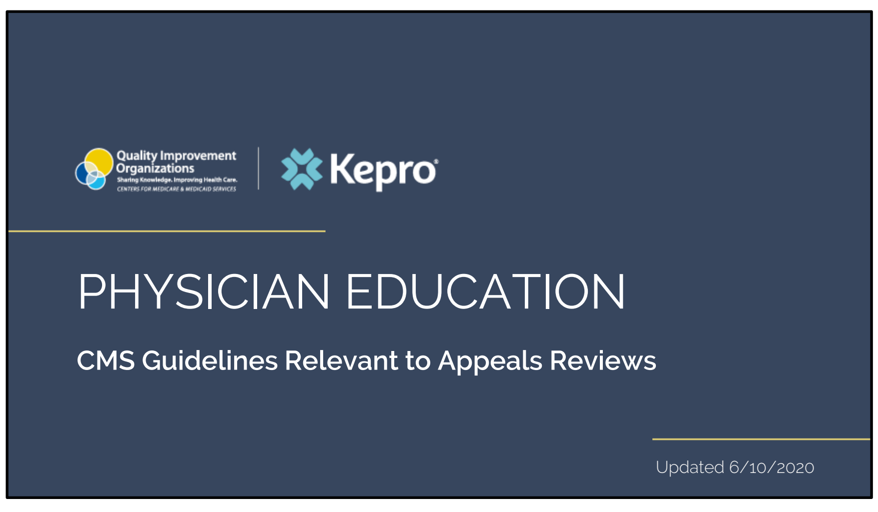


Thank you for taking time to review this important educational presentation. As a part of Kepro's appeals review team, you are charged with ensuring that claims are correctly adjudicated in accordance with existing Medicare policy. This ensures that Medicare beneficiaries receive the full coverage to which they are entitled and protects the integrity of the Medicare Trust Fund. The following slides will review pertinent CMS guidelines that regulate services in the various settings that are subject to appeals reviews. Please review the slides in their entirety.

QIO Program

Purpose of the Quality Improvement Organization (QIO)

- Improve the quality of care delivery to Medicare beneficiaries
- Protect the integrity of the Medicare Trust Fund by ensuring that Medicare only pay for services and goods that are:
  - Reasonable and medically necessary
  - Provided in the most appropriate setting
- Protect beneficiaries by expeditiously addressing individual complaints, notices, and appeals

Page 2

It is important to briefly review the purpose of the QIO program in order to provide overall guidance for the work that you do for Kepro and the Center for Medicare & Medicaid Services (CMS).

There has been recent litigation that has provided a clarification of the application of Medicare guidelines when making appeals decisions.

Jimmo v. Sebelius

- On January 24, 2013, the U.S. District Court for the District of Vermont approved a settlement agreement in the case of *Jimmo v. Sebelius*, involving skilled care for the skilled nursing facility, home health agency, inpatient rehabilitation facility, and outpatient therapy benefits.
- The settlement agreement includes language specifying that "Nothing in this Settlement Agreement modifies, contracts, or expands the existing eligibility requirements for receiving Medicare coverage."

Page 4

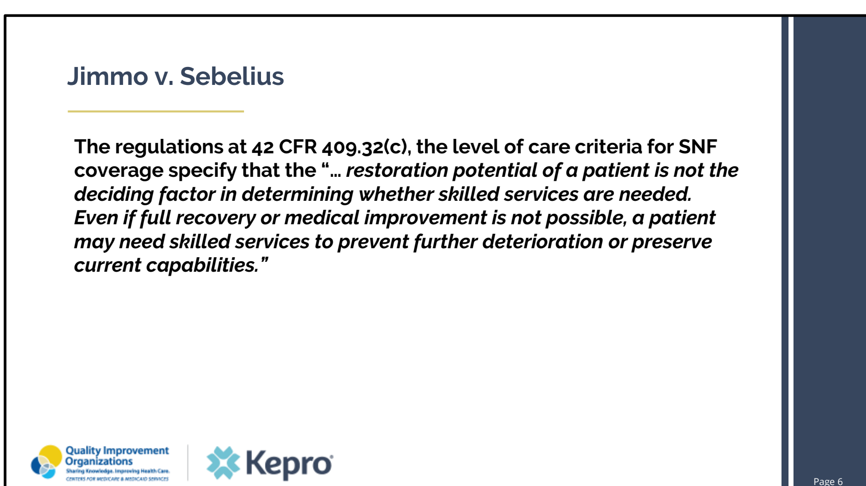
On January 24, 2013, the U.S. District Court for the District of Vermont approved a settlement agreement in the case of *Jimmo v. Sebelius.* The *Jimmo* settlement does not change any existing Medicare coverage requirements. The goal of the settlement agreement is to ensure that claims are correctly adjudicated in accordance with Medicare policy.

Jimmo v. Sebelius

While an expectation of improvement would be a reasonable criterion to consider when evaluating, for example, a claim in which the goal of treatment is restoring a prior capability, Medicare policy has long recognized that there may also be specific instances where no improvement is expected but skilled care is still required in order to prevent or slow deterioration and maintain a beneficiary at the maximum practicable level of function.

Page 5

A major point of clarification is that, when skilled nursing or skilled therapy services are required in order to provide care that is reasonable and necessary to prevent or slow further deterioration, coverage cannot be denied based on the absence of improvement or restoration potential. Conversely, such coverage would not be available when the beneficiary's care needs can be met safely and effectively through the use of non-skilled personnel.



A major point of clarification is that, when skilled nursing or skilled therapy services are required in order to provide care that is reasonable and necessary to prevent or slow further deterioration, coverage cannot be denied based on the absence of improvement or restoration potential. Conversely, such coverage would not be available when the beneficiary's care needs can be met safely and effectively through the use of non-skilled personnel.

Jimmo v. Sebelius

- A beneficiary's lack of restoration potential cannot, by itself, serve as the basis for denying coverage without regard to an individualized assessment of the beneficiary's medical condition and the reasonableness and necessity of the treatment, care, or services in question.
- Coverage would not be available in a situation where the beneficiary's needs can be addressed safely and effectively through the use of non-skilled personnel.

Page 7

A major point of clarification is that, when skilled nursing or skilled therapy services are required in order to provide care that is reasonable and necessary to prevent or slow further deterioration, coverage cannot be denied based on the absence of improvement or restoration potential. Conversely, such coverage would not be available when the beneficiary's care needs can be met safely and effectively through the use of non-skilled personnel.

The clarifications highlight that no improvement standard is to be applied in determining Medicare coverage for maintenance claims that require skilled care. Skilled nursing or therapy services are covered where such services are necessary to maintain the patient's current condition or prevent or slow further deterioration. This means that the beneficiary must not only require maintenance care but must require skilled involvement in order for the needed care to be furnished safely and effectively.

What is An Appeal?

- **Home health agencies, skilled nursing facilities, hospices, and comprehensive outpatient rehabilitation facilities are required to provide a Notice of Medicare Non-Coverage (NOMNC) to beneficiaries when their Medicare-covered service(s) are ending.**
- **The NOMNC informs beneficiaries how to request an expedited appeal determination from their QIO.**

What is An Appeal?

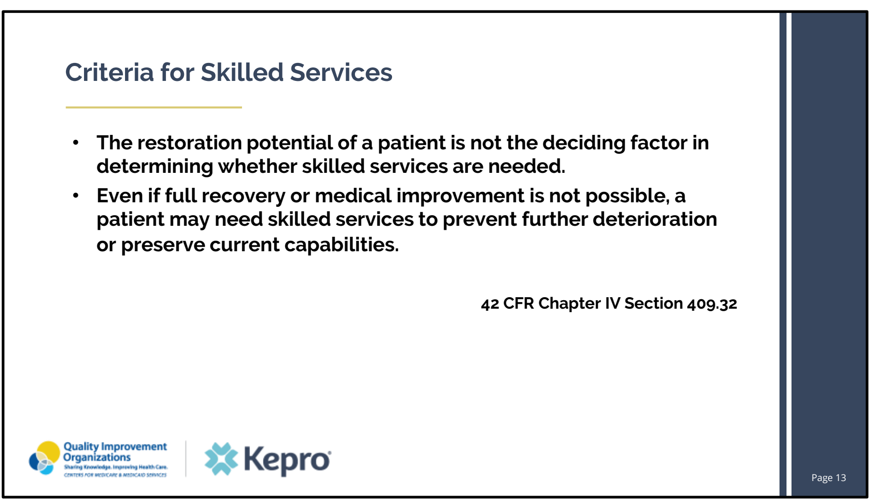
- Hospitals are required to deliver the Important Message from Medicare (IM), CMS-R-193 to all Medicare beneficiaries (Original Medicare beneficiaries and Medicare Advantage plan enrollees) who are hospital inpatients.
- The IM informs hospitalized inpatient beneficiaries of their hospital discharge appeal rights.

Acronyms

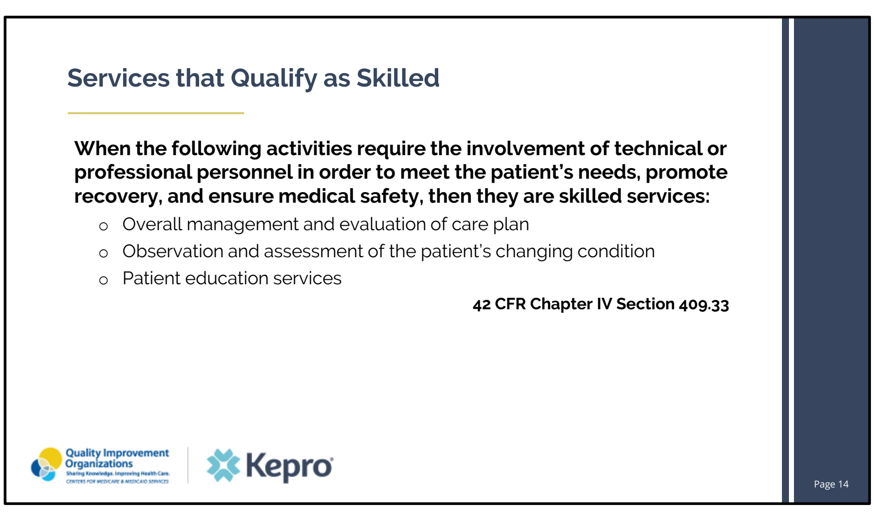
- **SNF - Skilled Nursing Facility**
- **HHA - Home Health Agency**
- **NOMNC - Notice of Medicare Non-Coverage**
- **IM - Important Message from Medicare**
- **HINN - Hospital-Issued Notices of Non-coverage**
- **HRR - Hospital Requested Review**

Criteria for Skilled Services

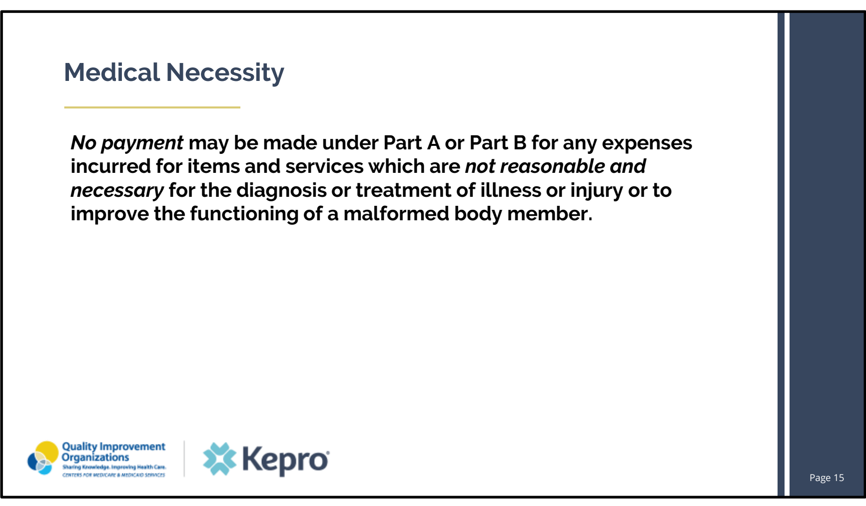
- To be considered a skilled service, the service must be so inherently complex that it can only be safely and effectively performed by or under the supervision of professional or technical personnel.
- A condition that does not ordinarily require skilled services may require them because of special medical complications. Under those circumstances, a service that is usually non-skilled may be considered skilled because it must be performed or supervised by skilled nursing or rehabilitation personnel.



Determining a beneficiary's need for skilled care that is reasonable and necessary is very important for certain appeal types. The Code of Federal Regulations outlines the criteria for skilled services. The key issue is whether the services need to be performed or supervised by skilled personnel or whether they can be provided by non-skilled personnel.



Skilled care that is reasonable and necessary may include the types of activities listed on this slide.



An understanding of the meaning of reasonable and necessary is important when making appeals decisions. In order to protect the Medicare Trust Fund, payment should not be made for items and services which are not reasonable and necessary.

What is Medical Necessity?

"Medical Necessity" means healthcare services that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of evaluating, diagnosing, or treating an illness, injury, disease, or its symptoms and that are:

- In accordance with the **generally accepted** standards of medical practice
- **Clinically appropriate**, in terms of type, frequency, extent, site, and duration, and considered effective for the patient's illness, injury, or disease

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This definition of medically necessary helps to clarify what is meant by reasonable and necessary.

What is Medical Necessity? (continued)

- Not primarily for the convenience of the patient or physician and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury, or disease

Medical Physician Guide: A Resource for Residents, Practicing Physicians, and Other Health Care Professionals ©2008

Reasonable and Necessary

- The services must be consistent with the nature and severity of the illness or injury, the patient's particular medical needs, including the requirement that the amount, frequency, and duration of the services must be reasonable.
- The services must be considered, under accepted standards of medical practice, to be specific, safe, and effective treatment for the patient's condition.

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To be considered reasonable and necessary for the treatment of illness or injury, the points outlined on this slide and the following slide should be present.

Reasonable and Necessary

Services involving activities for the general welfare of any patient (e.g., general exercises to promote overall fitness or flexibility and activities to provide diversion or general motivation) do not constitute skilled therapy. Non-skilled individuals without the supervision of a therapist can perform those services.

Medicare Benefit Policy Manual Chapter 7 Section 40.2.1

Requirements for Skilled Nursing Facility Services

- The patient must require skilled care – nursing, physical therapy (PT), occupational therapy (OT), or speech therapy (ST)
- The services are ordered by a physician and then 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 skilled nursing facility for a condition for which the patient received inpatient hospital services
- The patient requires these skilled services on a daily basis

Medicare Benefit Policy Manual Chapter 8 Section 30

Page 20

In order to conduct appeals reviews, it is important to be aware of the requirements specific to each setting. Medicare beneficiaries are eligible for skilled nursing facility care if they meet all of the 5 criteria that are listed on the next few slides.

Requirements for Skilled Nursing Facility Services

- As a practical matter, considering economy and efficiency, the daily skilled services can be provided only on an inpatient basis in a skilled nursing facility.
- The services are reasonable and necessary for the treatment of a patient's illness or injury (i.e., 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 are reasonable in terms of duration and quantity.

Medicare Benefit Policy Manual Chapter 8 Section 30

Page 21

If any one of these factors is not met, a stay in a skilled nursing facility, even though it might include the delivery of some skilled services, is not covered. For example, payment for a skilled nursing facility level of care could not be made if a patient needs intermittent rather than daily skilled services. In reviewing skilled nursing facility services to determine whether the level of care requirements are met, the reviewer should first consider whether a patient needs skilled care. If a need for a skilled service does not exist, then the other requirements need not be addressed.

Daily Requirement

- 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 seven days/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 five days a week. (If therapy services are provided less than five days a week, the "daily" requirement would not be met.)

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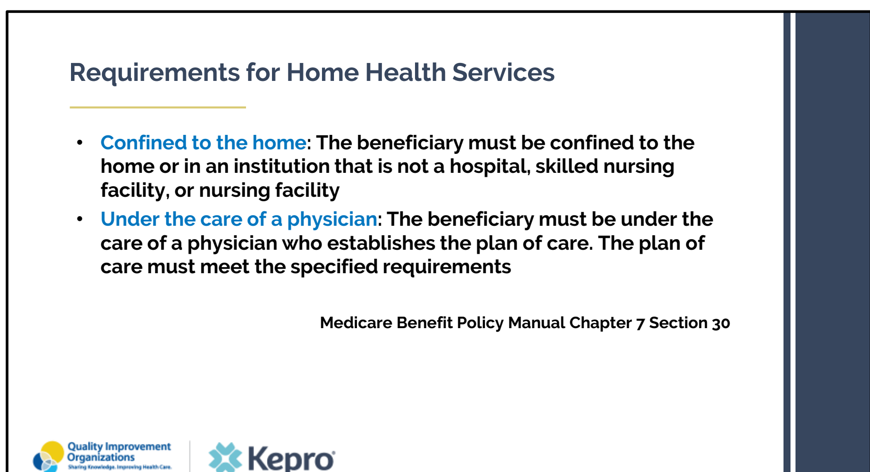
This slide, and the following slide, defines what is meant by provided on a daily basis. This requirement should not be applied so strictly that it would not be met merely because there is an isolated break of a day or two during which no skilled rehabilitation services are furnished and discharge from the facility would not be practical. For 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.

Daily Requirement

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 discharged from the facility would not be practical.

Medicare Benefit Policy Manual Chapter 8 Section 30.6



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

Requirements for Home Health Services

- **In need of skilled services: The beneficiary must need at least one of the following skilled services as certified by a physician:**
  - Intermittent skilled nursing services
  - Physical therapy services
  - Speech-language pathology services
  - Continuing occupational therapy services that have been established by virtue of a prior need for intermittent skilled nursing care, speech-language pathology services, or physical therapy in the current or prior certification period
- **The services are reasonable and necessary**

Medicare Benefit Policy Manual Chapter 7 Section 30.1

Page 25

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

Confined to Home

- In order for a patient to be eligible to receive covered home health services, the law requires that a physician certify in all cases that the patient is confined to his/her home.
- An individual does not have to be bedridden to be considered confined to the home.
- However, the condition of these patients should be such that there exists a normal inability to leave home and consequently, leaving home would require a considerable and taxing effort.

Medicare Benefit Policy Manual Chapter 7 Section 30.1

Page 26

In order for a patient to be eligible to receive covered home health services, the law requires that a physician certify in all cases that the patient is confined to his or her home. An individual does not have to be bedridden to be considered confined to the home. However, the condition of these patients should be such that there exists a normal inability to leave home, and consequently, leaving home would require a considerable and taxing effort. Any absence of an individual from the home attributable to the need to receive health care treatment, including regular absences for the purpose of participating in therapeutic, psychosocial, or medical treatment in an adult day-care program shall not disqualify an individual from being considered to be confined to his home. Any other absence of an individual from the home shall not disqualify an individual if the absence is of an infrequent or of relatively short duration.

It is expected that in most instances, absences from the home that occur will be for the purpose of receiving health care treatment. However, occasional absences from the home for nonmedical purposes, such as, an occasional trip to the barber, a walk around the block or a drive, attendance at a family reunion, funeral, graduation, or other infrequent or unique event would not necessitate a finding that the patient is not homebound if the absences are undertaken on an infrequent basis or are of relatively short duration and do not indicate that the patient has the capacity to obtain the health care provided outside rather than in the home.

Generally speaking, a patient will be considered to be homebound if they have a condition due to an illness or injury that

restricts their ability to leave their place of residence except with the aid of: supportive devices such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the assistance of another person; or if leaving home is medically contraindicated.

Intermittent Nursing Care

- **The law defines intermittent as skilled nursing care that is either provided or needed:**
  - On fewer than seven days each week or
  - For less than eight hours each day for periods of twenty-one days or less (with extensions in exceptional circumstances when the need for additional care is finite and predictable)
- **To meet the requirement for "intermittent" skilled nursing care, a patient must have a medically predictable recurring need for skilled nursing services.**

Medicare Benefit Policy Manual Chapter 7 Section 40.1.3

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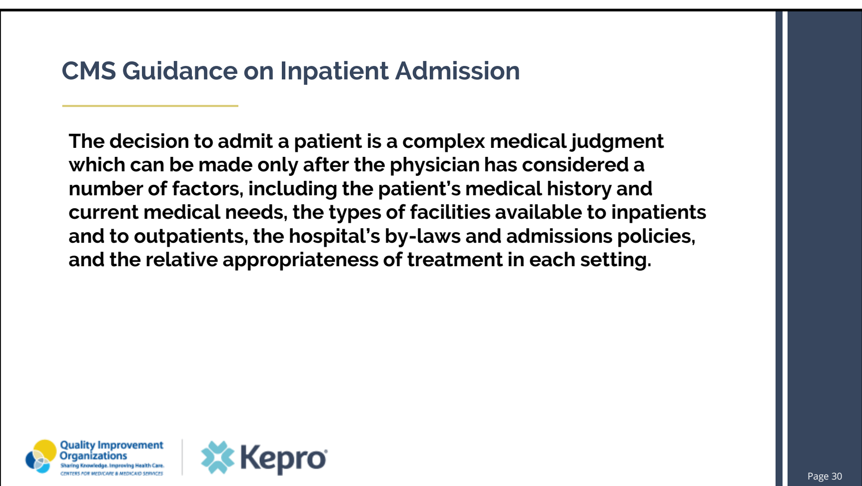
To meet the requirement for "intermittent" skilled nursing care, a patient must have a medically predictable recurring need for skilled nursing services. In most instances, this definition will be met if a patient requires a skilled nursing service at least once every 60 days. The exception to the intermittent requirement is daily skilled nursing services for diabetics unable to administer their insulin when there is no able and willing caregiver. It should be noted that venipuncture for the purposes of obtaining a blood sample can not be the sole reason for Medicare home health eligibility.

Points to Consider for Appeals Decisions

- Does the patient have a need for reasonable and necessary skilled services after consideration of his/her overall medical condition? The patient's diagnosis or prognosis alone should never be the sole factor in deciding that a service is not skilled.
- If the patient has a reasonable and necessary skilled service need, then what is the most appropriate setting to provide that need, considering the requirements to qualify for SNF and home health services?

Points to Consider for Appeals Decisions

Input from the ordering physician can be very useful to help to determine if the patient's condition warrants skilled nursing facility or home health services. It is certainly appropriate to contact this physician when you deem his/her input necessary.



When determining appropriateness for inpatient services, physician reviewers should apply their best medical judgment utilizing their education, clinical training, and work experience to the CMS guidance listed on the following slides. Physician reviewers should not apply any specified screening tools, such as InterQual®.

CMS Guidance on Inpatient Admission

***Factors to be considered when making the decision to admit include such things as*:**

- The severity of the signs and symptoms exhibited by the patient
- The medical predictability of something adverse happening to the patient
- The need for diagnostic studies that appropriately are outpatient services (i.e., their performance does not ordinarily require the patient to remain at the hospital for 24 hours or more) to assist in assessing whether the patient should be admitted
- The availability of diagnostic procedures at the time when and at the location where the patient presents

Medicare Benefit Policy Manual Chapter 1 Section 10

The Two-Midnight Rule

- FY 2014 Hospital IPPS Final Rule CMS-1599-F: **Patients are generally appropriate for inpatient admission and payment under Part A when:**
  - The physician expects the beneficiary to require a stay that crosses at least two midnights
  - The physician admits the beneficiary to the hospital based upon that expectation
- **Reviewers should evaluate whether at the time of admission order it was reasonable for the admitting practitioner to expect the beneficiary to require medically necessary hospital services over a period of time spanning at least two midnights.**

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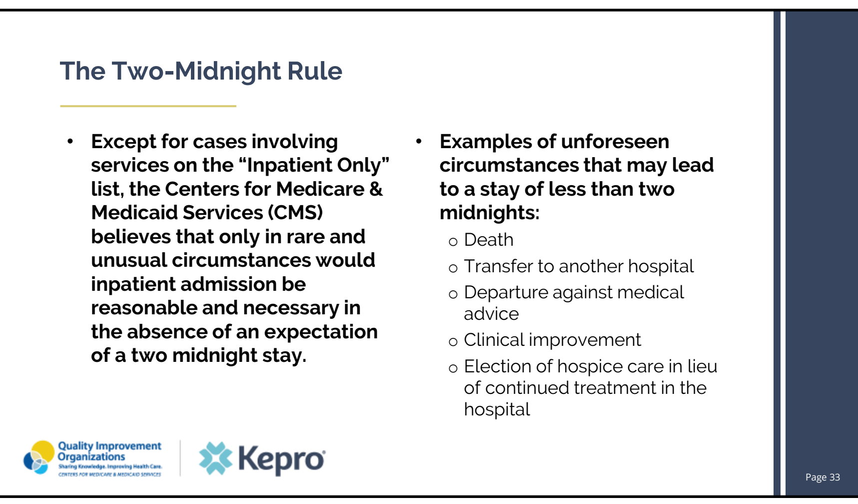
It is important to have an understanding of the fiscal year 2014 CMS-1599-F final rule when evaluating inpatient services.



Where the medical record indicates that the physician did not or could not reasonably have expected to keep the patient in the hospital for greater than 2 midnights, *Medicare review contractors* shall deny these inappropriate admissions unless the following circumstances exist:

If an unforeseen circumstance results in a shorter beneficiary stay than the physician’s reasonable expectation of at least 2 midnights, the patient may be considered to be appropriately treated on an inpatient basis and hospital inpatient payment may be made under Medicare Part A.

The Two-Midnight Rule

- **Delays in the Provision of Care: 1862(a)(1)(A) of the Social Security Act statutorily limits Medicare payment to the provision of reasonable and necessary medical treatment**
- **As such, CMS expects Medicare review contractors will continue to follow CMS' longstanding instruction that Medicare payment is prohibited for care rendered for social purposes or reasons of convenience.**

The Two-Midnight Rule

Therefore, QIOs will exclude extensive delays in the provision of medically necessary care from the Two-Midnight benchmark calculation. QIOs will only count the time in which the beneficiary received medically necessary hospital treatment.

CMS Guidance on Hospice Services

- To be eligible to elect hospice care under Medicare, an individual must be entitled to Part A of Medicare and be certified as being terminally ill.
- An individual is considered to be terminally ill if the medical prognosis is that the individual's life expectancy is six months or less if the illness runs its normal course.
- Predicting life expectancy is not always exact. The fact that a beneficiary lives longer than expected in itself is no cause to terminate benefits.

Medicare Benefit Policy Manual Chapter 9 Section 10

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Hospice care is a benefit under the hospital insurance program. To be eligible to elect hospice care under Medicare, an individual must be entitled to Part A of Medicare and be certified as being terminally ill. An individual is considered to be terminally ill if the medical prognosis is that the individual's life expectancy is 6 months or less if the illness runs its normal course. Predicting of life expectancy is not always exact. The fact that a beneficiary lives longer than expected in itself is not cause to terminate benefits.

Physician Reviewer Assessment Form

- **The Nurse Reviewer completes a review of the medical record, and the Physician Reviewer Assessment Form (PRAF) is then forwarded to the Peer Reviewer.**
- **This will provide the Peer Reviewer with a brief description of the nurses findings from the medical record.**

Physician Reviewer Assessment Form

- **The Peer Reviewer then reviews the medical record and completes the PRAF and provides his/her determination in the Reviewer Rationale portion. The Peer Reviewer must evaluate whether the criteria is met based on the facts of the case and directly link his/her decisions to elements contained in the evidence-based standard.**
- **The PRAF is then returned to the Nurse Reviewer, so the appeal can be completed.**

Physician Reviewer Assessment Form

- Noted here are the dates of service and the case number.
- Below that are the nurse reviewer's notes from the medical record.
- Finally, the rationale for your conclusion concerning whether or not the beneficiary met or did not meet the criteria.

Facility Name: General Medical Center
Dates of Service: 03/31/2016-04/04/2016
Appeal Type: Hospital Discharge

Nurse reviewer: A. SMITH RN
2 Midnight Rule: YES
Admission date: 03/31/2016
Attending Physician: Dr. Daniel Thomason

Physician Reviewer Rationale:

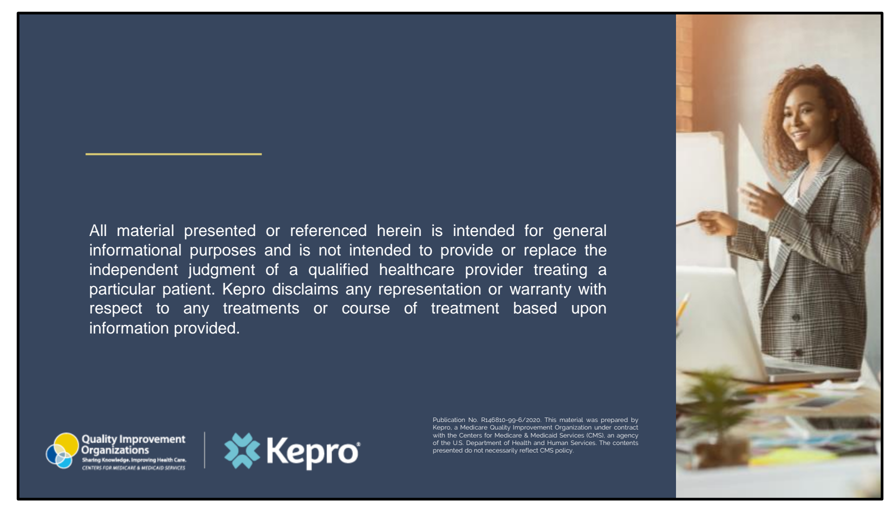
Quality Improvement Organizations
Sharing Knowledge. Improving Health Care.
CENTERS FOR MEDICARE & MEDICAID SERVICES

References

- Medicare Benefit Policy Manual – Chapter 1: Inpatient Services Covered Under Part A
- Medicare Benefit Policy Manual – Chapter 7: Home Health Services
- Medicare Benefit Policy Manual – Chapter 8: Coverage of Extended Care (SNF) Services

References

- **Medicare Benefit Policy Manual – Chapter 9: Coverage of Hospice Services Under Hospital Insurance**
- **CMS internet-only manuals: www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html**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