Physician Education
CMS Guidelines Relevant to Appeals Reviews
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
Recent Litigation
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.”
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
The regulations at 42 CFR 409.32(c), the level of care criteria for SNF coverage specify that 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”
- 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.
Jimmo v. Sebelius

- Coverage depends not on the beneficiary’s restoration potential, but whether skilled care is required along with the underlying reasonableness and necessity of the services themselves.
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.
Criteria for Skilled Services

- 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.

42 CFR Chapter IV Section 409.32
When the following activities require the involvement of technical or professional personnel in order to meet the patient’s needs, promote recovery, and ensure medical safety, then they are skilled services:

- Overall management and evaluation of care plan
- Observation and assessment of the patient’s changing condition
- Patient education services

42 CFR Chapter IV Section 409.33
Medical Necessity

- **No payment** may be made under Part A or Part B for any expenses incurred for items and services which are **not reasonable and necessary** for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.
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
What is Medical Necessity?

- **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

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.
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
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
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.)
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
Requirements for Home Health Services

- **Confined to the home:** The beneficiary must be confined to the home or in an institution that is not a hospital, skilled nursing facility, or nursing facility.

- **Under the care of a physician:** The beneficiary must be under the care of a physician who establishes the plan of care. The plan of care must meet the specified requirements.

Medicare Benefit Policy Manual Chapter 7 Section 30
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
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
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
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?
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.
The decision to admit a patient is a complex medical judgment which can be made only after the physician has considered a number of factors, including the patient’s medical history and current medical needs, the types of facilities available to inpatients and to outpatients, the hospital’s by-laws and admissions policies, and the relative appropriateness of treatment in each setting. 

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
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
Except for cases involving services on the “Inpatient Only” list, the Centers for Medicare & Medicaid Services (CMS) believes that only in rare and unusual circumstances would inpatient admission be reasonable and necessary in the absence of an expectation of a two midnight stay.

Examples of unforeseen circumstances that may lead to a stay of less than two midnights: death, transfer to another hospital, departure against medical advice, clinical improvement, and election of hospice care in lieu of continued treatment in the hospital.
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.
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.
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
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.
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.
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.
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
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