistive walking are appropriately provided by supportive personnel, e.g., aides or nursing personnel, and do not require the skills of a physical therapist. Thus, such services are not skilled physical therapy.

D. Range of Motion

Only the qualified physical therapist may perform range of motion tests and, therefore, such **tests** are skilled physical therapy. Range of motion **exercises** constitute skilled physical therapy only if they are part of active treatment for a specific disease state which has resulted in a loss or restriction of mobility (as evidenced by physical therapy notes showing the degree of motion lost, the degree to be restored and the impact on mobility and/or function).

Range of motion exercises which are not related to the restoration of a specific loss of function often may be provided safely by supportive personnel, such as aides or nursing personnel, and may not require the skills of a physical therapist. Passive exercises to

maintain range of motion in paralyzed extremities that can be carried out by aides or nursing personnel would not be considered skilled care.

E. Maintenance Therapy

The repetitive services required to maintain function sometimes involve the use of complex and sophisticated therapy procedures and, consequently, the judgment and skill of a physical therapist might be required for the safe and effective rendition of such services. (See §30.2)The specialized knowledge and judgment of a qualified physical therapist may be required to establish a maintenance program intended to prevent or minimize deterioration caused by a medical condition, if the program is to be safely carried out by caregivers and the treatment goals of the physician are achieved. Establishing such a program is a skilled service.

EXAMPLE: A patient with Parkinson's disease may require the services of a physical therapist to determine the type of exercises that are required to maintain his present level of function. The initial evaluation of the patient's needs, the designing of a maintenance program which is appropriate to the capacity and tolerance of the patient and the treatment objectives of the physician, the instruction of the patient or supportive personnel (e.g., aides or nursing personnel) in the carrying out of the program, would constitute skilled physical therapy.

While a patient is receiving a skilled physical therapy program, the physical therapist should regularly reevaluate the patient's condition and adjust any exercise program the patient is expected to carry out independently or with the aid of supportive personnel to maintain the function being restored. Consequently, by the time it is determined that no further restoration is possible, i.e., by the end of the last skilled session, the physical therapist will have already designed the maintenance program required and instructed the patient or supportive personnel in the carrying out of the program.

F. Ultrasound, Shortwave, and Microwave Diathermy Treatments

These modalities must always be performed by or under the supervision of a qualified physical therapist.

G. Hot Packs, Infra-Red Treatments, Paraffin Baths, and Whirlpool Baths

Heat treatments and baths of this type ordinarily do not require the skills of a qualified physical therapist. However, the skills, knowledge, and judgment of a qualified physical therapist might be required in the giving of such treatments or baths in a particular case, e.g., where the patient's condition is complicated by circulatory deficiency, areas of desensitization, open wounds, fractures, or other complications.

30.4.2 - Speech -Language Pathology

(Rev. 37, Issued: 08-12-05; Effective/Implementation: 09-12-05)

See the Medicare Benefit Policy Manual, Chapter 1, "Inpatient Hospital Services."

30.4.3 - Occupational Therapy
(Rev. 1, 10-01-03)

A3-3132.3.C, SNF-214.3.C

See the Medicare Benefit Policy Manual, Chapter 1, "Inpatient Hospital Services."

30.5 - Nonskilled Supportive or Personal Care Services
(Rev. 1, 10-01-03)

A3-3132.4, SNF-214.4

The following services are not skilled services unless rendered under circumstances detailed in §§30.2:

- Administration of routine oral medications, eye drops, and ointments (the fact that patients cannot be relied upon to take such medications themselves or that State law requires all medications to be dispensed by a nurse to institutional patients would not change this service to a skilled service);
- General maintenance care of colostomy and ileostomy;
- Routine services to maintain satisfactory functioning of indwelling bladder catheters (this would include emptying and cleaning containers and clamping the tubing);
- Changes of dressings for uninfected post-operative or chronic conditions;
- Prophylactic and palliative skin care, including bathing and application of creams, or treatment of minor skin problems;
- Routine care of the incontinent patient, including use of diapers and protective sheets;
- General maintenance care in connection with a plaster cast (skilled supervision or observation may be required where the patient has a preexisting skin or circulatory condition or requires adjustment of traction);
- Routine care in connection with braces and similar devices;
- Use of heat as a palliative and comfort measure, such as whirlpool or steam pack;

- Routine administration of medical gases after a regimen of therapy has been established (i.e., administration of medical gases after the patient has been taught how to institute therapy);

- Assistance in dressing, eating, and going to the toilet;

- Periodic turning and positioning in bed; and

- General supervision of exercises, which have been taught to the patient and the performance of repetitious exercises that do not require skilled rehabilitation personnel for their performance. (This includes the actual carrying out of maintenance programs where the performances of repetitive exercises that may be required to maintain function do not necessitate a need for the involvement and services of skilled rehabilitation personnel. It also includes the carrying out of repetitive 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.) (See Medicare Benefit Policy Manual, Chapter 1, "Inpatient Hospital Services.")

30.6 - Daily Skilled Services Defined

(Rev. 57, Issued: 11-08-06, Effective: 07-27-66, Implementation: 12-14-06)

Skilled nursing services or skilled rehabilitation services (or a combination of these services) must be needed and provided on a "daily basis," i.e., on essentially a 7 days a week basis. A patient whose inpatient stay is based solely on the need for skilled rehabilitation services would meet the "daily basis" requirement when they need and receive those services on at least 5 days a week. (If therapy services are provided less than 5 days a week, the "daily" requirement would not be met.)

This requirement should not be applied so strictly that it would not be met merely because there is an isolated break of a day or two during which no skilled rehabilitation services are furnished and discharge from the facility would not be practical.

EXAMPLE:

A patient who normally requires skilled rehabilitation services on a daily basis may exhibit extreme fatigue, which results in suspending therapy sessions for a day or two. Coverage may continue for these days since discharge in such a case would not be practical.

In instances when a patient requires a skilled restorative nursing program to positively affect his functional well-being, the expectation is that the program be rendered at least 6 days a week. (Note that when a patient's skilled status is based on a restorative program, medical evidence must exist to justify the services. In most instances, it is expected that a skilled restorative program will be, at most, only a few weeks in duration.)

30.7 - Services Provided on an Inpatient Basis as a "Practical Matter"
(Rev. 1, 10-01-03)

A3-3132.6, SNF-214.6

In determining whether the daily skilled care needed by an individual can, as a "practical matter," only be provided in a SNF on an inpatient basis, the intermediary considers the individual's physical condition and the availability and feasibility of using more economical alternative facilities or services.

As a "practical matter," daily skilled services can be provided only in a SNF if they are not available on an outpatient basis in the area in which the individual resides or transportation to the closest facility would be:

- An excessive physical hardship;
- Less economical; or
- Less efficient or effective than an inpatient institutional setting.

The availability of capable and willing family or the feasibility of obtaining other assistance for the patient at home should be considered. Even though needed daily skilled services might be available on an outpatient or home care basis, as a practical matter, the care can be furnished only in the SNF if home care would be ineffective because the patient would have insufficient assistance at home to reside there safely.

EXAMPLE: A patient undergoing skilled physical therapy can walk only with supervision but has a reasonable potential to learn to walk independently with further training. Further daily skilled therapy is available on an outpatient or home care basis, but the patient would be at risk for further injury from falling, dehydration, or malnutrition because insufficient supervision and assistance could not be arranged for the patient in his home. In these circumstances, the physical therapy services as a practical matter can be provided effectively only in the inpatient setting.

30.7.1 - The Availability of Alternative Facilities or Services
(Rev. 1, 10-01-03)

A3-3132.6.A, SNF-214.6.A

Alternative facilities or services may be available to a patient when health care providers such as home health agencies are utilized. These alternatives are not always available in all communities and even where they exist they may not be available when needed.

EXAMPLE: Where the residents of a rural community generally utilize the outpatient facilities of a hospital located some distance from the area, the hospital outpatient department constitutes an alternative source of care that is available to the community.

Roads in winter, however, may be impassable for some periods of time and in special situations institutionalization might be needed.

In determining the availability of more economical care alternatives, the coverage or noncoverage of that alternative care is not a factor to be considered. Home health care for a patient who is not homebound, for example, may be an appropriate alternative in some cases. The fact that Medicare cannot cover such care is irrelevant.

The issue is feasibility and not whether coverage is provided in one setting and not provided in another. For instance, an individual in need of daily skilled physical therapy might be able to receive the services needed on a more economical basis from an independently practicing physical therapist. However, the fact that Medicare payment could not be made for the services because the $500 expense limitation applicable to the services of an independent physical therapist had been exceeded or because the patient was not enrolled in Part B, would not be a basis for determining that, as a practical matter, the needed care could only be provided in a SNF.

In determining the availability of alternate facilities or services, whether the patient or another resource can pay for the alternate services is not a factor to be considered.

30.7.2 - Whether Available Alternatives Are More Economical in the Individual Case

(Rev. 1, 10-01-03)

A3-3132.6.B, SNF-214.6.B

If the intermediary determines that an alternative setting is available to provide the needed care, it considers whether the use of the alternative setting would actually be more economical in the individual case.

EXAMPLE 1:

If a patient's condition requires daily transportation to the alternative source of care (e.g., a hospital outpatient department) by ambulance, it might be more economical from a health care delivery viewpoint to provide the needed care in the SNF setting.

EXAMPLE 2:

If needed care could be provided in the home, but the patient's residence is so isolated that daily visits would entail inordinate travel costs, care in a SNF might be a more economical alternative.

30.7.3 - Whether the Patient's Physical Condition Would Permit Utilization of an Available, More Economical Care Alternative

(Rev. 1, 10-01-03)

A3-3132.6.C, SNF-214.6.C

In determining the practicality of using more economical care alternatives, the intermediary considers the patient's medical condition. If the use of those alternatives would adversely affect the patient's medical condition, the intermediary concludes that as a practical matter the daily skilled services can only be provided by a SNF on an inpatient basis.

If the use of a care alternative involves transportation of the individual on a daily basis, the intermediary considers whether daily transportation would cause excessive physical hardship. Determinations on whether a patient's condition would be adversely affected if an available, more economical care alternative were utilized should not be based solely on the fact that the patient is nonambulatory. There are individuals confined to wheelchairs who, though nonambulatory, could be transported daily by automobile from their homes to alternative care sources without any adverse impact. Conversely, there are instances where an individual's condition would be adversely affected by daily transportation to a care facility, even though the individual is able to ambulate to some extent.

EXAMPLE: A 75-year-old woman has suffered a cerebrovascular accident and cannot climb stairs safely. The patient lives alone in a second-floor apartment accessible only by climbing a flight of stairs. She requires physical therapy and occupational therapy on alternate days, and they are available in a CORF one mile away from her apartment. However, because of her inability to negotiate the stairs, the daily skilled services she requires cannot, as a practical matter, be provided to the patient outside the SNF.

The "practical matter" criterion should never be interpreted so strictly that it results in the automatic denial of coverage for patients who have been meeting all of the SNF level of care requirements, but who have occasion to be away from the SNF for a brief period of time. While most beneficiaries requiring a SNF level of care find that they are unable to leave the facility, the fact that a patient is granted an outside pass or short leave of absence for the purpose of attending a special religious service, holiday meal, family occasion, going on a car ride, or for a trial visit home, is not, by itself evidence that the individual no longer needs to be in a SNF for the receipt of required skilled care. Where frequent or prolonged periods away from the SNF become possible, the intermediary may question whether the patient's care can, as a practical matter, only be furnished on an inpatient basis in a SNF. Decisions in these cases should be based on information reflecting the care needed and received by the patient while in the SNF and on the arrangements needed for the provision, if any, of this care during any absences. (See the Medicare Benefit Policy Manual, Chapter 3, "Duration of Covered Inpatient Services," §20.1.2, for counting inpatient days during a leave of absence.)

A conservative approach to retain the presumption for limitation of liability may lead a facility to notify patients that leaving the facility will result in denial of coverage. Such a notice is not appropriate. If a SNF determines that covered care is no longer needed, the situation does not change whether the patient actually leaves the facility or not.