Medicare SNF Care Coverage Jimmo and the Improvement Myth Steps to Appeal 2013

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Our Focus

- Introduction
- Medicare Skilled Nursing Facility (SNF) Care Coverage
- The Medicare “Improvement” Myth
- Important Advocacy Tips
- Medicare Expedited Appeal

Introduction

- Medicare is a national health insurance program for all Social Security recipients who are either:
  - At least 65 years old, or
  - Permanently disabled
- Others who are eligible to receive Medicare:
  - Railroad Retirement benefits recipients
  - Individuals with End Stage Renal Disease (ESRD)

Medicare Skilled Nursing Facility (SNF) Care Coverage

- Limited coverage for nursing home (SNF) care (Part A):
  - Up to 100 days during each spell of illness (benefit period)
    - Full coverage for first 20 days
    - Days 21-100 Medicare pays for all covered services except the daily coinsurance amount
- Medicare does not cover Custodial care that helps with your usual daily activities like getting in and out of bed, dressing, eating, bathing, and using the bathroom.

Medicare SNF Care Coverage

- Requirements for Medicare SNF Coverage:
  - Physician must certify patient needs SNF care
  - Beneficiary must be admitted to SNF w/in 30 days of a 3-day qualifying hospital stay (Observation status does not count towards 3-day qualifying stay)
  - Beneficiary must require skilled nursing or rehabilitation services, they must be reasonable and necessary for the diagnosis or treatment of your condition
  - Care needed by patient must only be available in SNF on inpatient basis
  - SNF must be Medicare-certified provider

Medicare SNF Care Coverage

- If available, SNF care benefit intended to cover all services generally available in a SNF:
  - Skilled care is health care given when you need skilled nursing or rehabilitation to treat, manage, observe, and evaluate your care. Care given my non-professional staff isn't considered skill care.
  - Nursing care by registered professional nurses
  - Semi-private room
  - Physical therapy
  - Occupational therapy
  - Speech therapy
  - Audiology
  - Dietary Counseling
  - Medical social services
  - Medications, supplies, equipment
  - Other services necessary to health of patient

Medicare SNF Care Coverage

- The care you get in a SNF is based on:
  - Your Doctor's orders and your daily assessment
  - Doctor and SNF team (with patient input) use the assessment to determine services needed and your health goals (the result expected from your treatment)
  - The first assessment must be completed within the first 8 days of your stay, then days 14, 30, 60 and 90 of your Medicare covered stay
  - The assessment includes your current physical and mental condition, your medical history, medications, how well you perform your activities of daily living (ADL), your speech, your decision-making ability, and your physical limitations (i.e. hearing and/or vision loss, paralysis, balance issues)

SNF Care Plan

- Once the assessment is complete a Care Plan is developed. The plan may include:
  - What services you need
  - What type of health care professional should provide the services
  - How often you require the services
  - The equipment and supplies you need (walker, W/C, etc..)
  - Dietary restrictions
  - Your health goal and how your care plan will help you reach your goal

SNF Services

- If patient refuses the daily skilled care or therapy, they may lose their SNF coverage
- If the patient's condition will not allow them to get skilled care they may be able to continue to receive Medicare coverage temporarily

Medicare "Improvement" Myth

- **Long standing myth**:
  - Medicare coverage is not available for beneficiaries who have an underlying condition from which they will not improve, or patient is stable, or has a chronic condition, or requires maintenance services only
  - Improvement standard – claim would be denied due to a beneficiary's lack of restoration potential
    - Not stated anywhere in Medicare Act
- **Beneficiaries often denied coverage on grounds that**:
  - Not likely to "improve"
  - Are "stable"
  - Are "chronic"
  - Require "maintenance services only"
    - Not legitimate/legal reasons for Medicare denials

Medicare "Improvement" Myth

- *Jimmo vs. Sebelius*, (D. VT, 1/24/2013)
  - Federal case that resolved "improvement" issue
  - Judge approved settlement stating (nothing modifies existing eligibility requirements- clarifies coverage):
    - Coverage for nursing home care does <u>not</u> depend on potential for improvement
    - Rather, Coverage depends on need for skilled care, which <u>can</u> be to:
      - Maintain individual's condition, or
      - Prevent or Slow deterioration of individuals condition

Medicare "Improvement" Myth

- Following *Jimmo* settlement:
  - Coverage should be available now for those needing skilled maintenance care and meeting other qualifying criteria
  - Some beneficiaries still being denied coverage based on illegal "improvement" standard
    - Recommended action: Appeal if denied coverage because not improving

Medicare "Improvement" Myth

- *Jimmo* settlement applies equally to:
  - Traditional Medicare (Parts A and B)
  - Medicare Advantage (Part C)
    - By law, coverage in Medicare Advantage plans must be at least equivalent to that under Traditional Medicare
    - (This presentation is focused on SNF Coverage)

Medicare "Improvement" Myth

- *Jimmo* settlement:
  - Not limited to particular conditions/diseases
  - Applies to skilled maintenance services in all 3 care settings:
    - Medicare home health
    - Outpatient therapy
    - Skilled nursing facility benefits

Important Advocacy Tips

- Patient's restoration potential not deciding factor in determining whether skilled services are needed
- Skilled services are covered when the assessment demonstrates that the specialized judgment, knowledge, and skills of a qualified therapist are necessary for the performance of a safe and effective maintenance program
- Skilled nursing is covered when the assessment demonstrates the specialized judgment, knowledge, and skills of a RN or LPN are necessary.
- A skilled 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.
- Medicare recognizes that skilled care can be required to maintain condition or functioning, or to slow or prevent deterioration
    - Including physical therapy to maintain condition/functioning

Important Advocacy Tips

- A Medicare skilled care claim can *never* be denied for the following reasons:
  - Because a patient could not be expected to achieve complete independence in the domain of self-care
  - Because a patient could not be expected to return to his or her prior level of functioning

Important Advocacy Tips

- Ask doctor to help demonstrate that requirements for care are met
  - Specifically, ask doctor to state in writing why skilled services are required
- The management of a plan involving only a variety of “custodial” personal care services is skilled when:
  - In light of patient’s condition, the aggregate of those services requires the involvement of skilled personnel

Important Advocacy Tips

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

Important Advocacy Tips

- Medicare coverage is ***NOT*** limited to services that will *improve* the patient's condition
- Coverage can be available for items and services needed to maintain the person's condition or to arrest or slow down further deterioration
- It is not necessary for the patient's underlying condition to improve to qualify for Medicare coverage

Medicare Expedited Appeal

- Scenario:
  - Receiving medical care in SNF
  - Told care will be discontinued because you have plateaued and are not improving
  - When care stops, Medicare no longer pays
  - Not ready to go home and believe you will benefit from additional skilled care

Medicare Expedited Appeal

- Action Steps:
  - As an insurance program, Medicare pays only for care that has been provided
    - Once care is discontinued, an appeal will do no good
  - Must keep care in place
    - Expedited appeal is best way to keep care in place
    - With support from community doctor

Medicare Expedited Appeal

- Legal right to appeal when nursing home plans to stop providing:
  - Physical therapy 5 days per week
  - Occupational therapy 5 days per week, or
  - Speech therapy 5 days per week
- Also legal right to appeal when facility believes that the patient no longer requires *skilled* nursing care 7 days per week.

Medicare Expedited Appeal

- Nursing home must provide standardized notice at least 2 days prior to last day of covered care
  - Called “Notice of Medicare Provider Non-Coverage”
  - Must include:
    - Date coverage of care ends
    - Date you will become financially responsible for a continued stay at nursing home
    - Description of right to expedited determination

Medicare Expedited Appeal

- To prevent the discontinuation of Medicare covered services, take the following six action steps:

1. Contact Quality Improvement Organization (QIO)
2. Gather support for your case.
3. Obtain your medical record including the assessment and care plan (be sure to provide to the community physician).
4. If QIO rules against you, contact Qualified Independent Contractor (QIC) – the contact information will be on your denial.
5. Obtain your medical record at this stage if haven't already –and request any updated information.
6. If QIC rules against you, request ALJ hearing. The ALF hearings are not expedited.

Medicare Expedited Appeal

- Step 1 – Contact QIO
  - Read nursing home's standardized notice
  - Will include QIO's telephone number
  - Contact QIO (in writing or by telephone) no later than noon of calendar day following receipt of standardized notice
    - Once you have initiated the expedited appeal, you will continue to receive skilled services
  - Nursing home will then provide more specific notice
  - QIO should make decision w/in 72 hours
    - If the QIO agrees with the nursing home, you will be financially responsible for your continued stay at the nursing home
  - Be prepared to explain to QIO why you continue to need ongoing care

Medicare Expedited Appeal

- Step 2 – Gather Support for Your Case
  - While QIO is collecting info, gather support for case
  - Have community physician contact nursing home physician to explain why continued care is necessary
  - Have community physician submit written statement to QIO explaining why you continue to need daily skilled medical care
  - Ask community physician to be available to the QIO to answer questions

Medicare Expedited Appeal

- Step 3 – Obtain Your Medical Record
  - Have legal right to review medical record
  - Upon request, facility must provide copy of or access to any documentation it sends to QIO
    - Including records of any info sent by telephone
    - Must honor request first day after request
  - If you obtain records, provide copy to community physician

Medicare Expedited Appeal

- Step 4 – Contact the QIC
  - If QIO agrees with nursing home, you have right to "expedited reconsideration"
  - Must contact Qualified Independent Contractor (QIC) by noon of calendar day following notification of QIO decision
  - QIC should tell you decision w/in 72 hours of receipt of call and records necessary to make decision
  - Have the right to extend this period up to 14 days so you can gather medical records and prepare your argument
  - When a beneficiary appropriately requests an expedited reconsideration, the provider may not bill the beneficiary for any disputed services until the QIC makes its determination.

Medicare Expedited Appeal

- Step 5 – Get Medical Records if Haven't Yet
  - If you didn't get medical records at QIO stage, you can get them at this stage
  - You can request them from the QIO who must send you a copy or give you access to any documentation it sent to the QIC
  - 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, use the 14 day extension to get and submit that support
  - If you get your medical records be sure to submit them to your doctor

Medicare Expedited Appeal

- Step 6 – Request ALJ Hearing if QIC denies
  - ALJ hearings are not expedited (you may have to wait)
    - Thus, low value appeal if you started it to keep nursing or therapy services in place, and care has already stopped
  - Must request hearing within 60 days of QIC notice of denial
  - ALJ should issue decision w/in 90 days of request
  - If request ALJ hearing, and continue to get care at nursing home, you are financially responsible for ongoing care until ALJ writes a favorable decision
  - If ALJ issues unfavorable decision, you will remain financially responsible for the continued care
  - ALJ decision will tell you how to file the last administrative appeal with the Medicare Appeals Council

Medicare Home Health Care

- Home Health claims are suitable for Medicare coverage, and appeal if they have been denied, if they meet the following criteria:
  - A physician has signed or will sign a care plan.
  - The patient is homebound.
  - The patient needs skilled nursing care on an intermittent basis.
  - The care must be provided by a Medicare certified provider.

Coverable Home Health Services

- Part-time or intermittent nursing care provided by of under the supervision of an RN
- Physical, occupational, or speech therapy
- Medical social services under the direction of a physician and;
- To the extent permitted in regulations, part-time or intermittent services of a home health aide.

Medicare Home Health Care Advocacy

- Medicare coverage should not be denied simply because patient's condition is chronic, stable or unlikely to improve. Restorative potential is not required.
- Resist arbitrary caps on coverage imposed by the intermediary.
- There is no legal limit to the duration of the Medicare home health benefit.
- If it appears Medicare coverage will be denied, ask the doctor to help demonstrate that the standards are met. Home care services should not be ended or reduced unless it has been ordered by the doctor.
- Prior to discontinuing services the HHA must issue a written notice of non-coverage with your appeal rights described on the notice.

Medicare Home Health Plan of Care

- The plan of care developed by the agency staff should cover:
  - All pertinent diagnosis, including mental status
  - Types of services and equipment required
  - Frequency of visits, prognosis, rehab potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, safety measures to prevent injury, and instructions for discharge or referral
  - Plan of care must be reviewed every 60 days
  - Verbal orders are put in writing and signed and dated with the date of receipt by the RN

Notification of Medicare Home Health Services Terminating

- Must be in writing and include:
  - Date service ends
  - Date beneficiary's financial liability begins
  - Description of beneficiary's right to an expedited determination
  - Beneficiary needs to sign the notice, if refuses the provider may annotate its notice to indicate the refusal and the date of refusal is considered the date of receipt of the notice
  - The provider is liable for services until 2 days after the beneficiary receives notice
  - Expedited determination is same as outlined for skilled nursing facility care.

Thank you!

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