Self Help Packet for Skilled Nursing Facility Appeals Including "Improvement Standard" Denials

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1. Introduction

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

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

For additional assistance, contact your State Health Insurance Assistance Program (SHIP). You can find your state program's information at https://shipnpr.shiptalk.org/shipprofile.aspx.

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2. Checklist for Skilled Nursing Facility (SNF) Appeals (7 Steps)

Note: This list is for quick reference. Detailed information is available by clicking links included in the checklist below, reading the detailed description section.

There are several levels of appeal. The process begins when you receive the "Notice of Medicare Provider Non-Coverage."

☐ 1. Review the "Quick Screen" included in this packet to determine whether the care you need is covered by Medicare.

☐ 2. (1st appeal level) After you receive the "Notice of Medicare Provider Non-Coverage," contact the "Beneficiary and Family-Centered Care Quality Improvement Organization" (BFCC-QIO) at the number given on the notice to appeal a Medicare denial.

☐ 3. Gather support for your case.

- Ask the physician who ordered your care to contact the facility's physician to explain why your care continues to be medically reasonable and necessary.
- Ask the physician who ordered your care to submit a written statement to the BFCC-QIO explaining why you continue to need daily skilled medical care.
- Ask the physician who ordered your care to be available to the BFCC-QIO by telephone to answer questions.
- Request your medical record from the provider. At your request, the facility must give you a copy of, or access to, any documentation it sends to the BFCC-QIO, including records of any information provided by telephone. Note that many states allow facilities to charge a fee for copying medical records.
- If you get these records, give a copy to the physician who ordered your care.

☐ 4. Receive the BFCC-QIO decision.

- The BFCC-QIO is supposed to make its decision about Medicare coverage within 72 hours.
- If successful, you will continue to get your daily Medicare covered care.
- If the BFCC-QIO agrees with the nursing home's denial, you will be financially responsible for your continued stay.

☐ 5. (2nd Appeal Level) If the BFCC-QIO issues a denial, request an "Expedited Reconsideration," which is performed by the Qualified Independent Contractor (QIC). Call the QIC **no later than noon of the next calendar day** after you get the BFCC-QIO denial.

- Unless you request an extension of time, the QIC must tell you its decision within 72 hours of receipt of your call, as well as if any medical or other records are needed for the Expedited Reconsideration.
- You have the right to extend this period to up to 14 days to gather medical records and prepare your argument.
- If you did not get your medical record during the first review, you can get it from the BFCC-QIO now. The BFCC-QIO can charge you for the cost of copying. It must comply with your request for records by no later than close of business of the first day after your request for the documents.
- If you did not submit support from the physician who ordered your care at the BFCC-QIO level, use the 14 day extension to get and submit that support to the QIC now.
- During your appeal, you will be financially responsible for your continued stay at the nursing home.

☐ 6. Receive the QIC decision.

7. (3rd Appeal Level) If the QIC issues a denial, please review the detailed sections on Administrative Law

Judge (ALJ) Hearings and Other Options for Coverage, described below.

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3. Quick Screen: Should My SNF Care Be Covered by Medicare?

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

1. The patient must have been hospitalized as an **inpatient** for at least three days (not including day of discharge), and, in most cases, must have been admitted to the SNF within 30 days of hospital discharge.
2. A physician must certify that the patient needs SNF care.
3. The beneficiary must require "skilled nursing or skilled rehabilitation services, or both, on a daily basis." Skilled nursing and skilled rehabilitation services are those which require the skills of technical or professional personnel such as registered nurses, licensed practical nurses, physical therapists, and occupational therapists. In order to be deemed skilled the service must be so inherently complex that it can be safely and effectively performed only by, or under the supervision of, professional or technical personnel.
4. The skilled nursing facility must be a Medicare-certified facility.

Other Important Points:

1. The restoration potential of a patient is **not** the deciding factor in determining whether skilled services are needed. **Skilled services to maintain a patient's condition can be covered.**
2. The management of a plan involving only a variety of "custodial" personal care services is skilled when, in light of the patient's condition, the aggregate of those services requires the involvement of skilled personnel.
3. The requirement that a patient receive "daily" skilled services will be met if skilled rehabilitation services are provided **five days** per week.
4. Examples of skilled services:
    - Overall management and evaluation of care plan;
    - Observation and assessment of the patient's changing condition;
    - Levin tube and gastrostomy feedings;
    - Ongoing assessment of rehabilitation needs and potential;
    - Therapeutic exercises or activities;
    - Gait evaluation and training.
5. The doctor is the patient's most important ally. If it appears that Medicare coverage will be denied, ask the doctor to help demonstrate that the standards described above are met.
6. If the nursing home proposes to totally terminate all Medicare covered services or to discharge the patient from the skilled nursing facility, they must issue a written notice offering you a "fast-track" or "expedited" review of their proposed action. This review will be conducted by the "Beneficiary and Family-Centered Care Quality Improvement Organization" (BFCC-QIO). The patient or his/her helper can request the "fast-track" or "expedited" review, by following the instructions on the notice given to the patient or his/her helper by the skilled nursing facility.
7. Don't be satisfied with a Medicare determination unreasonably limiting coverage; appeal for the benefits the patient deserves.

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4. Skilled Nursing Facility Appeal Details

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

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

The SNF Issues a Notice of Medicare Provider Non-Coverage (also known as a Generic Notice): The facility must tell you that they are discharging you, or they believe Medicare will no longer cover your care. Medicare rules require that the nursing home give you (or your representative) a standardized notice at least two days prior to the last day of covered care. This standardized notice is called a "Notice of Medicare Provider Non-Coverage." It is also referred to as a "Generic Notice." The notice must include the date that coverage of care ends, the date you will become financially responsible for a continued stay at the nursing home, and a description of your right to an expedited appeal.

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

To Prevent the Discontinuation of Medicare Covered Care, Take the Following Action Steps.

1. Contact the Beneficiary Family-Centered Care Quality Improvement Organization (BFCC-QIO)

- Read the Standardized (Generic) Notice. It will contain the telephone number for your region's BFCC-QIO.
- To start the Expedited Appeal, you or your representative **must contact the BFCC-QIO by no later than noon of the calendar day following receipt of the standardized notice**.
- You can do this in writing or by telephone. If you call, get the name of the person you speak to, and keep written notes of what you are told.
- Once the contact is made, the nursing home should give you a more specific notice which will include a detailed explanation as to why it believes the Medicare covered care should end a description of any applicable Medicare coverage rules and information about how to obtain them, and other facts specific to your case.

2. While the BFCC-QIO is gathering information for its decision, gather support for your case.

- Ask your community physician(s) to contact your facility's physician.
- Have them explain why your care continues to be medically reasonable and necessary
- Ask your community physician to submit a written statement to the QIO explaining why you continue to need daily skilled medical care.

- Ask that your physician speak to the BFCC-QIO by telephone to support the need for continued care and to answer any questions.

3. Watch for the BFCC-QIO Decision

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

4. You have a legal right to review your medical record.

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

If the BFCC-QIO agrees with you:

- You will continue to get your daily Medicare-covered care.

If the BFCC-QIO agrees with the nursing home:

- You will be financially responsible for your continued stay at the nursing home.

5. You have the right to another appeal – an "Expedited Reconsideration."

- Expedited Reconsiderations are performed by an organization called the Qualified Independent Contractor (QIC).
- If the BFCC-QIO decided that Medicare coverage should end, it should give you the telephone number for the next appeal, to the QIC.
- If the BFCC-QIO ruled against you and you wish to continue your appeal, you or your representative must call the QIC **no later than noon of the calendar day** following notification by the BFCC-QIO of its decision.

6. Watch for the QIC (Reconsideration) decision.

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

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

If the QIC agrees with you:

- You will continue to get your daily care and it will be covered by Medicare.

If the QIC believes that your care is no longer medically reasonable and necessary:

- You have the right to appeal at an **Administrative Law Judge (ALJ) hearing**.

7. Request an ALJ Hearing

- The ALJ level is the best chance to obtain Medicare coverage.
- The QIC should provide a written copy of its decision with information about how to request an ALJ hearing.
- **You must request the hearing within 60 days of notice from the QIC** that it has denied Medicare coverage for your care.
- Unfortunately, ALJ hearings and decisions are not expedited. This means that you may have to wait a long time (several months) before your hearing is held. Further, while the ALJ is supposed to issue a decision within 90 days of receipt of the request for hearing, it often takes longer.
    - **To get a hearing decision as soon as possible, be sure to note on the envelope and the request for hearing that you are a "Medicare beneficiary."**
- If you request an ALJ hearing, and continue to get care at the nursing home, you will be financially responsible for the ongoing care unless the ALJ issues a favorable decision.
    - If a favorable decision is issued, whoever paid for the care will be reimbursed.
- **If the ALJ issues an unfavorable decision, you will remain financially responsible for the continued care unless you successfully appeal to the next step, the Medicare Appeals Council.** The ALJ's decision will tell you how to do so.

Other Ways to Get Medicare Covered Care

In the Nursing Home (Skilled Nursing Facility)

In the event that you are not successful with your expedited appeal, it is still possible to get more Medicare covered therapy or nursing so long as the daily skilled care is started again within thirty days of your last Medicare covered day and you still have days available within the benefit period (there are up to 100 skilled nursing facility days per benefit period). If at all possible have your primary physician educate the nursing home's physician as to why you still need daily therapy or nursing.

You might also ask your physician to consider whether other kinds of therapy would help you; for instance, occupational therapy. Occupational therapists work with patients on many of the skills necessary for independent living. **Daily** (5 days a week) occupational therapy or a combination of physical and occupational therapy can trigger further Part A skilled nursing facility coverage. If your physician thinks this would be valuable for you, s/he should

write an order for the care.

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

Alternatively, if, after receiving the QIC's decision denying coverage you plan to stay in the nursing home and you are receiving daily *skilled* nursing care, or nursing and therapy combined, you definitely *should* exercise your right to a standard Medicare appeal. Note that Medicare will only cover nursing care in a nursing home if you need it seven days a week and if it is **skilled** care. Note, however, that **five** days a week of therapy will satisfy the daily requirement. Skilled care is defined as care that requires a skilled professional in order to be safe and effective. Medicare does *not* cover care in a nursing home when it is only a "custodial." Examples of custodial care include the administration of medications or assisting a patient with bathing or toileting.

To begin a standard appeal, you need to have the nursing home submit a "demand bill." This means that you insist the nursing home submit a bill to Medicare for your care. The nursing home is required to submit a bill if you ask it to do so in writing. Call the Center for Medicare Advocacy if you want to discuss how to make this request.

At Home

If you are ready to return home, but need further care, speak to the nursing home physician or your community physician about ordering home health care services. Among other services, physical therapy, speech therapy, occupational therapy, skilled nursing, and home health aide care are all available under the Medicare home health benefit.

Conclusion

The best way to keep skilled care in place is to exercise your expedited appeal rights. You are most likely to succeed if you have the support of your physician.

Additional Information – The Medicare "Improvement" Myth: Skilled Care to Maintain an Individual's Condition *Can* Be Covered

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

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

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

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 Medicare benefit period, known as the "spell of illness." 42 USC §1395d(a)(2)(A).

If Medicare coverage requirements are met, the patient is entitled to full coverage of the first 20 days of SNF care. From the 21st through the 100th day, Medicare pays for all covered services except for a daily coinsurance amount. Beneficiaries in traditional Medicare are not entitled to any Medicare SNF coverage unless they were hospitalized as an inpatient for at least three days prior to the SNF admission. This requirement has become increasingly difficult to meet since hospitals often categorize patients as "outpatients" on Observation Status. These outpatient Observation stays do not count toward the SNF prior inpatient hospital requirement. Usually patients must be admitted to the SNF within 30 days of the inpatient 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 are:

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 inpatient hospital stay; and
3. The beneficiary must require daily skilled nursing or rehabilitation; and
4. The care needed by the patient must, as a practical matter, only be available in a skilled nursing facility on an inpatient basis; and
5. The skilled nursing facility must be a Medicare-certified provider.

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

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

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

42 USC §1395x(h).

Examples of services recognized as skilled by the Medicare SNF benefit include the following:

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

42 CFR §409.33

Important Advocacy Tips

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.**

Medicare **is** available for skilled care necessary to maintain an individual's condition. **The question to ask is "does the patient meet the qualifying criteria listed above and need skilled nursing and/or therapy on a daily basis" – NOT "does the patient have a particular disease or will she recover."**

1. The restoration potential of a patient is not the deciding factor in determining whether skilled services are needed.

42 USC §409.32(c); CMS Policy Manual 100-02, Chapter 8, §30.2.2.

2. Medicare recognizes that skilled care can be required to maintain an individual's condition or functioning, or to slow or prevent deterioration.

42 CFR §409.32(c)

Including physical therapy to maintain the individual's condition or function.

42 CFR §409.33(c)(5)

3. The doctor is the patient's most important ally. Ask the doctor to help demonstrate that the standards described above are met. In particular, *ask the individual's doctor to state in writing why skilled services are required.*
4. he management of a plan involving only a variety of "custodial" personal care services is skilled when, in light of the patient's condition, the aggregate of those services requires the involvement of skilled personnel.
5. The requirement that a patient receive "daily" skilled services will be met if skilled *rehabilitation* services (physical, speech or occupational therapy) are provided *five days* per week.

If a nursing home or Medicare Advantage plan says Medicare overage 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 initial 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 and has had a prior 3-day inpatient hospital stay. Further, 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 *Jimmo* and the Improvement Standard, see http://www.medicareadvocacy.org/medicare-info/improvement-standard/.

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 ADVANTAGE

Medicare offered by private, for-profit insurance companies subsidized by the federal government. Coverage is required to be equivalent to traditional Medicare, but choice is generally limited.

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.

OBSERVATION STATUS

The practice by hospitals of classifying beneficiaries' stays, regardless of length or services rendered, as "Outpatient" rather than "Inpatient." This designation has serious billing and coverage ramifications for beneficiaries.

SHIP

State Health Insurance Assistance Program. These programs are funded to help beneficiaries with insurance choices, enrollment and appeals. See www.shiptalk.org.

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.
