

—Toolkit—

Medicare Outpatient Therapy Coverage
And Jimmo v. Sebelius

1. Introduction

Medicare coverage of outpatient therapy services is an essential resource for Medicare beneficiaries in need of short-term or long-term skilled therapy for the safe and effective treatment of their conditions. Under Medicare Part B, beneficiaries have access to physical therapy, occupational therapy, and speech language pathology services when these services are medically reasonable and necessary. However, Medicare places certain conditions on the coverage of these outpatient therapy services:

1. The therapy must be reasonable and necessary;
2. The therapy must be provided by or, in some instances, directly supervised by, a qualified therapist;
3. A physician, non-physician practitioner, or therapist must develop a plan of care for providing the outpatient therapy services, and that plan of care must be periodically reviewed by the physician or nonphysician practitioner;
4. The beneficiary must be under the care of a physician at the time the services are provided;
5. The plan of care must include, at a minimum, the diagnoses, long-term treatment goals, and type, amount, duration and frequency of therapy services;
6. The beneficiary's functional limitations must be consistent with the functional limitations in the beneficiary's plan of care and must be included in the beneficiary's long-term goals.
7. The physician or non-physician practitioner must certify that the preceding conditions have been met by certifying the plan of care. (Medicare Beneficiary Policy Manual (MBPM), Chapter 15, Section 220.1.1-2).

Practice Tip: Certification requirements are met when the individual's physician certifies the plan of care. If a signed order includes a plan of care, no further certification is required. Medicare payment depends on certification of the plan of care rather than an order, but the use of an order is recommended to show a physician is involved in the care and available to certify the plan. (MBPM Chapter 15, Section 220.1.1-2).

Unfortunately, outpatient therapy entities and Medicare Contractors continue to deny Medicare outpatient therapy coverage, and/or access to care, even for patients who meet these coverage criteria. Too often, beneficiaries are told Medicare will not cover skilled therapy services because

they have “plateaued,” or are “chronic,” or “stable,” or lack potential for improvement. These denials, based on an erroneous “Improvement Standard,” violate the Court-approved settlement agreement in *Jimmo v. Sebelius*, No. 11-cv-17 (D. VT).

Jimmo is a nationwide class-action lawsuit brought on behalf of Medicare beneficiaries who received care in outpatient therapy, home health, and skilled nursing facilities and who were denied Medicare coverage on the basis that they were not improving or did not demonstrate a potential for improvement. The U.S. District Court for the District of Vermont approved the Settlement between the plaintiffs and the Centers for Medicare & Medicaid Services (CMS) on January 24, 2013. Under the terms of the *Jimmo* Settlement, CMS was required to revise relevant chapters of the Medicare Benefit Policy Manual to eliminate any misleading suggestion that a beneficiary must show improvement to qualify for Medicare and to confirm that the need for skilled care is the determinative factor for coverage.

As a result of the *Jimmo* Settlement, Medicare policy now clearly states that coverage,

“... does not turn on the presence or absence of a beneficiary’s potential for improvement, but rather on the beneficiary’s need for skilled care. **Skilled care may be necessary to improve a patient’s condition, to maintain a patient’s current condition, or to prevent or slow further deterioration of the patient’s condition.**” (CMS Transmittal 179, Pub 100-02, 1/14/2014).

Specifically, the relevant chapter of the Medicare Benefit Policy Manual states that “**Outpatient therapy services can be covered by Medicare to improve, and to maintain, prevent, or slow decline of an individual’s condition, when the skills of a therapist are necessary for the services to be safe and effective.** (MBPM Chapter 15, Section 220.2).

2. Unfair Medicare Denials Still Happen

The Center still hears from Medicare beneficiaries and their families about Medicare outpatient therapy denials based on some variation of the Improvement Standard. These stories often echo the story of Glenda Jimmo, the lead plaintiff in the “Improvement Standard” case. Ms. Jimmo was blind and her right leg had been amputated due to complications from diabetes, along with other conditions. She required a wheelchair, home health nursing, and aides to care for her multiple ongoing medical conditions. However, Medicare denied coverage for her home care on the grounds that she would not improve.

Ms. Jimmo’s story was just one example of tens of thousands. However, as a result of her lawsuit, the *Jimmo* Settlement should provide protection for all Medicare beneficiaries with long-term and debilitating conditions. The Settlement means that no Medicare beneficiary should be denied coverage for maintenance therapy provided by an **outpatient therapy entity** (or maintenance nursing and therapy services provided by a skilled nursing facility or home health agency) when skilled personnel must provide or supervise the care in order for it to be safe and effective.

Medicare-covered skilled care includes care that improves or maintains or slows decline of a patient’s condition. Medicare coverage decisions should hinge on the need for such skilled care, and in meeting the various specific level-of-care criteria, (such as the outpatient therapy services being certified and required in order to keep the individual’s condition from declining.) Coverage

should not be denied because an individual has an underlying condition that won't get better, (such as MS, paralysis, ALS, diabetes, or Parkinson's disease).

3. Using This Toolkit

The Center for Medicare Advocacy provides this Toolkit to help Medicare beneficiaries, their families and advocates respond to unfair Medicare denials. The Toolkit includes self-help materials to advocate for outpatient therapy services that have been denied by providers, Medicare Advantage plans, and/or traditional Medicare.

The Toolkit contains the following, to help obtain or restore Medicare when coverage is denied:

A. Official information About *Jimmo* and Outpatient Therapy Coverage

1. *An Important Message about the Jimmo Settlement* from Medicare's website, CMS.gov
2. The *Jimmo* Settlement Agreement
3. *Jimmo* Fact Sheet from Medicare's website, CMS.gov
4. *Medicare Benefit Policy Manual, Covered Medical and Other Health Services* – Chapter 15
5. *Medicare Expired Legislative Provisions Extended and Other Bipartisan Budget Act of 2018 Provisions*, from Medicare's MLN Connects newsletter, CMS.gov
6. *Frequently Asked Questions*, from Medicare's website, CMS.gov
7. *Medicare Appeals Booklet* from Medicare.gov

B. Information from the Center for Medicare Advocacy

1. *Frequently Asked Questions*
2. *Self-Help Packet for Outpatient Therapy Denials* (Including for "Improvement Standard" Denials)
3. *Sample Letters* for Skilled Care Professionals to Support Medicare Coverage

4. Conclusion

Although challenging a Medicare denial may seem daunting, beneficiaries and their representatives can win appeals when equipped with the right information. The Center for Medicare Advocacy hopes this Toolkit provides that information, to help beneficiaries, families, and advocates fight for fair Medicare coverage.

As always, the Center for Medicare Advocacy will continue working to ensure that Medicare beneficiaries receive the Medicare coverage they qualify for under the law – and the care they need.

Let us know if we can provide further guidance.

Center for Medicare Advocacy

March 2018

Important Message about the Jimmo Settlement
(www.CMS.gov)



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Jimmo Settlement

Important Message About the Jimmo Settlement

The Centers for Medicare & Medicaid Services (CMS) reminds the Medicare community of the *Jimmo* Settlement Agreement (January 2013), which clarified that the Medicare program covers skilled nursing care and skilled therapy services under Medicare's skilled nursing facility, home health, and outpatient therapy benefits when a beneficiary needs skilled care in order to maintain function or to prevent or slow decline or deterioration (provided all other coverage criteria are met). Specifically, the *Jimmo* Settlement Agreement required manual revisions to restate a "maintenance coverage standard" for both skilled nursing and therapy services under these benefits:

Skilled nursing services would be covered where such skilled nursing services are necessary to maintain the patient's current condition or prevent or slow further deterioration so long as the beneficiary requires skilled care for the services to be safely and effectively provided.

Skilled therapy services are covered when an individualized assessment of the patient's clinical condition demonstrates that the specialized judgment, knowledge, and skills of a qualified therapist ("skilled care") are necessary for the performance of a safe and effective maintenance program. Such a maintenance program to maintain the patient's current condition or to prevent or slow further deterioration is covered so long as the beneficiary requires skilled care for the safe and effective performance of the program.

The *Jimmo* Settlement Agreement may reflect a change in practice for those providers, adjudicators, and contractors who may have erroneously believed that the Medicare program covers nursing and therapy services under these benefits only when a beneficiary is expected to improve. The *Jimmo* Settlement Agreement is consistent with the Medicare program's regulations governing maintenance nursing and therapy in skilled nursing facilities, home health services, and outpatient therapy (physical, occupational, and speech) and nursing and therapy in inpatient rehabilitation hospitals for beneficiaries who need the level of care that such hospitals provide.

Important Links

Additional Information

In essence, the *Jimmo* Settlement Agreement clarifies Medicare's longstanding policy that coverage of skilled nursing and skilled therapy services in the Skilled Nursing Facility (SNF), Home Health (HH), and Outpatient Therapy (OPT) settings does not turn on the presence or absence of a beneficiary's potential for improvement, but rather on the beneficiary's need for skilled care.

For ready reference, this CMS web page serves to provide access, in one location, to various public documents related to the *Jimmo* Settlement Agreement. Included in those public documents is an FAQ document for easy access. The *Jimmo* Settlement Agreement does not alter or supersede any other applicable coverage requirements beyond those involving the need for skilled care, such as Medicare's overall requirement that covered services must be reasonable and necessary to diagnose or treat the beneficiary's condition, or existing statutory limitations on the amount or duration of Medicare benefits.

Resources

[Jimmo Settlement Agreement approved by the court on January 24, 2013 \[PDF, 134KB\]](#)

[Jimmo v. Sebelius Settlement Agreement – Program Manual Clarifications \(Fact Sheet\) - Updated 2/3/2014 \[PDF, 416KB\]](#)

[Jimmo v. Sebelius Settlement Agreement \(Fact Sheet\) - 4/4/2013 \[PDF, 88KB\]](#)

MLN Matters® Article [MM8458 \[PDF, 107KB\]](#) : Manual Updates to Clarify SNF, HH, and OPT Coverage Pursuant to Jimmo v. Sebelius Settlement Agreement

[CR 8458 \[PDF, 549KB\]](#): Manual Updates to Clarify SNF, HH, and OPT Coverage Pursuant to Jimmo v. Sebelius Settlement Agreement

[CR 8644 \[PDF, 43KB\]](#): Manual Updates to Clarify Skilled Nursing Facility Advanced Beneficiary Notice (SNF ABN) Requirements Pursuant to Jimmo v. Sebelius Settlement Agreement

[MLN Connects® Call materials](#) - December 2013

[Medicare Benefit Policy Manual](#) - Chapters 1, 7, 8, 15

Frequently Asked Questions

[FAQs \(August 2017\)](#)

Additional Questions

Providers and Suppliers: Contact your [Medicare Administrative Contractor](#)

Beneficiaries: Please call 1-800-Medicare



A federal government website managed and paid for by the U.S. Centers for Medicare & Medicaid Services. 7500 Security Boulevard, Baltimore, MD 21244



Jimmo Settlement Agreement
(www.CMS.gov)

**IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF VERMONT**

GLENDA JIMMO, <i>et al.</i> , on behalf of)	
themselves and all others similarly situated,)	
)	
Plaintiffs,)	
)	Civil Action No. 5:11-CV-17-CR
v.)	
)	
KATHLEEN SEBELIUS, Secretary of)	
Health and Human Services,)	
)	
Defendant.)	

SETTLEMENT AGREEMENT

I. INTRODUCTION

WHEREAS the parties desire to resolve amicably all the claims raised in this suit without admission of liability;

WHEREAS the parties have agreed upon mutually satisfactory terms for the complete resolution of this Federal Rule of Civil Procedure 23(b)(2) class action litigation;

NOW THEREFORE, the Plaintiffs and Defendant hereby consent to the entry of this Settlement Agreement with the following terms.

II. DEFINITIONS

1. “Approval Date” means the date upon which the Court approves this Settlement Agreement, after having determined that it is adequate, fair, reasonable, equitable, and just to the Class as a whole, after: (i) notice to the Class, (ii) an

opportunity for class members to submit timely objections to the Settlement Agreement, and (iii) a hearing on the fairness of the settlement.

2. “Class Counsel” or “Plaintiffs’ Counsel” means the Center for Medicare Advocacy, Inc., Vermont Legal Aid, and Wilson Sonsini Goodrich & Rosati. “Plaintiffs’ Lead Counsel” means the attorney Plaintiffs have authorized to be the main contact with Defendant’s counsel.

3. The “Class” or “Class Members” means all Medicare beneficiaries as defined in Section XI.

4. “CMS” refers to the Centers for Medicare & Medicaid Services.

5. “Court” means the United States District Court for the District of Vermont.

6. “Defendant” or “the Secretary” means the Secretary of Health and Human Services, in his or her official capacity.

7. “Final, non-appealable denial” or “final and non-appealable” denial means a denial for which the applicable deadline, as described in federal regulations, for an appeal of a decision has expired.

8. “Named Plaintiffs” refers to the individuals and organizations who are named in the First Amended Complaint and have not been dismissed from this action by the Court as of the Approval Date.

9. “Improvement Standard” refers to a standard that Plaintiffs have alleged, but that Defendant denies, exists under which Medicare coverage of skilled services is denied on the basis that a Medicare beneficiary is not improving, 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.

10. "Parties" refers to Plaintiffs and to Defendant.

11. "Plaintiffs" refers to the Named Plaintiffs, acting on their own behalf and on behalf of all Class Members.

12. "State Medicaid agencies" refers to the agencies or their contractors within the fifty States and the District of Columbia that are responsible for administering medical assistance benefits under Title XIX of the Social Security Act.

13. "End of the Educational Campaign" means the date upon which the Educational Campaign described in Section IX.9 has been conducted and completed as agreed, as evidenced by Defendant's notification to Plaintiffs' Lead Counsel and certification in good faith that all terms of the Educational Campaign have been conducted and completed.

14. "HH" refers to "home health services" as addressed by § 1861(m) of the Social Security Act/ 42 U.S.C. § 1395x(m);

15. "SNF" refers to "skilled nursing facility" as addressed by § 1819(a) of the Social Security Act/ 42 U.S.C. § 1395i-3(a);

16. "OPT" refers to outpatient therapy services as follows: outpatient physical therapy services as addressed by § 1861(p) of the Social Security Act/ 42 U.S.C. § 1395x(p), outpatient occupational therapy services as addressed by § 1861(g) of the Social Security Act/ 42 U.S.C. § 1395x(g), and outpatient speech-language pathology services as addressed by § 1861(ll)(2) of the Social Security Act/ 42 U.S.C. § 1395x(ll)(2),

17. “IRF” refers to “inpatient rehabilitation facility” as addressed by 42 C.F.R. Part 412, Subpart P.

18. “CORF” refers to “comprehensive rehabilitation facility” as addressed by § 1861(cc) of the Social Security Act/ 42 U.S.C. § 1395x(cc)

III. ENTIRE AGREEMENT

The terms of this Settlement Agreement and any attachments thereto are the exclusive and full agreement of the Parties with respect to all claims for declaratory and injunctive relief and attorney’s fees and costs as set forth in this Settlement Agreement and in the First Amended Complaint. No representations or inducements or promises to compromise this action or enter into this Settlement Agreement have been made, other than those recited or referenced in this Settlement Agreement.

IV. APPROVAL

1. This Settlement Agreement is expressly conditioned upon its approval by the Court.

2. The terms of this Settlement Agreement are fair, reasonable, and adequate. The entry of this Settlement Agreement is in the best interest of the Parties and the public.

V. FINAL JUDGMENT

If, after the fairness hearing, the Court approves this Settlement Agreement as fair, reasonable, and adequate, the Court shall direct the entry of Final Judgment (the “Final Judgment”) dismissing this action with prejudice, pursuant to the terms of this Settlement Agreement and Fed. R. Civ. P. 41, except that the Court shall retain jurisdiction for the limited purposes described in Section VI of this Settlement

Agreement. The Final Judgment shall incorporate and be subject to the terms of the Settlement Agreement.

VI. CONTINUING JURISDICTION

1. The Court has held, contrary to arguments made by Defendant, that it has subject matter jurisdiction over this matter. See Opinion and Order dated October 25, 2011 (Docket Entry No. 52).

2. If for any reason this Settlement Agreement (a) is not finalized by the parties, (b) is not approved by the Court following notice to class members and the fairness hearing, or (c) is in any way rendered null and void (in whole or in part), Defendant preserves all of her rights to argue (in this Court or on appeal) that the Court lacks subject matter jurisdiction over this matter.

3. Subject to the limitations and reservations set forth in the preceding paragraph, the Court will retain jurisdiction over this matter only for the limited purposes described in this paragraph for the following duration: (a) the Court will retain jurisdiction for a period not to exceed twenty-four (24) months following the End of the Educational Campaign if the Administrator of CMS issues a CMS Ruling communicating the clarified maintenance coverage standards for skilled nursing facility (SNF), home health (HH) and outpatient therapy (OPT) as set forth in Sections IX.6 and IX.7 of this Settlement Agreement within three (3) months after the effective date of the Manual Provisions; or (b) the Court will retain jurisdiction for a period not to exceed thirty-six (36) months following the End of the Educational Campaign if the Administrator of CMS does not issue such a CMS Ruling within three (3) months after the effective date of the Manual Provisions. Such limited jurisdiction shall be for the sole purposes of (a)

enforcing the provisions of the Settlement Agreement in the event that one of the Parties claims that there has been a breach of any of those provisions, (b) modifying the Settlement Agreement if jointly requested by the Parties pursuant to Section VII, (c) entering any other order authorized by the Settlement Agreement, and (d) deciding any fee petition filed by Plaintiffs, solely in the event that the parties are unable to agree on an amount of reasonable attorney's fees, as further described in Section X.

4. Notwithstanding the time frames for the Court's continuing jurisdiction discussed in the previous Section VI.3, the Court shall maintain jurisdiction to rule on a motion for enforcement of this Settlement Agreement, or for attorney's fees, filed prior to the end of the applicable time frame set out in Section VI.3. The Court will also have jurisdiction to rule on a motion for enforcement of this Settlement Agreement that was filed after the end of the applicable time frame in Section VI.3. if the Dispute Resolution process in Section VIII of this Settlement Agreement is initiated prior to the end of the time frame and if the Party files the motion for enforcement within 30 days of the other Party's written statement of disagreement with the relief requested by the moving Party.

VII. MODIFICATION

At any time while the Court retains jurisdiction over this matter as described in Section VI, Plaintiffs and Defendant may jointly agree to modify this Settlement Agreement. Any joint request for modification must be in writing, signed by both Class Counsel and Defendant's counsel, and is subject to approval by the Court.

VIII. DISPUTE RESOLUTION PROCEDURES

Either Party shall have the right to initiate steps to resolve any alleged noncompliance with any provision of the Settlement Agreement, subject to limitations and standards set forth in the Settlement Agreement.

1. If one party (the “Initiating Party”) has good reason to believe that an issue of noncompliance exists, it will first give timely written notice to the other party (the “Responding Party”), including: (a) a reference to all specific provisions of the Settlement Agreement that are involved; (b) a statement of the issue; (c) a statement of the remedial action sought by the Initiating Party; and (d) a brief statement of the specific facts, circumstances, and any other arguments supporting the position of the Initiating Party; and (e) if there is a good faith basis for expedited resolution, the circumstances that make expedited resolution appropriate, and the proposed date for a reasonable expedited response. To be timely, such notice must be provided promptly. Notice that is not provided promptly because of a lack of diligence on the part of the Initiating Party shall not serve as a basis for the Court to exercise jurisdiction as described in Section VI.4 above.

2. Within thirty (30) calendar days after receiving such timely notice or within a reasonable time for an expedited resolution, the Responding Party shall respond in writing to the statement of facts and arguments set forth in the notice and shall provide its written position, including the facts and arguments upon which it relies in support of its position.

3. The Parties shall undertake good-faith negotiations, including meeting and conferring by telephone or in person and exchanging relevant documents and/or other information, to attempt to resolve the alleged noncompliance. The written notice set

forth in Section VIII.1 may be amended solely to include issue(s) related to the original notice that may arise during the meet-and-confer process described in this paragraph.

4. If the Initiating Party believes in good faith that efforts to resolve the matter have failed or if sixty (60) calendar days have elapsed from the Receiving Party's receipt of timely notice, the Initiating Party, after providing written notice to the Responding Party, may file a motion with the Court, with a supporting brief, requesting resolution of the alleged noncompliance, provided however that the relief sought by such motion shall be limited to the issue(s) of alleged noncompliance described in the written notice, as to which the Parties have met and conferred as described in Section VIII.3.

5. The Responding Party shall be provided with appropriate notice of any such motion and an opportunity to be heard on the motion, as provided under the Civil Local Rules of the District of Vermont and the Federal Rules of Civil Procedure.

6. The Initiating Party cannot seek contempt sanctions as a remedy for alleged noncompliance with the Settlement Agreement. If, however, the Initiating Party successfully argues to the Court that there has been a breach of the Agreement and obtains an order from the Court compelling the Responding Party to remedy the breach, and if the Responding Party subsequently violates that order, then the Initiating Party is free to seek contempt sanctions for that violation.

IX. INJUNCTIVE PROVISIONS

Manual Revisions

1. The agency will revise the relevant portions of Chapters 7, 8, and 15 of the Medicare Benefit Policy Manual (MBPM) to clarify the coverage standards for the skilled nursing facility (SNF), home health (HH), and outpatient therapy (OPT) benefits

when a patient has no restoration or improvement potential but when that patient needs skilled SNF, HH, or OPT services (SNF, HH, OPT “maintenance coverage standard”).

The agency will also revise the relevant portions of Chapter 1, Section 110 of the MBPM to clarify the coverage standards for services performed in an inpatient rehabilitation facility (IRF).

2. The manual revisions to be made pursuant to this Settlement Agreement will clarify the SNF, HH, and OPT maintenance coverage standards and IRF coverage standard only as set forth below in Sections IX.6 through IX.8. Existing Medicare eligibility requirements for coverage remain in effect. Nothing in this Settlement Agreement modifies, contracts, or expands the existing eligibility requirements for receiving Medicare coverage, including such requirements found in:

- a. Posthospital SNF Care, as set forth in 42 C.F.R. Part 409, Subparts C and D, and related subregulatory guidance;
- b. Home Health Services, as set forth in 42 C.F.R. Part 409, Subpart E, 42 C.F.R. Part 410, Subpart C, and related subregulatory guidance;
- c. Outpatient Therapy Services, as set forth in 42 C.F.R. Part 410, Subpart B, and related subregulatory guidance; and
- d. Inpatient Rehabilitation Facility services, as set forth in 42 C.F.R. Part 412, Subpart P, and related subregulatory guidance.

3. CMS will revise or eliminate any manual provisions in Chapters 7, 8, and 15 and Chapter 1, Section 110 of the MBPM that CMS determines are in conflict with the standards set forth below in Sections IX.6 through IX.8.

4. CMS will afford Plaintiffs' Counsel 21 days to review and provide a single set of written comments on the manual provisions revised or eliminated as part of settlement before the manual provisions are finalized and issued. CMS will take any recommendations from Plaintiffs' Counsel under advisement and will make a good faith effort to utilize Plaintiffs' Counsel's reasonable recommendations that are limited to the coverage standards as clarified in Sections IX.6 through IX.8 and that are consistent with those coverage standards as well as all other statutory and regulatory requirements. If plaintiffs request, CMS will also afford Plaintiffs' Counsel a second opportunity for review and comment on these manual revisions before the manual provisions are finalized and issued; Plaintiffs' Counsel will have 14 days to review any subsequent changes made and either provide a second set of written comments or communicate its comments at a meeting between counsel. CMS will take any recommendations from Plaintiffs' Counsel under advisement and will make a good faith effort to utilize Plaintiffs' Counsel's reasonable recommendations that are limited to the coverage standards as clarified in Sections IX.6 through IX.8 and that are consistent with those coverage standards as well as all other statutory and regulatory requirements. CMS shall retain final authority as to the ultimate content of the manual provisions.

5. In providing any set of recommendations described in paragraph 4 above, Plaintiffs agree to collect all recommendations into one consolidated document to be provided by Plaintiffs' Lead Counsel.

Maintenance Coverage Standard for Therapy Services under the SNF, HH, and OPT Benefits

6. Manual revisions will clarify that SNF, HH, and OPT coverage of therapy to perform a maintenance program does not turn on the presence or absence of a

beneficiary's potential for improvement from the therapy, but rather on the beneficiary's need for skilled care.

a. The manual revisions will clarify that, under the SNF, HH, and OPT maintenance coverage standards, skilled therapy services are covered when an individualized assessment of the patient's clinical condition demonstrates that the specialized judgment, knowledge, and skills of a qualified therapist ("skilled care") are necessary for the performance of a safe and effective maintenance program. Such a maintenance program to maintain the patient's current condition or to prevent or slow further deterioration is covered so long as the beneficiary requires skilled care for the safe and effective performance of the program. When, however, the individualized assessment does not demonstrate such a necessity for skilled care, including when the performance of a maintenance program does not require the skills of a therapist because it could safely and effectively be accomplished by the patient or with the assistance of non-therapists, including unskilled caregivers, such maintenance services will not be covered under the SNF, HH, or OPT benefits.

b. The manual revisions will further clarify that, under the standard set forth in the previous paragraph (Section IX.6.a.), skilled care is necessary for the performance of a safe and effective maintenance program only when (a) the particular patient's special medical complications require the skills of a qualified therapist to perform a therapy service that would otherwise be considered non-skilled; or (b) the

needed therapy procedures are of such complexity that the skills of a qualified therapist are required to perform the procedure.

c. The manual revisions will further clarify that, to the extent provided by regulation, the establishment or design of a maintenance program by a qualified therapist, the instruction of the beneficiary or appropriate caregiver by a qualified therapist regarding a maintenance program, and the necessary periodic reevaluations by a qualified therapist of the beneficiary and maintenance program are covered to the degree that the specialized knowledge and judgment of a qualified therapist are required.

d. The maintenance coverage standard for therapy as outlined in this section does not apply to therapy services provided in an inpatient rehabilitation facility (IRF) or a comprehensive outpatient rehabilitation facility (CORF).

Maintenance Coverage Standard for Nursing Services under the SNF and HH Benefits

7. Manual revisions will clarify that SNF and HH coverage of nursing care does not turn on the presence or absence of an individual's potential for improvement from the nursing care, but rather on the beneficiary's need for skilled care.

a. The manual revisions will clarify that, under the SNF and HH benefits, skilled nursing services are covered when an individualized assessment of the patient's clinical condition demonstrates that the specialized judgment, knowledge, and skills of a registered nurse or, when

provided by regulation, a licensed practical (vocational) nurse (“skilled care”) are necessary. Skilled nursing services would be covered where such skilled nursing services are necessary to maintain the patient’s current condition or prevent or slow further deterioration so long as the beneficiary requires skilled care for the services to be safely and effectively provided. When, however, the individualized assessment does not demonstrate such a necessity for skilled care, including when the services needed do not require skilled nursing care because they could safely and effectively be performed by the patient or unskilled caregivers, such services will not be covered under the SNF or HH benefits.

b. The manual revisions will further clarify that, under the standard set forth in the previous paragraph (Section IX.7.a.), skilled nursing care is necessary only when (a) the particular patient’s special medical complications require the skills of a registered nurse or, when provided by regulation, a licensed practical nurse to perform a type of service that would otherwise be considered non-skilled; or (b) the needed services are of such complexity that the skills of a registered nurse or, when provided by regulation, a licensed practical nurse are required to furnish the services. 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 supervision of, professional or technical personnel as provided by regulation, including 42 C.F.R. 409.32.

- c. The maintenance coverage standard for nursing services as outlined in this section does not apply to nursing services provided in an inpatient rehabilitation facility (IRF) or a comprehensive outpatient rehabilitation facility (CORF).

IRF Coverage Standard

8. Manual revisions will clarify that an IRF claim could never be denied for the following reasons: (1) because a patient could not be expected to achieve complete independence in the domain of self-care or (2) because a patient could not be expected to return to his or her prior level of functioning.

Educational Campaign

9. CMS will engage in a nationwide educational campaign, as set forth in the following Sections IX.10 through IX.14, which will use written materials and interactive forums with providers and contractors, to communicate the SNF, home health, and OPT maintenance coverage standards and the IRF coverage standards as set forth in Sections IX.6 through IX.8.

10. The educational campaign will be directed to include the following contractors, adjudicators, and providers and suppliers (collectively “recipients”) through the following written educational materials (“written educational materials”):

- a. Medicare Administrative Contractors (MACs, Part A/B contractors): Program Transmittal and MLN Matters article

- b. Medicare Advantage (MA) Organizations (Part C contractors):
Health Plan Management System (HPMS) memorandum and MLN
Matters article
- c. Part A/B Qualified Independent Contractors (QICs): MLN Matters
article
- d. Part C QIC/Independent Review Entity (IRE): MLN Matters
article
- e. Quality Improvement Organizations (QIOs, formerly PROs):
Transmittal of Policy Systems (TOPS) memorandum and MLN Matters
article
- f. Recovery Audit Contractors (RACs): Program Transmittal and
MLN Matters article
- g. Administrative Law Judges (ALJs): MLN Matters article will be
distributed to the Chief Administrative Law Judge for dissemination to the
ALJs.
- h. Medicare Appeals Council: MLN Matters article will be
distributed to the Chair of the Departmental Appeals Board for
dissemination to the Administrative Appeals Judges.
- i. Providers and suppliers: MLN Matters article to be distributed by
the MACs, MA contractors, and CMS via listservs to subscribed
providers.
- j. Subscribers to CMS listservs: MLN Matters article

k. 1-800 MEDICARE Scripts: CMS will revise relevant 1-800 MEDICARE customer service scripts as necessary to ensure consistency with the revised manual provisions

11. CMS will include an accompanying message with the distribution of the MLN Matters article stating that the article was prepared and is being distributed as a result of this Settlement Agreement.

12. CMS will afford Plaintiffs' Counsel 21 days to review and provide a single set of written comments on the written educational materials created as part of settlement before the materials are finalized and issued. CMS will take any recommendations from Plaintiffs' Counsel under advisement and will make a good faith effort to utilize Plaintiffs' Counsel's reasonable recommendations that are limited to the coverage standards as clarified in Sections IX.6 through IX.8 and that are consistent with those coverage standards as well as all other statutory and regulatory requirements. If Plaintiffs request, CMS will also afford Plaintiffs' Counsel a second opportunity for review and comment on these written educational materials before they are finalized and disseminated: Plaintiffs' Counsel will have 14 days to review any subsequent changes made and either provide a second set of written comments or communicate its comments at a meeting between counsel. CMS will take any recommendations from Plaintiffs' Counsel under advisement and will make a good faith effort to utilize Plaintiffs' Counsel's reasonable recommendations that are limited to the coverage standards as clarified in Sections IX.6 through IX.8 and that are consistent with those coverage standards as well as all other statutory and regulatory requirements. CMS shall retain final authority as to the ultimate content of the written educational materials. CMS,

through counsel, agrees to tell Plaintiffs' Counsel (through Plaintiffs' Lead Counsel) when the written educational materials have been distributed.

13. In providing any set of recommendations described in paragraph 12 above, Plaintiffs agree to collect all recommendations into one consolidated document to be provided by Plaintiffs' Lead Counsel.

14. Other educational initiatives:

a. National Call for providers & suppliers: CMS will conduct a National Call for providers and suppliers for the sole purpose of communicating the policy clarifications reflected by the manual revisions agreed to as part of this Settlement Agreement as detailed in Sections IX.6 through IX.8. An audio and written transcript of the call will be made available on the CMS website, www.CMS.gov, for those providers and suppliers unable to attend the call.

b. National Call for contractors & adjudicators: CMS will conduct a National Call for contractors, ALJs, medical reviewers, and agency staff to communicate the policy clarifications reflected by the manual revisions agreed to as part of this Settlement Agreement as detailed in Sections IX.6 through IX.8. Following this National Call, CMS will provide all contractors and adjudicators invited to the call a summary of the call, consisting of a copy of the PowerPoint slides presented and the summary prepared by CMS of the questions posed and answers provided during this National Call.

c. For both National Calls, CMS will prepare a deck of PowerPoint slides to assist in communicating the policy clarifications reflected by the manual revisions. Before these slides are finalized, CMS will afford Plaintiffs' Counsel at least 7 days to review and provide a single set of written comments on the slides. CMS will take any recommendations from Plaintiffs' Counsel under advisement and will make a good faith effort to utilize in the final presentation Plaintiffs' Counsel's reasonable recommendations that are limited to the coverage standards as clarified in Sections IX.6 through IX.8 and that are consistent with those coverage standards as well as all other statutory and regulatory requirements. CMS shall retain final authority as to the ultimate content of these PowerPoint slides. In providing any set of recommendations described in this paragraph, Plaintiffs agree to collect all recommendations into one consolidated document to be provided by Plaintiffs' Lead Counsel.

d. Open Door Forum (ODF):

Following the issuance of the manual revisions made pursuant to this Settlement Agreement, CMS will include an announcement of the manual revisions and a reference to the above-described National Call for providers and suppliers as agenda items for a Home Health, Hospice, and Durable Medical Equipment ODF, a Hospital ODF, a Physicians, Nurses and Allied Health Professionals ODF, and a Skilled Nursing Facilities/Long-Term Care ODF. Following the issuance of the manual revisions, CMS

will also include an announcement of the manual revisions as an agenda item for a Medicare Beneficiary ombudsman ODF.

- e. CMS will post the Program Transmittal and MLN Matters article on CMS's website, www.CMS.gov. CMS will inform Plaintiffs' Lead Counsel when the Program Transmittal is issued.

15. CMS will make a good faith effort to notify Plaintiffs' Lead Counsel, in advance of the National Calls and Open Door Forums described above in Section IX.14 to be held to carry out the educational campaign provided in the settlement agreement. Plaintiffs and Plaintiffs' Counsel will be permitted to attend the Open Door Forums and the National Call for providers and suppliers described above in Section IX.14. Following the National Call for contractors and adjudicators described above in Section IX.14.b, CMS, through counsel, will provide to Plaintiffs' Counsel (1) a certification that this National Call occurred; (2) a certification that guidance was given consistent with the PowerPoint slides described in Section IX.14.c and the manual revisions revised as part of this Settlement Agreement as set forth in Sections IX.6 through IX.8; (3) a certification that any questions from contractors or adjudicators were answered consistent with those manual revisions; and (4) a summary prepared by CMS of the questions posed and answers provided during this National Call.

16. CMS agrees to finalize and issue the revised manual provisions and to carry out the educational campaign provided by the settlement agreement within one year of the Approval Date.

Accountability Measures

Claims Review

17. CMS will engage in the following measures:
- a. Sampling of QIC Decisions: CMS will develop protocols for reviewing a random sample of SNF, HH, and OPT coverage decisions by the QICs (for claims under Parts A, B, and C) under the SNF, HH, and OPT maintenance coverage standards set forth above in Sections IX.6 through IX.7 to determine overall trends and any problems in the application of these maintenance coverage standards. CMS will make a reasonable effort to draw the random sample of QIC decisions to reflect claims initially decided by a representative cross-section of contractors and MA Organizations. Plaintiffs' Counsel may provide suggestions to CMS as to how to identify appropriate claims for sampling, e.g., through target diagnosis codes.
 - b. CMS will provide updates to Plaintiffs' Counsel regarding the results of this random sampling during the bi-annual meetings referenced below in Section IX.17.f, beginning with the first meeting following completion of the educational campaign (which will be the second of the five bi-annual meetings). CMS's obligation to conduct sampling of QIC decisions as described above in Section IX.17.a pursuant to this Settlement Agreement terminates with the results reported at the fifth and final of the bi-annual meetings.
 - c. For any QIC decision from the random sample in which CMS finds reason to believe an error was made in applying the correct SNF, HH, and OPT maintenance coverage standards as set forth in Sections

IX.6 and IX.7, CMS will contact the QIC to determine whether an error was made. For those decisions in which an error by the QIC is confirmed, CMS will direct, or request if the agency does not have authority to direct, the QIC to correct its error.

d. If the random sampling indicates that a particular Medicare contractor or MA organization is not applying the correct SNF, HH, and OPT maintenance coverage standards as set forth in Sections IX.6 and IX.7, CMS will address this issue directly with that entity. The manner in which CMS addresses the issue will be within its discretion.

e. Review of Individual Claims Determinations: To address any individual beneficiary claims determinations that Plaintiffs believe were not decided in accordance with the SNF, HH, and OPT maintenance coverage standards as set forth above in Sections IX.6 and IX.7, CMS will agree to review and address individual claims determinations as follows:

1. During the bi-annual meetings referenced below in Section IX.17.f, Plaintiffs will present CMS (through Plaintiffs' Lead Counsel) individual claims determinations it believes were not decided in accordance with the SNF, HH, and OPT maintenance coverage standards as set forth in Sections IX.6 and IX.7. The total number of such individual claims determinations Plaintiffs' Counsel presents over the course of all bi-annual meetings is not to exceed 100.

2. CMS will direct, or request if the agency does not have authority to direct, the pertinent Medicare contractors or MA Organizations to review and evaluate these claims and related documentation. If the review of such claims indicates that a particular Medicare contractor or MA organization is not applying the correct SNF, HH, and OPT maintenance coverage standard as set forth in Sections IX.6 and IX.7, CMS will address this issue directly with that entity. The manner in which CMS addresses the issue will be within its discretion. Workload permitting, CMS will provide updates to Plaintiffs' Lead Counsel regarding the action taken on these cases during the subsequent bi-annual meeting referenced below in Section IX.17.f , provided that CMS receives proper authorization from the beneficiary.

f. Bi-Annual Meetings: CMS will meet with Plaintiffs' Counsel on a bi-annual basis to discuss the results of the sampling of claims data and the agency's review of the individual claims determinations as discussed above in Sections IX.17.a-b and IX.17.e. The meetings can also be used to bring any issues related to the settlement to the agency's attention. The first of these meetings will take place following the issuance of the revised manual provisions and prior to the completion of the educational

campaign, and meetings will continue on a bi-annual basis thereafter for a total of five (5) meetings.

18. The Parties recognize that Defendant's obligations are met under the Settlement Agreement once it has complied with the terms of this Settlement Agreement, and that Defendant is not guaranteeing to Plaintiffs that certain results will be achieved once the steps set forth in this Settlement Agreement have been implemented.

X. ATTORNEY'S FEES

Defendant agrees to pay reasonable and appropriate attorney's fees, costs, and expenses related to work performed by Plaintiffs' Counsel in the litigation and settlement of this matter up until the Approval Date, subject to appropriate documentation and exercise of business judgment by Plaintiffs and Plaintiffs' Counsel, pursuant to the Equal Access to Justice Act. For work performed by Plaintiffs' Counsel after the Approval Date, Defendant agrees to pay reasonable and appropriate attorney's fees, costs, and expenses only for the post-Approval Date work specified in this Settlement Agreement, to be capped at \$300,000, subject to appropriate documentation and exercise of business judgment by Plaintiffs and their attorneys and pursuant to the Equal Access to Justice Act. However, if Plaintiffs initiate proceedings to enforce this Settlement Agreement, as described above, and if the Court finds that Defendant has not complied with the Settlement Agreement, Plaintiffs reserve the right to seek the payment of additional fees, costs, and expenses in connection with that enforcement proceeding that will not be subject to the above cap. Plaintiffs' Lead Counsel may submit request(s) for post-Approval fees to Defendant's Counsel for periods no less than 12 months in length, except for the last period if one or more earlier periods has been for more than 12 months.

In the event that the parties are unable to agree upon the amount of fees, Plaintiffs may retain the right to file a fee petition with the Court. Notwithstanding their agreement to limit any post-Approval attorney's fees, costs, and expenses to the above fee cap, Plaintiffs and Plaintiffs' Counsel object to the principle of a fee cap and reserve their right to object to such a cap in future cases.

XI. CLASS CERTIFICATION AND RELIEF

Class Definition

1. Defendant will stipulate to the certification of a class pursuant to Federal Rule of Civil Procedure 23(b)(2) consisting of all Medicare beneficiaries who:
 - a. received skilled nursing or therapy services in a skilled nursing facility, home health setting, or outpatient setting; and
 - b. received a denial of Medicare coverage (in part or in full) for those services described in the previous paragraph based on a lack of improvement potential in violation of the SNF, HH, or OPT maintenance coverage standards as defined above in section Sections IX.6 and IX.7 and that denial became final and non-appealable on or after January 18, 2011; and
 - c. seek Medicare coverage on his or her own behalf; the definition of class members specifically excludes providers or suppliers of Medicare services or a Medicaid State Agency.

Re-Review Relief for Certain Members of the Class

2. Certain members of the class are eligible for re-review of the claim denials described above in Section XI.1.b, if the following requirements are met:

a. The services described above in Section XI.1.a that are the subject of the denial described above in Section XI.1.b must not have been covered or paid for by any third-party payer or insurer or Medicare, except in the case of an individual Medicare beneficiary whose services were paid for by Medicaid and who paid for the service or is personally or financially liable or subject to recovery for the services; and

b. There must not have been a basis for the denial of the claim for Medicare coverage that was separate and independent from the alleged failure to apply the SNF, HH, or OPT maintenance coverage standards as defined above in Sections IX.6 and IX.7. A separate and independent basis for denial would include the failure to satisfy any procedural requirement, any Medicare eligibility requirement, or any threshold requirement for coverage, but a conclusory determination that services were not “reasonable and necessary,” were not “medically necessary,” or that coverage is denied using other conclusory, non-specific language, that may be based on a failure to apply the SNF, HH, or OPT maintenance coverage standards as defined in Sections IX.6 and IX.7 above would not be such a separate and independent basis for denial.

3. Claim denials described in Section XI.1.b that become final and non-appealable after the End of the Educational Campaign are not eligible for re-review under this Section (XI).

4. Claims of class members other than of the Named Plaintiffs that are currently the subject of any lawsuit pending in an Article III United States Court or have been the subject of a final, non-appealable judgment by such courts are not eligible for re-review under this Section (XI).

5. Only class members on their own behalf may receive re-review of claims under this section. No provider or supplier of Medicare services or Medicaid State Agency is permitted to receive re-review under this section on behalf of or by assignment from a class member.

6. Class members who are eligible for re-review of claim denials will be partitioned into two groups.

a. Group 1 consists of all class members who received a final, non-appealable denial of Medicare coverage (in part or in full) where that denial became final and non-appealable after January 18, 2011 and up to and including the Approval Date.

b. Group 2 consists of all class members who received a final, non-appealable denial of Medicare coverage (in part or in full) from the day after the Approval Date through and including the End of the Educational Campaign.

7. Group 1 class members seeking re-review relief as set forth in this Section (XI) will be required to identify themselves and their final, non-appealable denials to CMS no later than six (6) months after the End of the Educational Campaign. Group 2 class members seeking re-review relief as set forth in this Section (XI) will be

required to identify themselves and their final, non-appealable denials to CMS no later than twelve (12) months after the End of the Educational Campaign.

8. For each Group 1 or 2 class member who identifies himself or herself to CMS within the specified timeframe for re-review as set forth in the previous paragraph, the agency will direct, or request if the agency does not have the authority to direct, the contractor or adjudicator who last denied the class member's claim for Medicare coverage to re-review the claim under the clarified maintenance coverage standards set forth above in Sections IX.6 and IX.7, subject to the exceptions described above in Sections XI.4 and XI.5.

9. When results of the re-review process confirm that the claim was denied in error and that the care should have been covered by Medicare, the agency will reimburse for that care, or, if the agency does not have the authority to reimburse, request reimbursement for the class member for that care, subject to applicable Medicare reimbursement limits.

10. Within 10 days of Approval of this Settlement Agreement, Defendant will inform Plaintiffs' Lead Counsel of the process, including to whom class members should identify themselves (pursuant to Section XI.7 through XI.8), by which class members should identify themselves in order to obtain re-review.

11. Within 30 days after the End of the Educational Campaign, Plaintiffs' Lead Counsel shall provide Defendant with the final claim denial that Ms. Jimmo received that is at issue in this lawsuit. Defendant shall promptly process Ms. Jimmo's claim under the re-review process as set forth in Section XI.2 through XI.10. Defendant

shall make a good faith effort to issue a final decision on Ms. Jimmo's claim, if appropriate, as soon as practicable.

XII. COMPLIANCE WITH LEGAL AUTHORITY

The parties recognize that Defendant is required to comply with applicable statutes and regulations, including any future revisions to the statutes and regulations that govern Medicare coverage, and that nothing in this Settlement Agreement shall prohibit Defendant from modifying its policies and procedures to comply with any relevant statutory or regulatory changes, even if such modifications are made during the period of the Court's continuing jurisdiction under this Settlement Agreement, or from otherwise changing Defendant's regulations in a manner consistent with the Administrative Procedure Act. If Plaintiffs' Counsel believes that any such modifications to Defendant's policies and procedures, such as the Medicare Benefits Policy Manual, are not authorized by any statutory or regulatory changes, and that any such modifications would constitute a breach of any of the provisions of this Settlement Agreement, they reserve the right to initiate the Dispute Resolution process in Section VIII.

XIII. RELEASE

1. In consideration for the promises of Defendant as set forth in this Settlement Agreement, the Named Plaintiffs and all Class Members, and their heirs, administrators, successors, or assigns (together, the "Releasors"), hereby release and forever discharge Defendant and the United States Department of Health and Human Services (HHS), along with Defendant's and HHS's administrators, successors, officers, employees, and agents (together, the "Releasees") from any and all claims and causes of action that have been asserted or could have been asserted in this action by reason of, or

with respect to, Plaintiffs' allegations that Defendant has illegally applied, or has failed to properly prevent the application of, an Improvement Standard under which Medicare coverage of skilled services is denied on the basis that a Medicare beneficiary is not improving, 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.

2. The above release shall not affect the right of any Class Member to seek any and all individual relief that is otherwise available in satisfaction of an individual claim against Defendant for Medicare benefits that is not based upon the allegations set forth in Section XIII.1 above.

3. The above release also shall not affect Plaintiffs' or any Class Member's right, if any, to bring a separate lawsuit challenging any new policy or procedure that is adopted by Defendant after the end of the Court's jurisdiction over this Settlement Agreement, as described in Section VI. Plaintiffs and Class Members will have no right to claim that such a change in policies or procedures violates the Settlement Agreement, but do not waive any right to claim that the new policy or procedure violates the Social Security Act, Defendant's regulations, or any other provision of law.

XIV. NO ADMISSION OF LIABILITY

Neither this Settlement Agreement nor any order approving this Settlement Agreement is or shall be construed as an admission by Defendant of the truth of any of the allegations set forth in the First Amended Complaint or the validity of the claims

asserted in the First Amended Complaint, or of Defendant's liability for any of those claims.

The undersigned representatives of the parties certify that they are fully authorized to consent to the Court's entry of the terms and conditions of this Settlement Agreement.

Dated: October 16, 2012

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Jimmo Fact Sheet
(www.CMS.gov)



***Jimmo v. Sebelius* Settlement Agreement Program Manual Clarifications Fact Sheet**



Overview:

As explained in the previously-issued *Jimmo v. Sebelius* Settlement Agreement Fact Sheet (available online at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/Jimmo-FactSheet.pdf>), the Centers for Medicare & Medicaid Services (CMS) is issuing revised portions of the relevant program manuals used by Medicare contractors. Specifically, in accordance with the settlement agreement, the manual revisions clarify that coverage of skilled nursing and skilled therapy services in the skilled nursing facility (SNF), home health (HH), and outpatient therapy (OPT) settings "...does not turn on the presence or absence of a beneficiary's potential for improvement, but rather on the beneficiary's need for skilled care." Skilled care may be necessary to improve a patient's current condition, to maintain the patient's current condition, or to prevent or slow further deterioration of the patient's condition.

The Settlement Agreement:

The settlement agreement itself includes language specifying that **"Nothing in this Settlement Agreement modifies, contracts, or expands the existing eligibility requirements for receiving Medicare coverage."**

Rather, the intent is to clarify Medicare's longstanding policy that when skilled 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 potential for improvement or restoration. As such, the manual revisions contained in Change Request (CR) 8458 do not represent an *expansion* of coverage, but rather, provide clarifications that are intended to help ensure that claims are adjudicated accurately and appropriately in accordance with the *existing* Medicare policy. Similarly, these revisions do not alter or supersede any other applicable coverage requirements beyond those involving the need for skilled care, such as Medicare's overall requirement that covered services must be reasonable and necessary to diagnose or treat the beneficiary's condition. The following are some significant aspects of the manual clarifications:

- **No "Improvement Standard" is to be applied in determining Medicare coverage for maintenance claims in which skilled care is required.**
There are situations in which the patient's potential for improvement would

be a reasonable criterion to consider, such as when the goal of treatment is to restore function. We note that this would always be the goal of treatment in the inpatient rehabilitation facility (IRF) setting, where skilled therapy must be reasonably expected to improve the patient's functional capacity or adaptation to impairments in order to be covered. However, Medicare has long recognized that there may be situations in the SNF, home health, and outpatient therapy settings where, even though no improvement is expected, skilled nursing and/or therapy services to prevent or slow a decline in condition are necessary because of the particular patient's special medical complications or the complexity of the needed services.

- The manual revisions clarify that a beneficiary's lack of restoration potential cannot, in itself, serve as the basis for denying coverage in this context, 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. Conversely, such coverage would not be available in a situation where the beneficiary's maintenance care needs can be addressed safely and effectively through the use of *nonskilled* personnel.
- Medicare has never supported the imposition of an "Improvement Standard" rule-of-thumb in determining whether skilled care is required to prevent or slow deterioration in a patient's condition. Thus, such coverage depends not on the beneficiary's restoration potential, but on *whether skilled care is required*, along with the underlying reasonableness and necessity of the services themselves. The manual revisions serve to reflect and articulate this basic principle more clearly. Therefore, denial notices for claims involving maintenance care in the SNF, HH, and OPT settings should contain an accurate summary of the reason for the determination, which should always be based on whether the beneficiary has a *need for skilled care* rather than on a lack of improvement.

Appropriate Documentation:

Portions of the revised manual provisions now include additional information on the role of appropriate documentation in facilitating accurate coverage determinations for claims involving skilled care. While the presence of appropriate documentation is not, in and of itself, an element of the definition of a "skilled" service, such documentation serves as the *means* by which a provider would be able to establish and a Medicare contractor would be able to confirm that skilled care is, in fact, needed and received in a given case. Thus, even though the

terms of the settlement agreement do not include an explicit reference to documentation requirements as such, we have nevertheless decided to use this opportunity to introduce additional guidance in this area, both generally and as it relates to particular clinical scenarios.

We note that this material on documentation does not serve to require the presence of any particular phraseology or verbal formulation as a prerequisite for coverage (although it does identify certain vague phrases like “patient tolerated treatment well,” “continue with POC,” and “patient remains stable” as being *insufficiently explanatory* to establish coverage). Rather, as indicated previously, coverage determinations must consider the *entirety* of the clinical evidence in the file, and our enhanced guidance on documentation is intended simply to assist providers in their efforts to identify and include the kind of clinical information that can most effectively serve to support a finding that skilled care is needed and received—which, in turn, will help to ensure more accurate and appropriate claims adjudication.

Care must be taken to assure that documentation justifies the necessity of the skilled services provided. Justification for treatment would include, for example, objective evidence or a clinically supportable statement of expectation that:

- In the case of rehabilitative therapy, the patient’s condition has the potential to improve or is improving in response to therapy; maximum improvement is yet to be attained; and, there is an expectation that the anticipated improvement is attainable in a reasonable and generally predictable period of time.
- In the case of maintenance therapy, the skills of a therapist are necessary to maintain, prevent, or slow further deterioration of the patient’s functional status, and the services cannot be safely and effectively carried out by the beneficiary personally, or with the assistance of non-therapists, including unskilled caregivers.

Forthcoming Activities:

As discussed in the previously-issued *Jimmo v. Sebelius* Settlement Agreement Fact Sheet, CMS is planning to conduct additional educational outreach and claims review activities in the near future pursuant to the settlement agreement.

*Medicare's Covered Medical and Other
Health Services Benefit Policy Manual*
(www.CMS.gov)

Medicare Benefit Policy Manual

Chapter 15 – Covered Medical and Other Health Services

Table of Contents ***(Rev. 179, 01-14-14)***

220.1.1 - Care of a Physician/Nonphysician *Practitioner* (NPP)

220 - Coverage of Outpatient Rehabilitation Therapy Services (Physical Therapy, Occupational Therapy, and Speech-Language Pathology Services) Under Medical Insurance

(Rev. 179, Issued: 01-14-14, Effective: 01-07-14, Implementation: 01-07-14)

A comprehensive knowledge of the policies that apply to therapy services cannot be obtained through manuals alone. The most definitive policies are Local Coverage Determinations found at the Medicare Coverage Database www.cms.hhs.gov/mcd. A list of Medicare contractors is found at the CMS Web site. Specific questions about all Medicare policies should be addressed to the contractors through the contact information supplied on their Web sites. General Medicare questions may be addressed to the Medicare regional offices <http://www.cms.hhs.gov/RegionalOffices/>.

A. Definitions

The following defines terms used in this section and §230:

ACTIVE PARTICIPATION of the clinician in treatment means that the clinician personally furnishes in its entirety at least 1 billable service on at least 1 day of treatment.

ASSESSMENT is separate from evaluation, and is included in services or procedures, (it is not separately payable). The term assessment as used in Medicare manuals related to therapy services is distinguished from language in Current Procedural Terminology (CPT) codes that specify assessment, e.g., 97755, Assistive Technology Assessment, which may be payable). Assessments shall be provided only by clinicians, because assessment requires professional skill to gather data by observation and patient inquiry and may include limited objective testing and measurement to make clinical judgments regarding the patient's condition(s). Assessment determines, e.g., changes in the patient's status since the last visit/treatment day and whether the planned procedure or service should be modified. Based on these assessment data, the professional may make judgments about progress toward goals and/or determine that a more complete evaluation or re-evaluation (see definitions below) is indicated. Routine weekly assessments of expected progression in accordance with the plan are not payable as re-evaluations.

CERTIFICATION is the physician's/nonphysician practitioner's (NPP) approval of the plan of care. Certification requires a dated signature on the plan of care or some other document that indicates approval of the plan of care.

The **CLINICIAN** is a term used in this manual and in Pub 100-04, chapter 5, section 10 or section 20, to refer to only a physician, nonphysician practitioner or a therapist (but not to an assistant, aide or any other personnel) providing a service within their scope of practice and consistent with state and local law. Clinicians make clinical judgments and are responsible for all services they are permitted to supervise. Services that require the skills of a therapist, may be appropriately furnished by clinicians, that is, by or under the supervision of qualified physicians/NPPs when their scope of practice, state and local

laws allow it and their personal professional training is judged by Medicare contractors as sufficient to provide to the beneficiary skills equivalent to a therapist for that service.

COMPLEXITIES are complicating factors that may influence treatment, e.g., they may influence the type, frequency, intensity and/or duration of treatment. Complexities may be represented by diagnoses (ICD-9 codes), by patient factors such as age, severity, acuity, multiple conditions, and motivation, or by the patient's social circumstances such as the support of a significant other or the availability of transportation to therapy.

A DATE may be in any form (written, stamped or electronic). The date may be added to the record in any manner and at any time, as long as the dates are accurate. If they are different, refer to both the date a service was performed and the date the entry to the record was made. For example, if a physician certifies a plan and fails to date it, staff may add "Received Date" in writing or with a stamp. The received date is valid for certification/re-certification purposes. Also, if the physician faxes the referral, certification, or re-certification and forgets to date it, the date that prints out on the fax is valid. If services provided on one date are documented on another date, both dates should be documented.

The EPISODE of Outpatient Therapy – For the purposes of therapy policy, an outpatient therapy episode is defined as the period of time, in calendar days, from the first day the patient is under the care of the clinician (e.g., for evaluation or treatment) for the current condition(s) being treated by one therapy discipline (PT, or OT, or SLP) until the last date of service for that discipline in that setting.

During the episode, the beneficiary may be treated for more than one condition; including conditions with an onset after the episode has begun. For example, a beneficiary receiving PT for a hip fracture who, after the initial treatment session, develops low back pain would also be treated under a PT plan of care for rehabilitation of low back pain. That plan may be modified from the initial plan, or it may be a separate plan specific to the low back pain, but treatment for both conditions concurrently would be considered the same episode of PT treatment. If that same patient developed a swallowing problem during intubation for the hip surgery, the first day of treatment by the SLP would be a new episode of SLP care.

EVALUATION is a separately payable comprehensive service provided by a clinician, as defined above, that requires professional skills to make clinical judgments about conditions for which services are indicated based on objective measurements and subjective evaluations of patient performance and functional abilities. Evaluation is warranted e.g., for a new diagnosis or when a condition is treated in a new setting. These evaluative judgments are essential to development of the plan of care, including goals and the selection of interventions.

FUNCTIONAL REPORTING, which is required on claims for all outpatient therapy services pursuant to 42CFR410.59, 410.60, and 410.62, uses nonpayable G-codes and

related modifiers to convey information about the patient's functional status at specified points during therapy. (See Pub 100-04, chapter 5, section 10.6)

RE-EVALUATION provides additional objective information not included in other documentation. Re-evaluation is separately payable and is periodically indicated during an episode of care when the professional assessment of a clinician indicates a significant improvement, or decline, or change in the patient's condition or functional status that was not anticipated in the plan of care. Although some state regulations and state practice acts require re-evaluation at specific times, for Medicare payment, reevaluations must also meet Medicare coverage guidelines. The decision to provide a reevaluation shall be made by a clinician.

INTERVAL of certified treatment (certification interval) consists of 90 calendar days or less, based on an individual's needs. A physician/NPP may certify a plan of care for an interval length that is less than 90 days. There may be more than one certification interval in an episode of care. The certification interval is not the same as a Progress Report period.

MAINTENANCE PROGRAM (MP) means a program established by a therapist that consists of activities and/or mechanisms that will assist a beneficiary in maximizing or maintaining the progress he or she has made during therapy or to prevent or slow further deterioration due to a disease or illness.

NONPHYSICIAN PRACTITIONERS (NPP) means physician assistants, clinical nurse specialists, and nurse practitioners, who may, if state and local laws permit it, and when appropriate rules are followed, provide, certify or supervise therapy services.

PHYSICIAN with respect to outpatient rehabilitation therapy services means a doctor of medicine, osteopathy (including an osteopathic practitioner), podiatric medicine, or optometry (for low vision rehabilitation only). Chiropractors and doctors of dental surgery or dental medicine are not considered physicians for therapy services and may neither refer patients for rehabilitation therapy services nor establish therapy plans of care.

PATIENT, client, resident, and beneficiary are terms used interchangeably to indicate enrolled recipients of Medicare covered services.

PROVIDERS of services are defined in §1861(u) of the Act, 42CFR400.202 and 42CFR485 Subpart H as participating hospitals, critical access hospitals (CAH), skilled nursing facilities (SNF), comprehensive outpatient rehabilitation facilities (CORF), home health agencies (HHA), hospices, participating clinics, rehabilitation agencies or outpatient rehabilitation facilities (ORF). Providers are also defined as public health agencies with agreements only to furnish outpatient therapy services, or community mental health centers with agreements only to furnish partial hospitalization services. To qualify as providers of services, these providers must meet certain conditions enumerated in the law and enter into an agreement with the Secretary in which they agree not to

charge any beneficiary for covered services for which the program will pay and to refund any erroneous collections made. Note that the word PROVIDER in sections 220 and 230 is not used to mean a person who provides a service, but is used as in the statute to mean a facility or agency such as rehabilitation agency or home health agency.

QUALIFIED PROFESSIONAL means a physical therapist, occupational therapist, speech-language pathologist, physician, nurse practitioner, clinical nurse specialist, or physician's assistant, who is licensed or certified by the state to *furnish* therapy services, and who also may appropriately *furnish* therapy services under Medicare policies. Qualified *professional* may also include *a* physical therapist *assistant* (PTA) *or an* occupational therapy *assistant* (OTA) when *furnishing services* under the supervision of a qualified therapist, *who is working* within the *state* scope of practice *in the state in which the services are furnished*. Assistants are limited in the services they may *furnish* (see section 230.1 and 230.2) and may not supervise *other therapy caregivers*.

QUALIFIED PERSONNEL means staff (auxiliary personnel) who have been educated and trained as therapists and qualify to furnish therapy services only under direct supervision incident to a physician or NPP. See §230.5 of this *chapter*. Qualified personnel may or may not be licensed as therapists but meet all of the requirements for therapists with the exception of licensure.

SIGNATURE means a legible identifier of any type acceptable according to policies in Pub. 100-08, Medicare Program Integrity Manual, chapter 3, §3.3.2.4. concerning signatures.

SUPERVISION LEVELS for outpatient rehabilitation therapy services are the same as those for diagnostic tests defined in 42CFR410.32. Depending on the setting, the levels include personal supervision (in the room), direct supervision (in the office suite), and general supervision (physician/NPP is available but not necessarily on the premises).

SUPPLIERS of therapy services include individual practitioners such as physicians, NPPs, physical therapists and occupational therapists who have Medicare provider numbers. Regulatory references on physical therapists in private practice (PTPPs) and occupational therapists in private practice (OTPPs) are at 42CFR410.60 (C)(1), 485.701-729, and 486.150-163.

THERAPIST refers only to qualified physical therapists, occupational therapists and speech-language pathologists, as defined in §230. Qualifications that define therapists are in §§230.1, 230.2, and 230.3. Skills of a therapist are defined by the scope of practice for therapists in the state).

THERAPY (or outpatient rehabilitation services) includes only outpatient physical therapy (*PT*), occupational therapy (*OT*) and speech-language pathology (*SLP*) services paid using the Medicare Physician Fee Schedule or the same services when provided in hospitals that are exempt from the hospital Outpatient Prospective Payment System and paid on a reasonable cost basis, including critical access hospitals.

Therapy services referred to in this *chapter* are those skilled services *furnished* according to the standards and conditions in CMS manuals, (e.g., in this chapter and in Pub. 100-04, Medicare Claims Processing Manual, chapter 5), within their scope of practice by qualified professionals or qualified personnel, as defined in this section, represented by procedures found in the American Medical Association's "Current Procedural Terminology (CPT)." A list of CPT (HCPCS) codes is provided in Pub. 100-04, chapter 5, §20, and in Local Coverage Determinations developed by contractors.

TREATMENT DAY means a single calendar day on which treatment, evaluation and/or reevaluation is provided. There could be multiple visits, treatment sessions/encounters on a treatment day.

VISITS OR TREATMENT SESSIONS begin at the time the patient enters the treatment area (of a building, office, or clinic) and continue until all services (e.g., activities, procedures, services) have been completed for that session and the patient leaves that area to participate in a non-therapy activity. It is likely that not all minutes in the visits/treatment sessions are billable (e.g., rest periods). There may be two treatment sessions in a day, for example, in the morning and afternoon. When there are two visits/treatment sessions in a day, plans of care indicate treatment amount of twice a day.

B. References

Paper Manuals. The following manuals, now outdated, were resources for the Internet Only Manuals:

- Part A Medicare Intermediary Manual, (Pub. 13)
- Part B Medicare Carrier Manual, (Pub. 14)
- Hospital Manual, (Pub. 10)
- Outpatient Physical Therapy/CORF Manual, (Pub. 9)

Regulation and Statute. The information in this section is based in part on the following current references:

- 42CFR refers to Title 42, Code of Federal Regulation (CFR).
- The Act refers to the Social Security Act.

Internet Only Manuals. Current Policies that concern providers and suppliers of therapy services are located in many places throughout CMS Manuals. Sites that may be of interest include:

- Pub.100-01 GENERAL INFORMATION, ELIGIBILITY, AND ENTITLEMENT
 - Chapter 1- General Overview

10.1 - Hospital Insurance (Part A) for Inpatient Hospital, Hospice, Home Health and SNF Services - A Brief Description
10.2 - Home Health Services
10.3 - Supplementary Medical Insurance (Part B) - A Brief Description
20.2 - Discrimination Prohibited

- Pub. 100-02, MEDICARE BENEFIT POLICY MANUAL

- Ch 6 - Hospital Services Covered Under Part B

- 10 - Medical and Other Health Services Furnished to Inpatients of Participating Hospitals
 - 20 - Outpatient Hospital Services
 - 20.2 - Outpatient Defined
 - 20.4.1 - Diagnostic Services Defined
 - 70 - Outpatient Hospital Psychiatric Services

- Ch 8 - Coverage of Extended Care (SNF) Services Under Hospital Insurance

- 30.4. - Direct Skilled Rehabilitation Services to Patients
 - 40 - Physician Certification and Recertification for Extended Care Services
 - 50.3 - Physical Therapy, Speech-Language Pathology, and Occupational Therapy Furnished by the Skilled Nursing Facility or by Others Under Arrangements with the Facility and Under Its Supervision
 - 70.3 - Inpatient Physical Therapy, Occupational Therapy, and Speech Pathology Services

- Ch 12 - Comprehensive Outpatient Rehabilitation Facility (CORF) Coverage

- 10 - Comprehensive Outpatient Rehabilitation Facility (CORF) Services Provided by Medicare
 - 20 - Required and Optional CORF Services
 - 20.1 - Required Services
 - 20.2 - Optional CORF Services
 - 30 - Rules for Provision of Services
 - 30.1 - Rules for Payment of CORF Services
 - 40 - Specific CORF Services
 - 40.1 - Physicians' Services
 - 40.2 - Physical Therapy Services
 - 40.3 - Occupational Therapy Services
 - 40.4 - Speech Language Pathology Services

- Pub. 100-03 MEDICARE NATIONAL COVERAGE DETERMINATIONS MANUAL

- Part 1

20.10 - Cardiac Rehabilitation Programs

30.1 - Biofeedback Therapy

30.1.1 - Biofeedback Therapy for the Treatment of Urinary Incontinence

50.1 – Speech Generating Devices

50.2 - Electronic Speech Aids

50.4 - Tracheostomy Speaking Valve

- Part 2

150.2 - Osteogenic Stimulator

160.7 - Electrical Nerve Stimulators

160.12 - Neuromuscular Electrical Stimulation (NMES)

160.13 - Supplies Used in the Delivery of Transcutaneous Electrical Nerve Stimulation (TENS) and Neuromuscular Electrical Stimulation (NMES)

160.17 - L-Dopa

- Part 3

170.1 - Institutional and Home Care Patient Education Programs

170.2 - Melodic Intonation Therapy

170.3 - Speech Pathology Services for the Treatment of Dysphagia

180 – Nutrition

- Part 4

230.8 - Non-implantable Pelvic Flood Electrical Stimulator

240.7 - Postural Drainage Procedures and Pulmonary Exercises

270.1 -Electrical Stimulation (ES) and Electromagnetic Therapy for the Treatment of Wounds

270.4 - Treatment of Decubitus Ulcers

280.3 - Mobility Assisted Equipment (MAE)

280.4 - Seat Lift

280.13 - Transcutaneous Electrical Nerve Stimulators (TENS)

290.1 - Home Health Visits to A Blind Diabetic

- Pub. 100-08 PROGRAM INTEGRITY MANUAL

- Chapter 3 - Verifying Potential Errors and Taking Corrective Actions

3.4.1.1 - Linking LCD and NCD ID Numbers to Edits

- Chapter 13 - Local Coverage Determinations

13.5.1 - Reasonable and Necessary Provisions in LCDs

Specific policies may differ by setting. Other policies concerning therapy services are found in other manuals. When a therapy service policy is specific to a setting, it takes precedence over these general outpatient policies. For special rules on:

- CORFs - See chapter 12 of this manual and also Pub. 100-04, chapter 5;
- SNF - See chapter 8 of this manual and also Pub. 100-04, chapter 6, for SNF claims/billing;
- HHA - See chapter 7 of this manual, and Pub. 100-04, chapter 10;
- GROUP THERAPY AND STUDENTS - See Pub. 100-02, chapter 15, §230;
- ARRANGEMENTS - Pub. 100-01, chapter 5, §10.3;
- COVERAGE is described in the Medicare Program Integrity Manual, Pub. 100-08, chapter 13, §13.5.1; and
- THERAPY CAPS - See Pub. 100-04, chapter 5, §10.2, for a complete description of this financial limitation.

C. General

Therapy services are a covered benefit in §§1861(g), 1861(p), and 1861(ll) of the Act. Therapy services may also be provided incident to the services of a physician/NPP under §§1861(s)(2) and 1862(a)(20) of the Act.

Covered therapy services are furnished by providers, by others under arrangements with and under the supervision of providers, or furnished by suppliers (e.g., physicians, NPP, enrolled therapists), who meet the requirements in Medicare manuals for therapy services.

Where a prospective payment system (PPS) applies, therapy services are paid when services conform to the requirements of that PPS. Reimbursement for therapy provided to Part A inpatients of hospitals or residents of SNFs in covered stays is included in the respective PPS rates.

Payment for therapy provided by an HHA under a plan of treatment is included in the home health PPS rate. Therapy may be billed by an HHA on bill type 34x if there are no home health services billed under a home health plan of care at the same time (e.g., the patient is not homebound), and there is a valid therapy plan of treatment.

In addition to the requirements described in this chapter, the services must be furnished in accordance with health and safety requirements set forth in regulations at 42CFR484, and 42CFR485.

When therapy services may be furnished appropriately in a community pool by a clinician in a physical therapist or occupational therapist private practice, physician office, outpatient hospital, or outpatient SNF, the practice/office or provider shall rent or

lease the pool, or a specific portion of the pool. The use of that part of the pool during specified times shall be restricted to the patients of that practice or provider. The written agreement to rent or lease the pool shall be available for review on request. When part of the pool is rented or leased, the agreement shall describe the part of the pool that is used exclusively by the patients of that practice/office or provider and the times that exclusive use applies. Other providers, including rehabilitation agencies (*previously referred to as OPTs and ORFs*) and CORFs, are subject to the requirements outlined in the respective State Operations Manual regarding rented or leased community pools.

220.1.1 - Care of a Physician/Nonphysician *Practitioner* (NPP) **(Rev. 179, Issued: 01-14-14, Effective: 01-07-14, Implementation: 01-07-14)**

Although there is no Medicare requirement for an order, when documented in the medical record, *an order* provides evidence that the patient *both needs therapy services and* is under the care of a physician. *The* certification requirements are met when the physician certifies the plan of care. If the signed order includes a plan of care (see essential requirements of plan in [§220.1.2](#)), no further certification of the plan is required. Payment is dependent on the certification of the plan of care rather than the order, but the use of an order is prudent to determine that a physician is involved in care and available to certify the plan.

(The CORF services benefit does not recognize an NPP for orders and certification.)

220.1.2 - Plans of Care for Outpatient Physical Therapy, Occupational Therapy, or Speech-Language Pathology Services **(Rev. 179, Issued: 01-14-14, Effective: 01-07-14, Implementation: 01-07-14)**

Reference: 42CFR 410.61 and 410.105(c) (for CORFs)

A. Establishing the plan (See §220.1.3 for certifying the plan.)

The services must relate directly and specifically to a written treatment plan as described in this chapter. The plan, (also known as a plan of care or plan of treatment) must be established before treatment is begun. The plan is established when it is developed (e.g., written or dictated).

The signature and professional identity (e.g., MD, OTR/L) of the person who established the plan, and the date it was established must be recorded with the plan. Establishing the plan, which is described below, is not the same as certifying the plan, which is described in §§220.1.1 and 220.1.3

Outpatient therapy services shall be furnished under a plan established by:

- A physician/NPP (consultation with the treating physical therapist, occupational therapist, or speech-language pathologist is recommended. Only a physician may establish a plan of care in a CORF;

- The physical therapist who will provide the physical therapy services;
- The occupational therapist who will provide the occupational therapy services; or
- The speech-language pathologist who will provide the speech-language pathology services.

The plan may be entered into the patient's therapy record either by the person who established the plan or by the provider's or supplier's staff when they make a written record of that person's oral orders before treatment is begun.

Treatment under a Plan. The evaluation and treatment may occur and are both billable either on the same day or at subsequent visits. It is appropriate that treatment begins when a plan is established.

Therapy may be initiated by qualified professionals or qualified personnel based on a dictated plan. Treatment may begin before the plan is committed to writing only if the treatment is performed or supervised by the same clinician who establishes the plan. Payment for services provided before a plan is established may be denied.

Two Plans. It is acceptable to treat under two separate plans of care when different physician's/NPP's refer a patient for different conditions. It is also acceptable to combine the plans of care into one plan covering both conditions if one or the other referring physician/NPP is willing to certify the plan for both conditions. The treatment notes continue to require timed code treatment minutes and total treatment time and need not be separated by plan. Progress reports should be combined if it is possible to make clear that the goals for each plan are addressed. Separate progress reports referencing each plan of care may also be written, at the discretion of the treating clinician, or at the request of the certifying physician/NPP, but shall not be required by contractors.

B. Contents of Plan (See §220.1.3 for certifying the plan.)

The plan of care shall contain, at minimum, the following information as required by regulation (42CFR424.24, 410.61, and 410.105(c) (for CORFs)). (See §220.3 for further documentation requirements):

- Diagnoses;
- Long term treatment goals; and
- Type, amount, duration and frequency of therapy services.

The plan of care shall be consistent with the related evaluation, which may be attached and is considered incorporated into the plan. The plan should strive to provide treatment

in the most efficient and effective manner, balancing the best achievable outcome with the appropriate resources.

Long term treatment goals should be developed for the entire episode of care in the current setting. When the episode is anticipated to be long enough to require more than one certification, the long term goals may be specific to the part of the episode that is being certified. Goals should be measurable and pertain to identified functional impairments. *Therapists typically also establish short term goals, such as goals for a week or month of therapy, to help track progress toward the goal for the episode of care. If the expected episode of care is short, for example therapy is expected to be completed in 4 to 6 treatment days, the long term and short term goals may be the same. In other instances measurable goals may not be achievable, such as when treatment in a particular setting is unexpectedly cut short (such as when care is transferred to another therapy provider) or when the beneficiary suffers an exacerbation of his/her existing condition terminating the current episode;* documentation should state the clinical reasons progress cannot be shown. The functional impairments identified and expressed in the long term treatment goals must be consistent with those used in the claims-based functional reporting, using nonpayable G-codes and severity modifiers, for services furnished on or after January 1, 2013. (Reference: 42CFR410.61 and 42CFR410.105 (for CORFs)).

The type of treatment may be PT, OT, or SLP, or, where appropriate, the type may be a description of a specific treatment or intervention. (For example, where there is a single evaluation service, but the type is not specified, the type is assumed to be consistent with the therapy discipline (PT, OT, SLP) ordered, or of the therapist who provided the evaluation.) Where a physician/NPP establishes a plan, the plan must specify the type (PT, OT, SLP) of therapy planned.

There shall be different plans of care for each type of therapy discipline. When more than one discipline is treating a patient, each must establish a diagnosis, goals, etc. independently. However, the form of the plan and the number of plans incorporated into one document are not limited as long as the required information is present and related to each discipline separately. For example, a physical therapist may not provide services under an occupational therapist plan of care. However, both may be treating the patient for the same condition at different times in the same day for goals consistent with their own scope of practice.

The amount of treatment refers to the number of times in a day the type of treatment will be provided. Where amount is not specified, one treatment session a day is assumed.

The frequency refers to the number of times in a week the type of treatment is provided. Where frequency is not specified, one treatment is assumed. If a scheduled holiday occurs on a treatment day that is part of the plan, it is appropriate to omit that treatment day unless the clinician who is responsible for writing progress reports determines that a brief, temporary pause in the delivery of therapy services would adversely affect the patient's condition.

The duration is the number of weeks, or the number of treatment sessions, for THIS PLAN of care. If the episode of care is anticipated to extend beyond the 90 calendar day limit for certification of a plan, it is desirable, although not required, that the clinician also estimate the duration of the entire episode of care in this setting.

The frequency or duration of the treatment may not be used alone to determine medical necessity, but they should be considered with other factors such as condition, progress, and treatment type to provide the most effective and efficient means to achieve the patients' goals. For example, it may be clinically appropriate, medically necessary, most efficient and effective to provide short term intensive treatment or longer term and less frequent treatment depending on the individuals' needs.

It may be appropriate for therapists to taper the frequency of visits as the patient progresses toward an independent or caregiver assisted self-management program with the intent of improving outcomes and limiting treatment time. For example, treatment may be provided 3 times a week for 2 weeks, then 2 times a week for the next 2 weeks, then once a week for the last 2 weeks. Depending on the individual's condition, such treatment may result in better outcomes, or may result in earlier discharge than routine treatment 3 times a week for 4 weeks. When tapered frequency is planned, the exact number of treatments per frequency level is not required to be projected in the plan, because the changes should be made based on assessment of daily progress. Instead, the beginning and end frequencies shall be planned. For example, amount, frequency and duration may be documented as "once daily, 3 times a week tapered to once a week over 6 weeks". Changes to the frequency may be made based on the clinicians clinical judgment and do not require recertification of the plan unless requested by the physician/NPP. The clinician should consider any comorbidities, tissue healing, the ability of the patient **and/or caregiver to do more independent self-management** as treatment progresses, and any other factors related to frequency and duration of treatment.

The above policy describes the minimum requirements for payment. It is anticipated that clinicians may choose to make their plans more specific, in accordance with good practice. For example, they may include these optional elements: short term goals, goals and duration for the current episode of care, specific treatment interventions, procedures, modalities or techniques and the amount of each. Also, notations in the medical record of beginning date for the plan are recommended but not required to assist Medicare contractors in determining the dates of services for which the plan was effective.

C. Changes to the Therapy Plan

Changes are made in writing in the patient's record and signed by one of the following professionals responsible for the patient's care:

- The physician/NPP;

- The physical therapist (in the case of physical therapy);
- The speech-language pathologist (in the case of speech-language pathology services);
- The occupational therapist (in the case of occupational therapy services); or
- The registered professional nurse or physician/NPP on the staff of the facility pursuant to the oral orders of the physician/NPP or therapist.

While the physician/NPP may change a plan of treatment established by the therapist providing such services, the therapist may not significantly alter a plan of treatment established or certified by a physician/NPP without their documented written or verbal approval (see §220.1.3(C)). A change in long-term goals, (for example if a new condition was to be treated) would be a significant change. Physician/NPP certification of the significantly modified plan of care shall be obtained within 30 days of the initial therapy treatment under the revised plan. An insignificant alteration in the plan would be a change in the frequency or duration due to the patient's illness, or a modification of short-term goals to adjust for improvements made toward the same long-term goals. If a patient has achieved a goal and/or has had no response to a treatment that is part of the plan, the therapist may delete a specific intervention from the plan of care prior to physician/ NPP approval. This shall be reported to the physician/NPP responsible for the patient's treatment prior to the next certification.

Procedures (e.g., neuromuscular reeducation) and modalities (e.g., ultrasound) are not goals, but are the means by which long and short term goals are obtained. Changes to procedures and modalities do not require physician signature when they represent adjustments to the plan that result from a normal progression in the patient's disease or condition or adjustments to the plan due to lack of expected response to the planned intervention, when the goals remain unchanged. Only when the patient's condition changes significantly, making revision of long term goals necessary, is a physician's/NPP's signature required on the change, (long term goal changes may be accompanied by changes to procedures and modalities).

220.1.4 - Requirement That Services Be Furnished on an Outpatient Basis

(Rev. 179, Issued: 01-14-14, Effective: 01-07-14, Implementation: 01-07-14)

Reference: 42CFR410.60

Therapy services are payable under the Physician Fee Schedule when furnished by 1.) a provider to its outpatients in the patient's home; 2.) a provider to patients who come to the facility's outpatient department; 3.) a provider to inpatients of other institutions, or 4.) a supplier to patients in the office or in the patient's home. (CORF rules differ on providing therapy at home.)

Coverage includes therapy services furnished by participating hospitals and SNFs to their inpatients who have exhausted Part A inpatient benefits or who are otherwise not eligible for Part A benefits. Providers of therapy services that have inpatient facilities, other than participating hospitals and SNFs, may not furnish covered therapy services to their own inpatients. However, since the inpatients of one institution may be considered the outpatients of another institution, all providers of therapy services may furnish such services to inpatients of another health facility.

A certified distinct part of an institution is considered to be a separate institution from a nonparticipating part of the institution. Consequently, the certified distinct part may render covered therapy services to the inpatients of the noncertified part of the institution or to outpatients. The certified part must bill the *MAC or* intermediary under Part B.

Therapy services are payable when furnished in the home at the same physician fee schedule *payment rates* as in other outpatient settings. Additional expenses incurred by providers *of outpatient therapy* due to travel to *the beneficiary are* not covered.

Under the Medicare law, there is no authority to require a provider to furnish a type of service. Therefore, a hospital or SNF may furnish therapy to its inpatients without having to set up facilities and procedures for furnishing those services to its outpatients. However, if the provider chooses to furnish a particular service, it may not charge any individual or other person for items or services for which the individual is entitled to have payment made under the program because it is bound by its agreement with Medicare. Thus, whenever a hospital or SNF furnishes outpatient therapy to a Medicare beneficiary (either directly or under arrangements with others) it must bill the program under Part B and may charge the patient only for the applicable deductible and coinsurance.

220.2 - Reasonable and Necessary Outpatient Rehabilitation Therapy Services

(Rev. 179, Issued: 01-14-14, Effective: 01-07-14, Implementation: 01-07-14)

References: [Pub. 100-08, chapter 13](#), §13.5.1,
[42CFR410.59](#),
[42CFR410.60](#)

A. General

To be covered, services must be skilled therapy services as described in this chapter and be rendered under the conditions specified. Services provided by professionals or personnel who do not meet the qualification standards, and services by qualified people that are not appropriate to the setting or conditions are unskilled services. *A service is not considered a skilled therapy service merely because it is furnished by a therapist or by a therapist/therapy assistant under the direct or general supervision, as applicable, of a therapist. If a service can be self-administered or safely and effectively furnished by an unskilled person, without the direct or general supervision, as applicable, of a therapist, the service cannot be regarded as a skilled therapy service even though a therapist*

actually furnishes the service. Similarly, the unavailability of a competent person to provide a non-skilled service, notwithstanding the importance of the service to the patient, does not make it a skilled service when a therapist furnishes the service.

Skilled therapy services may be necessary to improve a patient's current condition, to maintain the patient's current condition, or to prevent or slow further deterioration of the patient's condition. For further information see 220.2, subsections C (Rehabilitative Services) and subsection D (Maintenance Programs).

Services *that* do not meet the requirements for covered therapy services in Medicare manuals are not payable using codes and descriptions *as* therapy services. For example, services related to activities for the general good and welfare of patients, e.g., general exercises to promote overall fitness and flexibility and activities to provide diversion or general motivation, do not constitute therapy services for Medicare purposes. Also, services not provided under a therapy plan of care, or provided by staff who are not qualified or appropriately supervised, are not payable therapy services.

Examples of coverage policies that apply to all outpatient therapy claims are in this chapter, in Pub. [100-04, chapter 5](#), and Pub. [100-08, chapter 13](#). Some policies in other manuals are repeated here for emphasis and clarification. Further details on documenting reasonable and necessary services are found in section 220.3 of this chapter.

B. Reasonable and Necessary

To be considered reasonable and necessary, *each of* the following conditions must be met. (This is a representative list of required conditions and does not fully describe reasonable and necessary services. See the remainder of this section and associated information in section 230.)

- The services shall be considered under accepted standards of medical practice to be a specific and effective treatment for the patient's condition. Acceptable practices for therapy services are found in:
 - Medicare manuals (such as this manual and Publications [100-03](#) and [100-04](#)),
 - Contractors Local Coverage Determinations (LCDs and NCDs are available on the Medicare Coverage Database: <http://www.cms.hhs.gov/mcd>, and
 - Guidelines and literature of the professions of physical therapy, occupational therapy and speech-language pathology.
- The services shall be of such a level of complexity and sophistication or the condition of the patient shall be such that the services required can be safely and effectively performed only by a therapist, or in the case of physical therapy and occupational therapy by or under the supervision of a therapist. Services that do not require the performance or supervision of a therapist are not skilled and are

not considered reasonable or necessary therapy services, even if they are performed or supervised by a qualified professional. *Medicare coverage does not turn on the presence or absence of a beneficiary's potential for improvement from the therapy, but rather on the beneficiary's need for skilled care. (For additional guidance, see subsection D below related to Maintenance Programs.)*

- If the contractor determines the services furnished were of a type that could have been safely and effectively performed only by or under the supervision of such a qualified professional, *the contractor* shall presume that such services were properly supervised when required. However, this presumption is rebuttable and, if in the course of processing *a claim, the contractor* finds that services *were not* furnished under proper supervision, it shall deny the claim and bring this matter to the attention of the Division of Survey and Certification of the Regional Office.
- While a beneficiary's particular medical condition is a valid factor in deciding if skilled therapy services are needed, a beneficiary's diagnosis or prognosis *cannot* be the sole factor in deciding that a service is or is not skilled. The key issue is whether the skills of a therapist are needed to treat the illness or injury, or whether the services can be carried out by nonskilled personnel. See *items C and D* for descriptions of *covered* skilled services; *and*
- The amount, frequency, and duration of the services must be reasonable under accepted standards of practice. The contractor shall consult local professionals or the state or national therapy associations in the development of any utilization guidelines.

NOTE: Claims for therapy services denied because they are not considered reasonable and necessary *under §1862(a)(1)(A) of the Act and, for services furnished on or after January 1, 2013, those denied as a result of application of the therapy caps under §1833(g)(1) or (g)(3) are subject* to consideration under the waiver of liability provision in [§1879](#) of the Act.

C. Rehabilitative Therapy

Rehabilitative therapy includes *services designed to address* recovery or improvement in function and, when possible, restoration to a previous level of health and well-being. Therefore, evaluation, re-evaluation and assessment documented in the Progress Report should describe objective measurements which, when compared, show improvements in function, decrease in severity or rationalization for an optimistic outlook to justify continued treatment. *Improvement is evidenced by successive objective measurements whenever possible (see objective measurement and other instruments for evaluation in the §220.3.C of this chapter). If an individual's expected rehabilitation potential is insignificant in relation to the extent and duration of therapy services required to achieve such potential, rehabilitative therapy is not reasonable and necessary.*

Rehabilitative therapy services are skilled procedures that may include but are not limited to:

- Evaluations *and* reevaluations;
- Establishment of treatment goals specific to the patient's disability or dysfunction and designed to specifically address each problem identified in the evaluation;
- Design of a plan of care addressing the patient's disorder, including establishment of procedures to obtain goals, determining the frequency and intensity of treatment;
- Continued assessment and analysis during implementation of the services at regular intervals;
- Instruction leading to establishment of compensatory skills;
- Selection of devices to replace or augment a function (e.g., for use as an alternative communication system and short-term training on use of the device or system); and
- *Training of patient* and family to augment rehabilitative treatment. *Training* of staff and family should be ongoing *throughout* treatment and instructions modified intermittently *as* the patient's status changes.

Rehabilitative therapy *requires* the skills of a therapist to safely and effectively furnish a recognized therapy service whose goal is improvement of an impairment or functional limitation. (See *definition of therapist* in section 220.A of this chapter.) *Services that can be safely and effectively furnished by nonskilled personnel or by PTAs or OTAs without the supervision of therapists are not rehabilitative therapy services.*

Rehabilitative therapy may be needed, and improvement in a patient's condition may occur, even *when* a chronic, *progressive, degenerative*, or terminal condition exists. For example, a terminally ill patient may begin to exhibit self-care, mobility, and/or safety dependence requiring skilled therapy services. The fact that full or partial recovery is not possible does not necessarily mean that skilled therapy is not needed to improve the patient's condition *or to maximize his/her functional abilities*. The deciding factors are always whether the services are considered reasonable, effective treatments for the patient's condition and require the skills of a therapist, or whether they can be safely and effectively carried out by nonskilled personnel.

Rehabilitative therapy is not required to effect improvement or restoration of function when a patient suffers a transient and easily reversible loss or reduction of function (e.g., temporary *and generalized* weakness, which may follow a brief period of bed rest following surgery) *that* could reasonably be expected to improve spontaneously as the

patient gradually resumes normal activities. Therapy furnished in such situations is not considered reasonable and necessary for the treatment of the individual's illness or injury and the services are not covered.

If at any point in the treatment of an illness it is determined that the treatment is not rehabilitative, the services will no longer be considered reasonable and necessary under this section. (See Section 220.2 D for additional covered therapy benefits under maintenance programs). Services that are not reasonable or necessary are excluded from coverage under §1862(a)(1)(A) of the Act.

D. Maintenance Programs

*Skilled therapy services that do not meet the criteria for rehabilitative therapy may be covered in certain circumstances as maintenance therapy under a maintenance program. The goals of a maintenance program would be, for example, to maintain functional status or to prevent or slow further deterioration *in function*.*

Coverage for skilled therapy services related to a reasonable and necessary maintenance program is available in the following circumstances:

- ***Establishment or design of maintenance programs.*** *If the specialized skill, knowledge and judgment of a qualified therapist are required to establish or design a maintenance program to maintain the patient's current condition or to prevent or slow further deterioration, the establishment or design of a maintenance program by a qualified therapist is covered. If skilled therapy services by a qualified therapist are needed to instruct the patient or appropriate caregiver regarding the maintenance program, such instruction is covered. If skilled therapy services are needed for periodic reevaluations or reassessments of the maintenance program, such periodic reevaluations or reassessments are covered.*
- ***Delivery of maintenance programs.*** *Once a maintenance program is established, coverage of therapy services to carry out a maintenance program turns on the beneficiary's need for skilled care. A maintenance program can generally be performed by the beneficiary alone or with the assistance of a family member, caregiver or unskilled personnel. In such situations, coverage is not provided. However, skilled therapy services are covered when an individualized assessment of the patient's clinical condition demonstrates that the specialized judgment, knowledge, and skills of a qualified therapist are necessary for the performance of safe and effective services in a maintenance program. Such skilled care is necessary for the performance of a safe and effective maintenance program only when (a) the therapy procedures required to maintain the patient's current function or to prevent or slow further deterioration are of such complexity and sophistication that the skills of a qualified therapist are required to furnish the therapy procedure or (b) the particular patient's special medical complications require the skills of a qualified therapist to furnish a therapy service required to*

maintain the patient's current function or to prevent or slow further deterioration, even if the skills of a therapist are not ordinarily needed to perform such therapy procedures. Unlike coverage for rehabilitation therapy, coverage of therapy services to carry out a maintenance program does not depend on the presence or absence of the patient's potential for improvement from the therapy.

The deciding factors are always whether the services are considered reasonable, effective treatments for the patient's condition and require the skills of a therapist, or whether they can be safely and effectively carried out by nonskilled personnel or caregivers.

The examples that follow are intended to provide illustrations of how coverage determinations are made. These examples are not intended to include all possible situations in which coverage is provided or all reasons for denying coverage. Rather they are intended only to show how to analyze the coverage issue.

Example #1 reflects a typical outpatient scenario in which a patient has been receiving ongoing therapy under a physical therapy plan of care and the physical therapist begins the establishment of the maintenance program prior to the patient's anticipated discharge date.

EXAMPLE: *A patient with Parkinson's disease is nearing the end of a rehabilitative physical therapy program and requires the services of a therapist during the last week(s) of treatment to determine what type of exercises will contribute the most to maintain function or to prevent or slow further deterioration of the patient's present functional level following cessation of treatment. In such situations, the establishment of a maintenance program appropriate to the capacity and tolerance of the patient by the qualified therapist, the instruction of the patient or family members in carrying out the program, and such reassessments and/or reevaluations as may be required may constitute covered therapy because of the need for the skills of a qualified therapist.*

Example #2 is an outpatient scenario in which a patient who has not been receiving ongoing therapy under a therapy plan of care needs a maintenance plan.

EXAMPLE: *A patient with multiple sclerosis needs a maintenance program to slow or prevent deterioration in communication ability caused by the medical condition. Therapy services from a qualified speech-language pathologist may be covered to establish a maintenance program even though the patient's current medical condition does not yet justify the need for individual skilled therapy sessions. Evaluation, establishment of the program, and training the family or support personnel may require the skills of a therapist and would be covered. NOTE: In this example, the skills of a therapist are not required to actually carry out the maintenance program services and, as a result, are not covered.*

Example #3 describes a scenario where the skilled services of a therapist would be necessary to actually carry out the maintenance program services.

EXAMPLE: Where there is an unhealed, unstable fracture *that* requires regular exercise to maintain function until the fracture heals, the skills of a therapist *may* be needed to ensure that the fractured extremity is maintained in proper position and alignment during *range of motion exercises*. *In this case, since the skills of a therapist may be required to safely carry out the maintenance program given this particular patient's special medical complications, therapy services would be covered.*

Example #4 describes another scenario where the skilled services of a therapist are needed to actually carry out the maintenance program services.

EXAMPLE: A patient with a long history of Multiple Sclerosis has difficulties transferring in and out of the wheelchair and maintaining range of motion (ROM) of the lower extremities (LEs) due to increased spasticity muscle tone since the most recent exacerbation episode of her Multiple Sclerosis. The beneficiary is unable to walk but is independent with the use of her wheelchair. The beneficiary needs to be able to safely transfer in and out of her wheelchair by herself or with the assistance of a family member or other caregiver(s). After an individualized assessment by the physical therapist, and given the patient's overall medical and physical condition, the skills of the physical therapist are required to instruct the patient and/or caregivers in proper techniques of wheelchair transfers and LE stretches due to the special medical complications from the progression of Multiple Sclerosis. When the physical therapist determines that the patient can carry out the transfers and stretching activities safely and effectively, either alone or with the assistance of the caregivers, the skills of the physical therapist are no longer necessary to furnish the maintenance therapy; and, the patient is discharged from PT.

Example #5 describes a scenario where a patient on a maintenance program needs intermittent review and possibly a new or revised maintenance program.

EXAMPLE: A patient who has a progressive degenerative disease is performing the activities in a maintenance program established by a therapist with the assistance of family members. The program needs to be re-evaluated to determine whether assistive equipment is needed and to establish a new or revised maintenance program to maintain function or to prevent or slow further deterioration. Intermittent re-evaluation of the maintenance program would generally be covered as this is a service that requires the skills of a therapist. Should the therapist conducting the re-evaluation determine that the program needs to be revised, these services would generally be covered.

Maintenance program services that do not meet the criteria of this section are not reasonable or necessary and are not covered under §1862(a)(1)(A) of the Act.

The maintenance program provisions outlined in this section do not apply to the PT, OT, or SLP services furnished in a comprehensive outpatient rehabilitation facility (CORF) because the statute specifies that CORF services are rehabilitative.

220.3 - Documentation Requirements for Therapy Services

(Rev. 179, Issued: 01-14-14, Effective: 01-07-14, Implementation: 01-07-14)

A. General

To be payable, the medical record and the information on the claim form *must* consistently and accurately report covered therapy services, *as documented in the medical record*. Documentation must be legible, relevant and sufficient to justify the services billed. In general, services must be covered therapy services provided according to *Medicare* requirements. Medicare requires that the services billed be supported by documentation that justifies payment. Documentation must comply with all requirements applicable to Medicare claims.

The documentation guidelines in sections 220 and 230 of this chapter identify the minimal expectations of documentation by providers or suppliers or beneficiaries submitting claims for payment of therapy services to the Medicare program. State or local laws and policies, or the policies *or professional guidelines* of the *relevant* profession, the practice, or the facility may be more stringent. It is encouraged but not required that narratives that specifically justify the medical necessity of services be included in order to support approval when those services are reviewed. (See also section 220.2- Reasonable and Necessary Outpatient Rehabilitation Therapy Services)

Contractors shall consider the entire record when reviewing claims for medical necessity so that the absence of an individual item of documentation does not negate the medical necessity of a service when the documentation as a whole indicates the service is necessary. Services are medically necessary if the documentation indicates they meet the requirements for medical necessity including that they are skilled, rehabilitative services, provided by clinicians (or qualified professionals when appropriate) with the approval of a physician/NPP, safe, and effective (i.e., progress indicates that the care is effective in rehabilitation of function).

B. Documentation Required

List of required documentation. These types of documentation of therapy services are expected to be submitted in response to any requests for documentation, unless the contractor requests otherwise. The timelines are minimum requirements for Medicare payment. Document as often as the clinician's judgment dictates but no less than the frequency required in Medicare policy:

- Evaluation and Plan of Care (may be one or two documents). Include the initial evaluation and any re-evaluations relevant to the episode being reviewed;

- Certification (physician/NPP approval of the plan) and recertifications when records are requested after the certification/recertification is due. See definitions in section 220 and certification policy in section 220.1.3 of this chapter. Certification (and recertification of the plan when applicable) are required for payment and must be submitted when records are requested after the certification or recertification is due.
- Progress Reports (including Discharge Notes, if applicable) when records are requested after the reports are due. (See definitions in section 220 and descriptions in 220.3 D);
- Treatment notes for each treatment day (may also serve as progress reports when required information is included in the notes);
- A separate justification statement may be included either as a separate document or within the other documents if the provider/supplier wishes to assure the contractor understands their reasoning for services that are more extensive than is typical for the condition treated. A separate statement is not required if the record justifies treatment without further explanation.

Limits on Requirements. Contractors shall not require more specific documentation unless other Medicare policies require it. Contractors may request further information to be included in these documents concerning specific cases under review when that information is relevant, but not submitted with records.

Dictated Documentation. For Medicare purposes, dictated therapy documentation is considered completed on the day it was dictated. The qualified professional may edit and electronically sign the documentation at a later date.

Dates for Documentation. The date the documentation was made is important only to establish the date of the initial plan of care because therapy cannot begin until the plan is established unless treatment is performed or supervised by the same clinician who establishes the plan. However, contractors may require that treatment notes and progress reports be entered into the record within 1 week of the last date to which the progress report or treatment note refers. For example, if treatment began on the first of the month at a frequency of twice a week, a progress report would be required at the end of the month. Contractors may require that the progress report that describes that month of treatment be dated not more than 1 week after the end of the month described in the report.

Document Information to Meet Requirements. In *preparing* records, clinicians must be familiar with the requirements for covered and payable outpatient therapy services. For example, the records should justify:

- The patient is under the care of a physician/NPP;

Physician/NPP care shall be documented by physician/NPP certification (approval) of the plan of care; and

Although not required, other evidence of physician/NPP involvement in the patient's care may include, for example: order/referral, conference, team meeting notes, and correspondence.

- Services require the skills of a therapist.

Services must not only be provided by the qualified professional or qualified personnel, but they must require, for example, the expertise, knowledge, clinical judgment, decision making and abilities of a therapist that assistants, qualified personnel, caretakers or the patient cannot provide independently. A clinician may not merely supervise, but must apply the skills of a therapist by actively participating in the treatment of the patient during each progress report period. In addition, a therapist's skills may be documented, for example, by the clinician's descriptions of their skilled treatment, the changes made to the treatment due to a clinician's assessment of the patient's needs on a particular treatment day or changes due to progress the clinician judged sufficient to modify the treatment toward the next more complex or difficult task.

- Services are of appropriate type, frequency, intensity and duration for the individual needs of the patient.

Documentation should establish the variables that influence the patient's condition, especially those factors that influence the clinician's decision to provide more services than are typical for the individual's condition.

Clinicians and contractors shall determine typical services using published professional literature and professional guidelines. The fact that services are typically billed is not necessarily evidence that the services are typically appropriate. Services that exceed those typically billed should be carefully documented to justify their necessity, but are payable if the individual patient benefits from medically necessary services. Also, some services or episodes of treatment should be less than those typically billed, when the individual patient reaches goals sooner than is typical.

Documentation should establish through objective measurements that the patient is making progress toward goals. Note that regression and plateaus can happen during treatment. It is recommended that the reasons for lack of progress be noted and the justification for continued treatment be documented if treatment continues after regression or plateaus.

Needs of the Patient. When a service is reasonable and necessary, the patient also needs the services. Contractors determine the patient's needs through

knowledge of the individual patient's condition, and any complexities that impact that condition, as described in documentation (usually in the evaluation, re-evaluation, and progress report). Factors that contribute to need vary, but in general they relate to such factors as the patient's diagnoses, complicating factors, age, severity, time since onset/acuity, self-efficacy/motivation, cognitive ability, prognosis, and/or medical, psychological and social stability. *Changes* in objective and sometimes to subjective measures of improvement also help establish the need for *rehabilitative* services. The use of scientific evidence, obtained from professional literature, and sequential measurements of the patient's condition during treatment is encouraged to support the potential for continued improvement that may justify the patients need for *rehabilitative therapy or the patient's need for maintenance* therapy.

- Functional information included on claims as required.

The clinician is required to document in the patient's medical record, using the G-codes and severity modifiers used in functional reporting, the patient's current, projected goal, and discharge status, as reported pursuant to functional reporting requirements for each date of service for which the reporting is required. See section 220.4 below for details on documenting G-code and modifiers.

C. Evaluation/Re-Evaluation and Plan of Care

The initial evaluation, or the plan of care including an evaluation, should document the necessity for a course of therapy through objective findings and subjective patient self-reporting. Utilize the guidelines of the American Physical Therapy Association, the American Occupational Therapy Association, or the American Speech-Language and Hearing Association as guidelines, and not as policy. Only a clinician may perform an initial examination, evaluation, re-evaluation and assessment or establish a diagnosis or a plan of care. A clinician may include, as part of the evaluation or re-evaluation, objective measurements or observations made by a PTA or OTA within their scope of practice, but the clinician must actively and personally participate in the evaluation or re-evaluation. The clinician may not merely summarize the objective findings of others or make judgments drawn from the measurements and/or observations of others.

Documentation of the evaluation should list the conditions and complexities and, where it is not obvious, describe the impact of the conditions and complexities on the prognosis and/or the plan for treatment such that it is clear to the contractor who may review the record that the services planned are appropriate for the individual.

Evaluation shall include:

- A diagnosis (where allowed by state and local law) and description of the specific problem(s) to be evaluated and/or treated. The diagnosis should be specific and

as relevant to the problem to be treated as possible. In many cases, both a medical diagnosis (obtained from a physician/NPP) and an impairment based treatment diagnosis related to treatment are relevant. The treatment diagnosis may or may not be identified by the therapist, depending on their scope of practice. Where a diagnosis is not allowed, use a condition description similar to the appropriate ICD-9 code. For example the medical diagnosis made by the physician is CVA; however, the treatment diagnosis or condition description for PT may be abnormality of gait, for OT, it may be hemiparesis, and for SLP, it may be dysphagia. For PT and OT, be sure to include body part evaluated. Include all conditions and complexities that may impact the treatment. A description might include, for example, the premorbid function, date of onset, and current function;

- **Results of one of the following four measurement instruments are recommended, but not required:**

National Outcomes Measurement System (NOMS) by the American Speech-Language Hearing Association

Patient Inquiry by Focus On Therapeutic Outcomes, Inc. (FOTO)

Activity Measure – Post Acute Care (AM-PAC)

OPTIMAL by Cedaron through the American Physical Therapy Association

- If results of one of the four instruments above is not recorded, the record shall contain instead the following information indicated by asterisks (*) and should contain (but is not required to contain) all of the following, as applicable. Since published research supports its impact on the need for treatment, information in the following indented bullets may also be included with the results of the above four instruments in the evaluation report at the clinician's discretion. This information may be incorporated into a test instrument or separately reported within the required documentation. If it changes, update this information in the re-evaluation, and/or treatment notes, and/or progress reports, and/or in a separate record. When it is provided, contractors shall take this documented information into account to determine whether services are reasonable and necessary.

Documentation supporting illness severity or complexity including, e.g.,

- Identification of other health services concurrently being provided for this condition (e.g., physician, PT, OT, SLP, chiropractic, nurse, respiratory therapy, social services, psychology, nutritional/dietetic services, radiation therapy, chemotherapy, etc.), and/ or

- Identification of durable medical equipment needed for this condition, and/or
- Identification of the number of medications the beneficiary is taking (and type if known); and/or
- If complicating factors (complexities) affect treatment, describe why or how. For example: Cardiac dysrhythmia is not a condition for which a therapist would directly treat a patient, but in some patients such dysrhythmias may so directly and significantly affect the pace of progress in treatment for other conditions as to require an exception to caps for necessary services. Documentation should indicate how the progress was affected by the complexity. Or, the severity of the patient's condition as reported on a functional measurement tool may be so great as to suggest extended treatment is anticipated; and/or
- Generalized or multiple conditions. The beneficiary has, in addition to the primary condition being treated, another disease or condition being treated, or generalized musculoskeletal conditions, or conditions affecting multiple sites and these conditions will directly and significantly impact the rate of recovery; and/or.
- Mental or cognitive disorder. The beneficiary has a mental or cognitive disorder in addition to the condition being treated that will directly and significantly impact the rate of recovery; and/or.
- Identification of factors that impact severity including e.g., age, time since onset, cause of the condition, stability of symptoms, how typical/atypical are the symptoms of the diagnosed condition, availability of an intervention/treatment known to be effective, predictability of progress.

Documentation supporting medical care prior to the current episode, if any, (or document none) including, e.g.,

- Record of discharge from a Part A qualifying inpatient, SNF, or home health episode within 30 days of the onset of this outpatient therapy episode, or
- Identification of whether beneficiary was treated for this same condition previously by the same therapy discipline (regardless of where prior services were furnished; and
- Record of a previous episode of therapy treatment from the same or different therapy discipline in the past year.

Documentation required to indicate beneficiary health related to quality of life, specifically,

- The beneficiary's response to the following question of self-related health: "At the present time, would you say that your health is excellent, very good, fair, or poor?" If the beneficiary is unable to respond, indicate why; and

Documentation required to indicate beneficiary social support including, specifically,

- Where does the beneficiary live (or intend to live) at the conclusion of this outpatient therapy episode? (e.g., private home, private apartment, rented room, group home, board and care apartment, assisted living, SNF), and
- Who does beneficiary live with (or intend to live with) at the conclusion of this outpatient therapy episode? (e.g., lives alone, spouse/significant other, child/children, other relative, unrelated person(s), personal care attendant), and
- Does the beneficiary require this outpatient therapy plan of care in order to return to a premorbid (or reside in a new) living environment, and
- Does the beneficiary require this outpatient therapy plan of care in order to reduce Activities of Daily Living (ADL) or Instrumental Activities of Daily Living or (IADL) assistance to a premorbid level or to reside in a new level of living environment (document prior level of independence and current assistance needs); and

*Documentation required to indicate objective, measurable beneficiary physical function including, e.g.,

- Functional assessment individual item and summary scores (and comparisons to prior assessment scores) from commercially available therapy outcomes instruments other than those listed above; or
- Functional assessment scores (and comparisons to prior assessment scores) from tests and measurements validated in the professional literature that are appropriate for the condition/function being measured; or
- Other measurable progress towards identified goals for functioning in the home environment at the conclusion of this therapy episode of care.

- Clinician's clinical judgments or subjective impressions that describe the current functional status of the condition being evaluated, when they provide further information to supplement measurement tools; and
- A determination that treatment is not needed, or, if treatment is needed a prognosis for return to premorbid condition or maximum expected condition with expected time frame and a plan of care.

NOTE: When the Evaluation Serves as the Plan of Care. When an evaluation is the only service provided by a provider/supplier in an episode of treatment, the evaluation serves as the plan of care if it contains a diagnosis, or in states where a therapist may not diagnose, a description of the condition from which a diagnosis may be determined by the referring physician/NPP. The goal, frequency, and duration of treatment are implied in the diagnosis and one-time service. The referral/order of a physician/NPP is the certification that the evaluation is needed and the patient is under the care of a physician. Therefore, when evaluation is the only service, a referral/order and evaluation are the only required documentation. If the patient presented for evaluation without a referral or order and does not require treatment, a physician referral/order or certification of the evaluation is required for payment of the evaluation. A referral/order dated after the evaluation shall be interpreted as certification of the plan to evaluate the patient.

The time spent in evaluation shall not also be billed as treatment time. Evaluation minutes are untimed and are part of the total treatment minutes, but minutes of evaluation shall not be included in the minutes for timed codes reported in the treatment notes.

Re-evaluations shall be included in the documentation sent to contractors when a re-evaluation has been performed. See the definition in section 220. Re-evaluations are usually focused on the current treatment and might not be as extensive as initial evaluations. Continuous assessment of the patient's progress is a component of ongoing therapy services and is not payable as a re-evaluation. A re-evaluation is not a routine, recurring service but is focused on evaluation of progress toward current goals, making a professional judgment about continued care, modifying goals and/or treatment or terminating services. A formal re-evaluation is covered only if the documentation supports the need for further tests and measurements after the initial evaluation. Indications for a re-evaluation include new clinical findings, a significant change in the patient's condition, or failure to respond to the therapeutic interventions outlined in the plan of care.

A re-evaluation may be appropriate prior to planned discharge for the purposes of determining whether goals have been met, or for the use of the physician or the treatment setting at which treatment will be continued.

A re-evaluation is focused on evaluation of progress toward current goals and making a professional judgment about continued care, modifying goals and/or treatment or terminating services. Reevaluation requires the same professional skills as evaluation.

The minutes for re-evaluation are documented in the same manner as the minutes for evaluation. Current Procedural Terminology does not define a re-evaluation code for speech-language pathology; use the evaluation code.

Plan of Care. See section 220.1.2 for requirements of the plan. The evaluation and plan may be reported in two separate documents or a single combined document.

D. Progress Report

The progress report provides justification for the medical necessity of treatment.

Contractors shall determine the necessity of services based on the delivery of services as directed in the plan and as documented in the treatment notes and progress report. For Medicare payment purposes, information required in progress reports shall be written by a clinician that is, either the physician/NPP who provides or supervises the services, or by the therapist who provides the services and supervises an assistant. It is not required that the referring or supervising physician/NPP sign the progress reports written by a PT, OT or SLP.

Timing. The minimum progress report period shall be at least once every 10 treatment days. The day beginning the first reporting period is the first day of the episode of treatment regardless of whether the service provided on that day is an evaluation, re-evaluation or treatment. Regardless of the date on which the report is actually written (and dated), the end of the progress report period is either a date chosen by the clinician or the 10th treatment day, whichever is shorter. The next treatment day begins the next reporting period. The progress report period requirements are complete when both the elements of the progress report and the clinician's active participation in treatment have been documented.

For example, for a patient evaluated on Monday, October 1 and being treated five times a week, on weekdays: On October 5, (before it is required), the clinician may choose to write a progress report for the last week's treatment (from October 1 to October 5). October 5 ends the reporting period and the next treatment on Monday, October 8 begins the next reporting period. If the clinician does not choose to write a report for the next week, the next report is required to cover October 8 through October 19, which would be 10 treatment days.

It should be emphasized that the dates for recertification of plans of care do not affect the dates for required progress reports. (Consideration of the case in preparation for a report may lead the therapist to request early recertification. However, each report does not require recertification of the plan, and there may be several reports between recertifications). In many settings, weekly progress reports are voluntarily prepared to review progress, describe the skilled treatment, update goals, and inform physician/NPPs or other staff. The clinical judgment demonstrated in frequent reports may help justify that the skills of a therapist are being applied, and that services are medically necessary.

Absences. Holidays, sick days or other patient absences may fall within the progress report period. Days on which a patient does not encounter qualified professional or qualified personnel for treatment, evaluation or re-evaluation do not count as treatment days. However, absences do not affect the requirement for a progress report at least once during each progress report period. If the patient is absent unexpectedly at the end of the reporting period, when the clinician has not yet provided the required active participation during that reporting period, a progress report is still required, but without the clinician's active participation in treatment, the requirements of the progress report period are incomplete.

Delayed Reports. If the clinician has not written a progress report before the end of the progress reporting period, it shall be written within 7 calendar days after the end of the reporting period. If the clinician did not participate actively in treatment during the progress report period, documentation of the delayed active participation shall be entered in the treatment note as soon as possible. The treatment note shall explain the reason for the clinician's missed active participation. Also, the treatment note shall document the clinician's guidance to the assistant or qualified personnel to justify that the skills of a therapist were required during the reporting period. It is not necessary to include in this treatment note any information already recorded in prior treatment notes or progress reports.

The contractor shall make a clinical judgment whether continued treatment by assistants or qualified personnel is reasonable and necessary when the clinician has not actively participated in treatment for longer than one reporting period. Judgment shall be based on the individual case and documentation of the application of the clinician's skills to guide the assistant or qualified personnel during and after the reporting period.

Early Reports. Often, progress reports are written weekly, or even daily, at the discretion of the clinician. Clinicians are encouraged, but not required to write progress reports more frequently than the minimum required in order to allow anyone who reviews the records to easily determine that the services provided are appropriate, covered and payable.

Elements of progress reports may be written in the treatment notes if the provider/supplier or clinician prefers. If each element required in a progress report is included in the treatment notes at least once during the progress report period, then a separate progress report is not required. Also, elements of the progress report may be incorporated into a revised plan of care when one is indicated. Although the progress report written by a therapist does not require a physician/NPP signature when written as a stand-alone document, the revised plan of care accompanied by the progress report shall be re-certified by a physician/NPP. See section 220.1.2C, Changes to the Therapy Plan, for guidance on when a revised plan requires certification.

Progress Reports for Services Billed Incident to a Physician's Service. The policy for incident to services requires, for example, the physician's initial service, direct supervision of therapy services, and subsequent services of a frequency which reflect

his/her active participation in and management of the course of treatment (see section 60.1B of this chapter. Also, see the billing requirements for services incident to a physician in Pub. 100-04, chapter 26, Items 17, 19, 24, and 31.) Therefore, supervision and reporting requirements for supervising physician/NPPs supervising staff are the same as those for PTs and OTs supervising PTAs and OTAs with certain exceptions noted below.

When a therapy service is provided by a therapist, supervised by a physician/NPP and billed incident to the services of the physician/NPP, the progress report shall be written and signed by the therapist who provides the services.

When the services incident to a physician are provided by qualified personnel who are not therapists, the ordering or supervising physician/NPP must personally provide at least one treatment session during each progress report period and sign the progress report.

Documenting Clinician Participation in Treatment in the Progress Report. Verification of the clinician's required participation in treatment during the progress report period shall be documented by the clinician's signature on the treatment note and/or on the progress report. When unexpected discontinuation of treatment occurs, contractors shall not require a clinician's participation in treatment for the incomplete reporting period.

The Discharge Note (or Discharge Summary) is required for each episode of outpatient treatment. In provider settings where the physician/NPP writes a discharge summary and the discharge documentation meets the requirements of the provider setting, a separate discharge note written by a therapist is not required. The discharge note shall be a progress report written by a clinician, and shall cover the reporting period from the last progress report to the date of discharge. In the case of a discharge unanticipated in the plan or previous progress report, the clinician may base any judgments required to write the report on the treatment notes and verbal reports of the assistant or qualified personnel.

In the case of a discharge anticipated within 3 treatment days of the progress report, the clinician may provide objective goals which, when met, will authorize the assistant or qualified personnel to discharge the patient. In that case, the clinician should verify that the services provided prior to discharge continued to require the skills of a therapist, and services were provided or supervised by a clinician. The discharge note shall include all treatment provided since the last progress report and indicate that the therapist reviewed the notes and agrees to the discharge.

At the discretion of the clinician, the discharge note may include additional information; for example, it may summarize the entire episode of treatment, or justify services that may have extended beyond those usually expected for the patient's condition. Clinicians should consider the discharge note the last opportunity to justify the medical necessity of the entire treatment episode in case the record is reviewed. The record should be reviewed and organized so that the required documentation is ready for presentation to the contractor if requested.

Assistant's Participation in the Progress Report. PTAs or OTAs may write elements of the progress report dated between clinician reports. Reports written by assistants are not complete progress reports. The clinician must write a progress report during each progress report period regardless of whether the assistant writes other reports. However, reports written by assistants are part of the record and need not be copied into the clinician's report. Progress reports written by assistants supplement the reports of clinicians and shall include:

- Date of the beginning and end of the reporting period that this report refers to;
- Date that the report was written (not required to be within the reporting period);
- Signature, and professional identification, or for dictated documentation, the identification of the qualified professional who wrote the report and the date on which it was dictated;
- Objective reports of the patient's subjective statements, if they are relevant. For example, "Patient reports pain after 20 repetitions". Or, "The patient was not feeling well on 11/05/06 and refused to complete the treatment session."; and
- Objective measurements (preferred) or description of changes in status relative to each goal currently being addressed in treatment, if they occur. Note that assistants may not make clinical judgments about why progress was or was not made, but may report the progress objectively. For example: "increasing strength" is not an objective measurement, but "patient ambulates 15 feet with maximum assistance" is objective.

Descriptions shall make identifiable reference to the goals in the current plan of care. Since only long term goals are required in the plan of care, the progress report may be used to add, change or delete short term goals. Assistants may change goals only under the direction of a clinician. When short term goal changes are dictated to an assistant or to qualified personnel, report the change, clinician's name, and date. Clinicians verify these changes by co-signatures on the report or in the clinician's progress report. (See section 220.1.2(C) to modify the plan for changes in long term goals).

The evaluation and plan of care are considered incorporated into the progress report, and information in them is not required to be repeated in the report. For example, if a time interval for the treatment is not specifically stated, it is assumed that the goals refer to the plan of care active for the current progress report period. If a body part is not specifically noted, it is assumed the treatment is consistent with the evaluation and plan of care.

Any consistent method of identifying the goals may be used. Preferably, the long term goals may be numbered (1, 2, 3,) and the short term goals that relate to the long term goals may be numbered and lettered 1.A, 1.B, etc. The identifier of a goal on the plan of care may not be changed during the episode of care to which the plan refers. A clinician, an assistant on the order of a therapist or qualified personnel on the order of a

physician/NPP shall add new goals with new identifiers or letters. Omit reference to a goal after a clinician has reported it to be met, and that clinician's signature verifies the change.

Content of Clinician (Therapist, Physician/NPP) Progress Reports. In addition to the requirements above for notes written by assistants, the progress report of a clinician shall also include:

- Assessment of improvement, extent of progress (or lack thereof) toward each goal;
- Plans for continuing treatment, reference to additional evaluation results, and/or treatment plan revisions should be documented in the clinician's progress report; and
- Changes to long or short term goals, discharge or an updated plan of care that is sent to the physician/NPP for certification of the next interval of treatment.
- Functional documentation is required as part of the progress report at the end of each progress reporting period. It is also required at the time of discharge on the discharge note or summary, as applicable. The clinician documents, on the applicable dates of service, the specific nonpayable G-codes and severity modifiers used in the required reporting of the patient's functional limitation(s) on the claim for services, including how the modifier selection was made. See subsection C of 220.4 below for details relevant to documentation requirements.

A re-evaluation should not be required before every progress report routinely, but may be appropriate when assessment suggests changes not anticipated in the original plan of care.

Care must be taken to assure that documentation justifies the necessity of the services provided during the reporting period, particularly when reports are written at the minimum frequency. Justification for treatment must include, for example, objective evidence or a clinically supportable statement of expectation that:

- *In the case of rehabilitative therapy, the patient's condition has the potential to improve or is improving in response to therapy, maximum improvement is yet to be attained; and there is an expectation that the anticipated improvement is attainable in a reasonable and generally predictable period of time.*
- *In the case of maintenance therapy, treatment by the therapist is necessary to maintain, prevent or slow further deterioration of the patient's functional status and the services cannot be safely carried out by the beneficiary him or herself, a family member, another caregiver or unskilled personnel.*

Objective evidence consists of standardized patient assessment instruments, outcome measurements tools or measurable assessments of functional outcome. Use of objective measures at the beginning of treatment, during and/or after treatment is recommended to quantify progress and support justifications for continued treatment. Such tools are not required, but their use will enhance the justification for needed therapy.

Example: The Plan states diagnosis is 787.2- Dysphagia secondary to other late effects of CVA. Patient is on a restricted diet and wants to drink thick liquids. Therapy is planned 3X week, 45 minute sessions for 6 weeks. Long term goal is to consume a mechanical soft diet with thin liquids without complications such as aspiration pneumonia. Short Term Goal 1: Patient will improve rate of laryngeal elevation/timing of closure by using the super-supraglottic swallow on saliva swallows without cues on 90% of trials. Goal 2: Patient will compensate for reduced laryngeal elevation by controlling bolus size to ½ teaspoon without cues 100%. The progress report for 1/3/06 to 1/29/06 states: 1. Improved to 80% of trials; 2. Achieved. Comments: Highly motivated; spouse assists with practicing, compliant with current restrictions. New Goal: “5. Patient will implement above strategies to swallow a sip of water without coughing for 5 consecutive trials. Mary Johns, CCC-SLP, 1/29/06.” Note the provider is billing 92526 three times a week, consistent with the plan; progress is documented; skilled treatment is documented.

E. Treatment Note

The purpose of these notes is simply to create a record of all treatments and skilled interventions that are provided and to record the time of the services in order to justify the use of billing codes on the claim. Documentation is required for every treatment day, and every therapy service. The format shall not be dictated by contractors and may vary depending on the practice of the responsible clinician and/or the clinical setting.

The treatment note is not required to document the medical necessity or appropriateness of the ongoing therapy services. Descriptions of skilled interventions should be included in the plan or the progress reports and are allowed, but not required daily. Non-skilled interventions need not be recorded in the treatment notes as they are not billable. However, notation of non-skilled treatment or report of activities performed by the patient or non-skilled staff may be reported voluntarily as additional information if they are relevant and not billed. Specifics such as number of repetitions of an exercise and other details included in the plan of care need not be repeated in the treatment notes unless they are changed from the plan.

Documentation of each treatment shall include the following required elements:

- Date of treatment; and
- Identification of each specific intervention/modality provided and billed, for both timed and untimed codes, in language that can be compared with the billing on the claim to verify correct coding. Record each service provided that is

represented by a timed code, regardless of whether or not it is billed, because the unbilled timed services may impact the billing; and

- Total timed code treatment minutes and total treatment time in minutes. Total treatment time includes the minutes for timed code treatment and untimed code treatment. Total treatment time does not include time for services that are not billable (e.g., rest periods). For Medicare purposes, it is not required that unbilled services that are not part of the total treatment minutes be recorded, although they may be included voluntarily to provide an accurate description of the treatment, show consistency with the plan, or comply with state or local policies. The amount of time for each specific intervention/modality provided to the patient may also be recorded voluntarily, but contractors shall not require it, as it is indicated in the billing. The billing and the total timed code treatment minutes must be consistent. See Pub. 100-04, chapter 5, section 20.2 for description of billing timed codes; and
- Signature and professional identification of the qualified professional who furnished or supervised the services and a list of each person who contributed to that treatment (i.e., the signature of Kathleen Smith, PTA, with notation of phone consultation with Judy Jones, PT, supervisor, when permitted by state and local law). The signature and identification of the supervisor need not be on each treatment note, unless the supervisor actively participated in the treatment. Since a clinician must be identified on the plan of care and the progress report, the name and professional identification of the supervisor responsible for the treatment is assumed to be the clinician who wrote the plan or report. When the treatment is supervised without active participation by the supervisor, the supervisor is not required to cosign the treatment note written by a qualified professional. When the responsible supervisor is absent, the presence of a similarly qualified supervisor on the clinic roster for that day is sufficient documentation and it is not required that the substitute supervisor sign or be identified in the documentation.

If a treatment is added or changed under the direction of a clinician during the treatment days between the progress reports, the change must be recorded and justified on the medical record, either in the treatment note or the progress report, as determined by the policies of the provider/supplier. New exercises added or changes made to the exercise program help justify that the services are skilled. For example: The original plan was for therapeutic activities, gait training and neuromuscular re-education. “On Feb. 1 clinician added electrical stim. to address shoulder pain.”

Documentation of each treatment may also include the following optional elements to be mentioned only if the qualified professional recording the note determines they are appropriate and relevant. If these are not recorded daily, any relevant information should be included in the progress report.

- Patient self-report;

- Adverse reaction to intervention;
- Communication/consultation with other providers (e.g., supervising clinician, attending physician, nurse, another therapist, etc.);
- Significant, unusual or unexpected changes in clinical status;
- Equipment provided; and/or
- Any additional relevant information the qualified professional finds appropriate.

See Pub. 100-04, Medicare Claims Processing Manual, chapter 5, section 20.2 for instructions on how to count minutes. It is important that the total number of timed treatment minutes support the billing of units on the claim, and that the total treatment time reflects services billed as untimed codes.

230.1 - Practice of Physical Therapy

(Rev. 179, Issued: 01-14-14, Effective: 01-07-14, Implementation: 01-07-14)

A. General

Physical therapy services are those services provided within the scope of practice of physical therapists and necessary for the diagnosis and treatment of impairments, functional limitations, disabilities or changes in physical function and health status. (See Pub. 100-03, the Medicare National Coverage Determinations Manual, for specific conditions or services.) For descriptions of aquatic therapy in a community center pool see section 220C of this chapter.

B. Qualified Physical Therapist Defined

Reference: 42CFR484.4

The new personnel qualifications for physical therapists were discussed in the 2008 Physician Fee Schedule. See the Federal Register of November 27, 2007, for the full text. See also the correction notice for this rule, published in the Federal Register on January 15, 2008.

The regulation provides that a qualified physical therapist (PT) is a person who is licensed, if applicable, as a PT by the state in which he or she is practicing unless licensure does not apply, has graduated from an accredited PT education program and passed a national examination approved by the state in which PT services are provided. The phrase, “by the state in which practicing” includes any authorization to practice provided by the same state in which the service is provided, including temporary licensure, regardless of the location of the entity billing the services. The curriculum accreditation is provided by the Commission on Accreditation in Physical Therapy Education (CAPTE) or, for those who graduated before CAPTE, curriculum approval was provided by the American Physical Therapy Association (APTA). For

internationally educated PTs, curricula are approved by a credentials evaluation organization either approved by the APTA or identified in 8 CFR 212.15(e) as it relates to PTs. For example, in 2007, 8 CFR 212.15(e) approved the credentials evaluation provided by the Federation of State Boards of Physical Therapy (FSBPT) and the Foreign Credentialing Commission on Physical Therapy (FCCPT). The requirements above apply to all PTs effective January 1, 2010, if they have not met any of the following requirements prior to January 1, 2010.

Physical therapists whose current license was obtained on or prior to December 31, 2009, qualify to provide PT services to Medicare beneficiaries if they:

- graduated from a CAPTE approved program in PT on or before December 31, 2009 (examination is not required); or,
- graduated on or before December 31, 2009, from a PT program outside the U.S. that is determined to be substantially equivalent to a U.S. program by a credentials evaluating organization approved by either the APTA or identified in 8 CFR 212.15(e) and also passed an examination for PTs approved by the state in which practicing.

Or, PTs whose current license was obtained before January 1, 2008, may meet the requirements in place on that date (i.e., graduation from a curriculum approved by either the APTA, the Committee on Allied Health Education and Accreditation of the American Medical Association, or both).

Or, PTs meet the requirements who are currently licensed and were licensed or qualified as a PT on or before December 31, 1977, and had 2 years appropriate experience as a PT, and passed a proficiency examination conducted, approved, or sponsored by the U.S. Public Health Service.

Or, PTs meet the requirements if they are currently licensed and before January 1, 1966, they were:

- admitted to membership by the APTA; or
- admitted to registration by the American Registry of Physical Therapists; or
- graduated from a 4-year PT curriculum approved by a State Department of Education; or
- licensed or registered and prior to January 1, 1970, they had 15 years of full-time experience in PT under the order and direction of attending and referring doctors of medicine or osteopathy.

Or, PTs meet requirements if they are currently licensed and they were trained outside the U.S. before January 1, 2008, and after 1928 graduated from a PT curriculum approved in the country in which the curriculum was located, if that country had an organization that was a member of the World Confederation for Physical Therapy, and that PT qualified as a member of the organization.

For outpatient PT services that are provided incident to the services of physicians/NPPs, the requirement for PT licensure does not apply; all other personnel qualifications do apply. The qualified personnel providing PT services incident to the services of a physician/NPP must be trained in an accredited PT curriculum. For example, a person who, on or before December 31, 2009, graduated from a PT curriculum accredited by CAPTE, but who has not passed the national examination or obtained a license, could provide Medicare outpatient PT therapy services incident to the services of a physician/NPP if the physician assumes responsibility for the services according to the incident to policies. On or after January 1, 2010, although licensure does not apply, both education and examination requirements that are effective January 1, 2010, apply to qualified personnel who provide PT services incident to the services of a physician/NPP.

C. Services of Physical Therapy Support Personnel

Reference: 42CFR 484.4

Personnel Qualifications. The new personnel qualifications for physical therapist assistants (PTA) were discussed in the 2008 Physician Fee Schedule. See the Federal Register of November 27, 2007, for the full text. See also the correction notice for this rule, published in the Federal Register on January 15, 2008.

The regulation provides that a qualified PTA is a person who is licensed as a PTA unless licensure does not apply, is registered or certified, if applicable, as a PTA by the state in which practicing, and graduated from an approved curriculum for PTAs, and passed a national examination for PTAs. The phrase, “by the state in which practicing” includes any authorization to practice provided by the same state in which the service is provided, including temporary licensure, regardless of the location or the entity billing for the services. Approval for the curriculum is provided by CAPTE or, if internationally or military trained PTAs apply, approval will be through a credentialing body for the curriculum for PTAs identified by either the American Physical Therapy Association or identified in 8 CFR 212.15(e). A national examination for PTAs is, for example the one furnished by the Federation of State Boards of Physical Therapy. These requirements above apply to all PTAs effective January 1, 2010, if they have not met any of the following requirements prior to January 1, 2010.

Those PTAs also qualify who, on or before December 31, 2009, are licensed, registered or certified as a PTA and met one of the two following requirements:

1. Is licensed or otherwise regulated in the state in which practicing; or

2. In states that have no licensure or other regulations, or where licensure does not apply, PTAs have:

- graduated on or before December 31, 2009, from a 2-year college-level program approved by the APTA or CAPTE; and
- effective January 1, 2010, those PTAs must have both graduated from a CAPTE approved curriculum and passed a national examination for PTAs; or

PTAs may also qualify if they are licensed, registered or certified as a PTA, if applicable and meet requirements in effect before January 1, 2008, that is,

- they have graduated before January 1, 2008, from a 2 year college level program approved by the APTA; or
- on or before December 31, 1977, they were licensed or qualified as a PTA and passed a proficiency examination conducted, approved, or sponsored by the U.S. Public Health Service.

Services. The services of PTAs used when providing covered therapy benefits are included as part of the covered service. These services are billed by the supervising physical therapist. PTAs may not provide *evaluative or assessment* services, make clinical judgments or decisions; *develop, manage, or furnish skilled maintenance program services*; or take responsibility for the service. They act at the direction and under the supervision of the treating physical therapist and in accordance with state laws.

A physical therapist must supervise PTAs. The level and frequency of supervision differs by setting (and by state or local law). General supervision is required for PTAs in all settings except private practice (which requires direct supervision) unless state practice requirements are more stringent, in which case state or local requirements must be followed. See specific settings for details. For example, in clinics, rehabilitation agencies, and public health agencies, 42CFR485.713 indicates that when a PTA provides services, either on or off the organization's premises, those services are supervised by a qualified physical therapist who makes an onsite supervisory visit at least once every 30 days or more frequently if required by state or local laws or regulation.

The services of a PTA shall not be billed as services incident to a physician/NPP's service, because they do not meet the qualifications of a therapist.

The cost of supplies (e.g., theraband, hand putty, electrodes) used in furnishing covered therapy care is included in the payment for the HCPCS codes billed by the physical therapist, and are, therefore, not separately billable. Separate coverage and billing provisions apply to items that meet the definition of brace in §130.

Services provided by aides, even if under the supervision of a therapist, are not therapy services and are not covered by Medicare. Although an aide may help the therapist by providing unskilled services, those services that are unskilled are not covered by Medicare and shall be denied as not reasonable and necessary if they are billed as therapy services.

D. Application of Medicare Guidelines to PT Services

This subsection will be used in the future to illustrate the application of the above guidelines to some of the physical therapy modalities and procedures utilized in the treatment of patients.

230.2 - Practice of Occupational Therapy

(Rev. 179, Issued: 01-14-14, Effective: 01-07-14, Implementation: 01-07-14)

A. General

Occupational therapy services are those services provided within the scope of practice of occupational therapists and necessary for the diagnosis and treatment of impairments, functional disabilities or changes in physical function and health status. (See Pub. 100-03, the Medicare National Coverage Determinations Manual, for specific conditions or services.)

Occupational therapy is medically prescribed treatment concerned with improving or restoring functions which have been impaired by illness or injury or, where function has been permanently lost or reduced by illness or injury, to improve the individual's ability to perform those tasks required for independent functioning. Such therapy may involve:

- The evaluation, and reevaluation as required, of a patient's level of function by administering diagnostic and prognostic tests;
- The selection and teaching of task-oriented therapeutic activities designed to restore physical function; e.g., use of woodworking activities on an inclined table to restore shoulder, elbow, and wrist range of motion lost as a result of burns;
- The planning, implementing, and supervising of individualized therapeutic activity programs as part of an overall "active treatment" program for a patient with a diagnosed psychiatric illness; e.g., the use of sewing activities which require following a pattern to reduce confusion and restore reality orientation in a schizophrenic patient;
- The planning and implementing of therapeutic tasks and activities to restore sensory-integrative function; e.g., providing motor and tactile activities to increase sensory input and improve response for a stroke patient with functional loss resulting in a distorted body image;

- The teaching of compensatory technique to improve the level of independence in the activities of daily living *or adapt to an evolving deterioration in health and function*, for example:
 - o Teaching a patient who has lost the use of an arm how to pare potatoes and chop vegetables with one hand;
 - o Teaching an upper extremity amputee how to functionally utilize a prosthesis;
 - o Teaching a stroke patient new techniques to enable the patient to perform feeding, dressing, and other activities as independently as possible; or
 - o Teaching a patient with a hip fracture/hip replacement techniques of standing tolerance and balance to enable the patient to perform such functional activities as dressing and homemaking tasks.
- The designing, fabricating, and fitting of orthotics and self-help devices; e.g., making a hand splint for a patient with rheumatoid arthritis to maintain the hand in a functional position or constructing a device which would enable an individual to hold a utensil and feed independently; or
- Vocational and prevocational assessment and training, subject to the limitations specified in item B below.

Only a qualified occupational therapist has the knowledge, training, and experience required to evaluate and, as necessary, reevaluate a patient's level of function, determine whether an occupational therapy program could reasonably be expected to improve, restore, or compensate for lost function, recommend to the physician/NPP a plan of treatment, *where appropriate*.

B. Qualified Occupational Therapist Defined

Reference: 42CFR484.4

The new personnel qualifications for occupational therapists (OT) were discussed in the 2008 Physician Fee Schedule. See the Federal Register of November 27, 2007, for the full text. See also the correction notice for this rule, published in the Federal Register on January 15, 2008.

The regulation provides that a qualified OT is an individual who is licensed, if licensure applies, or otherwise regulated, if applicable, as an OT by the state in which practicing, and graduated from an accredited education program for OTs, and is eligible to take or has passed the examination for OTs administered by the National Board for Certification in Occupational Therapy, Inc. (NBCOT). The phrase, "by the state in which practicing" includes any authorization to practice provided by the same state in which the service is provided, including temporary licensure, regardless of the location of the entity billing

the services. The education program for U.S. trained OTs is accredited by the Accreditation Council for Occupational Therapy Education (ACOTE). The requirements above apply to all OTs effective January 1, 2010, if they have not met any of the following requirements prior to January 1, 2010.

The OTs may also qualify if on or before December 31, 2009:

- they are licensed or otherwise regulated as an OT in the state in which practicing (regardless of the qualifications they met to obtain that licensure or regulation); or
- when licensure or other regulation does not apply, OTs have graduated from an OT education program accredited by ACOTE and are eligible to take, or have successfully completed the NBCOT examination for OTs.

Also, those OTs who met the Medicare requirements for OTs that were in 42CFR484.4 prior to January 1, 2008, qualify to provide OT services for Medicare beneficiaries if:

- on or before January 1, 2008, they graduated an OT program approved jointly by the American Medical Association and the AOTA, or
- they are eligible for the National Registration Examination of AOTA or the National Board for Certification in OT.

Also, they qualify who on or before December 31, 1977, had 2 years of appropriate experience as an occupational therapist, and had achieved a satisfactory grade on a proficiency examination conducted, approved, or sponsored by the U.S. Public Health Service.

Those educated outside the U.S. may meet the same qualifications for domestic trained OTs. For example, they qualify if they were licensed or otherwise regulated by the state in which practicing on or before December 31, 2009. Or they are qualified if they:

- graduated from an OT education program accredited as substantially equivalent to a U.S. OT education program by ACOTE, the World Federation of Occupational Therapists, or a credentialing body approved by AOTA; and
- passed the NBCOT examination for OT; and
- Effective January 1, 2010, are licensed or otherwise regulated, if applicable as an OT by the state in which practicing.

For outpatient OT services that are provided incident to the services of physicians/NPPs, the requirement for OT licensure does not apply; all other personnel qualifications do apply. The qualified personnel providing OT services incident to the services of a physician/NPP must be trained in an accredited OT curriculum. For example, a person

who, on or before December 31, 2009, graduated from an OT curriculum accredited by ACOTE and is eligible to take or has successfully completed the entry-level certification examination for OTs developed and administered by NBCOT, could provide Medicare outpatient OT services incident to the services of a physician/NPP if the physician assumes responsibility for the services according to the incident to policies. On or after January 1, 2010, although licensure does not apply, both education and examination requirements that are effective January 1, 2010, apply to qualified personnel who provide OT services incident to the services of a physician/NPP.

C. Services of Occupational Therapy Support Personnel

Reference: 42CFR 484.4

The new personnel qualifications for occupational therapy assistants were discussed in the 2008 Physician Fee Schedule. See the Federal Register of November 27, 2007, for the full text. See also the correction notice for this rule, published in the Federal Register on January 15, 2008.

The regulation provides that an occupational therapy assistant is a person who is licensed, unless licensure does not apply, or otherwise regulated, if applicable, as an OTA by the state in which practicing, and graduated from an OTA education program accredited by ACOTE and is eligible to take or has successfully completed the NBCOT examination for OTAs. The phrase, “by the state in which practicing” includes any authorization to practice provided by the same state in which the service is provided, including temporary licensure, regardless of the location of the entity billing the services.

If the requirements above are not met, an OTA may qualify if, on or before December 31, 2009, the OTA is licensed or otherwise regulated as an OTA, if applicable, by the state in which practicing, or meets any qualifications defined by the state in which practicing.

Or, where licensure or other state regulation does not apply, OTAs may qualify if they have, on or before December 31, 2009:

- completed certification requirements to practice as an OTA established by a credentialing organization approved by AOTA; and
- after January 1, 2010, they have also completed an education program accredited by ACOTE and passed the NBCOT examination for OTAs.

OTAs who qualified under the policies in effect prior to January 1, 2008, continue to qualify to provide OT directed and supervised OTA services to Medicare beneficiaries. Therefore, OTAs qualify who after December 31, 1977, and on or before December 31, 2007:

- completed certification requirements to practice as an OTA established by a credentialing organization approved by AOTA; or

- completed the requirements to practice as an OTA applicable in the state in which practicing.

Those OTAs who were educated outside the U.S. may meet the same requirements as domestically trained OTAs. Or, if educated outside the U.S. on or after January 1, 2008, they must have graduated from an OTA program accredited as substantially equivalent to OTA entry level education in the U.S. by ACOTE, its successor organization, or the World Federation of Occupational Therapists or a credentialing body approved by AOTA. In addition, they must have passed an exam for OTAs administered by NBCOT.

Services. The services of OTAs used when providing covered therapy benefits are included as part of the covered service. These services are billed by the supervising occupational therapist. OTAs may not provide *evaluative or assessment* services, make clinical judgments or decisions; *develop, manage, or furnish skilled maintenance program services*; or take responsibility for the service. They act at the direction and under the supervision of the treating occupational therapist and in accordance with state laws.

An occupational therapist must supervise OTAs. The level and frequency of supervision differs by setting (and by state or local law). General supervision is required for OTAs in all settings except private practice (which requires direct supervision) unless state practice requirements are more stringent, in which case state or local requirements must be followed. See specific settings for details. For example, in clinics, rehabilitation agencies, and public health agencies, 42CFR485.713 indicates that when an OTA provides services, either on or off the organization's premises, those services are supervised by a qualified occupational therapist who makes an onsite supervisory visit at least once every 30 days or more frequently if required by state or local laws or regulation.

The services of an OTA shall not be billed as services incident to a physician/NPP's service, because they do not meet the qualifications of a therapist.

The cost of supplies (e.g., looms, ceramic tiles, or leather) used in furnishing covered therapy care is included in the payment for the HCPCS codes billed by the occupational therapist and are, therefore, not separately billable. Separate coverage and billing provisions apply to items that meet the definition of brace in §130 of this manual.

Services provided by aides, even if under the supervision of a therapist, are not therapy services in the outpatient setting and are not covered by Medicare. Although an aide may help the therapist by providing unskilled services, those services that are unskilled are not covered by Medicare and shall be denied as not reasonable and necessary if they are billed as therapy services.

D. Application of Medicare Guidelines to Occupational Therapy Services

Occupational therapy may be required for a patient with a specific diagnosed psychiatric illness. If such services are required, they are covered assuming the coverage criteria are met. However, where an individual's motivational needs are not related to a specific diagnosed psychiatric illness, the meeting of such needs does not usually require an individualized therapeutic program. Such needs can be met through general activity programs or the efforts of other professional personnel involved in the care of the patient. Patient motivation is an appropriate and inherent function of all health disciplines, which is interwoven with other functions performed by such personnel for the patient. Accordingly, since the special skills of an occupational therapist are not required, an occupational therapy program for individuals who do not have a specific diagnosed psychiatric illness is not to be considered reasonable and necessary for the treatment of an illness or injury. Services furnished under such a program are not covered.

Occupational therapy may include vocational and prevocational assessment and training. When services provided by an occupational therapist are related solely to specific employment opportunities, work skills, or work settings, they are not reasonable or necessary for the diagnosis or treatment of an illness or injury and are not covered. However, carriers and intermediaries exercise care in applying this exclusion, because the assessment of level of function and the teaching of compensatory techniques to improve the level of function, especially in activities of daily living, are services which occupational therapists provide for both vocational and nonvocational purposes. For example, an assessment of sitting and standing tolerance might be nonvocational for a mother of young children or a retired individual living alone, but could also be a vocational test for a sales clerk. Training an amputee in the use of prosthesis for telephoning is necessary for everyday activities as well as for employment purposes. Major changes in life style may be mandatory for an individual with a substantial disability. The techniques of adjustment cannot be considered exclusively vocational or nonvocational.

230.4 - Services Furnished by a Therapist in Private Practice (TPP) ***(Rev. 179, Issued: 01-14-14, Effective: 01-07-14, Implementation: 01-07-14)***

A. General

See section 220 of this chapter for definitions. Therapist refers only to a qualified physical therapist, occupational therapist or speech-language pathologist. TPP refers to therapists in private practice (qualified physical therapists, occupational therapists and speech-language pathologists).

In order to qualify to bill Medicare directly as a therapist, each individual must be enrolled as a private practitioner and employed in one of the following practice types: an unincorporated solo practice, unincorporated partnership, unincorporated group practice, physician/NPP group or groups that are not professional corporations, if allowed by state and local law. Physician/NPP group practices may employ TPP if state and local law permits this employee relationship.

For purposes of this provision, a physician/NPP group practice is defined as one or more physicians/NPPs enrolled with Medicare who may bill as one entity. For further details on issues concerning enrollment, see the provider enrollment Web site at www.cms.hhs.gov/MedicareProviderSupEnroll and Pub. 100-08, Medicare Program Integrity Manual, chapter 15, section 15.4.4.9.

Private practice also includes therapists who are practicing therapy as employees of another supplier, of a professional corporation or other incorporated therapy practice. Private practice does not include individuals when they are working as employees of an institutional provider.

Services should be furnished in the therapist's or group's office or in the patient's home. The office is defined as the location(s) where the practice is operated, in the state(s) where the therapist (and practice, if applicable) is legally authorized to furnish services, during the hours that the therapist engages in the practice at that location. If services are furnished in a private practice office space, that space shall be owned, leased, or rented by the practice and used for the exclusive purpose of operating the practice. For descriptions of aquatic therapy in a community center pool see section 220C of this chapter.

Therapists in private practice must be approved as meeting certain requirements, but do not execute a formal provider agreement with the Secretary.

If therapists who have their own Medicare National Provider Identifier (NPI) are employed by therapist groups, physician/NPP groups, or groups that are not professional organizations, the requirement that therapy space be owned, leased, or rented may be satisfied by the group that employs the therapist. Each therapist employed by a group should enroll as a TPP.

When therapists with a Medicare NPI provide services in the physician's/NPP's office in which they are employed, and bill using their NPI for each therapy service, then the direct supervision requirement for enrolled staff apply.

When the therapist who has a Medicare NPI is employed in a physician's/NPP's office the services are ordinarily billed as services of the therapist, with the therapist identified on the claim as the supplier of services. However, services of the therapist who has a Medicare NPI may also be billed by the physician/NPP as services incident to the physician's/NPP's service. (See §230.5 for rules related to therapy services incident to a physician.) In that case, the physician/NPP is the supplier of service, the NPI of the supervising physician/NPP is reported on the claim with the service and all the rules for both therapy services and incident to services (§230.5) must be followed.

B. Private Practice Defined

Reference: **Federal Register** November, 1998, pages 58863-58869; 42CFR 410.38(b), 42CFR410.59, 42CFR410.60, 42CFR410.62

The contractor considers a therapist to be in private practice if the therapist maintains office space at his or her own expense and furnishes services only in that space or the patient's home. Or, a therapist is employed by another supplier and furnishes services in facilities provided at the expense of that supplier.

The therapist need not be in full-time private practice but must be engaged in private practice on a regular basis; i.e., the therapist is recognized as a private practitioner and for that purpose has access to the necessary equipment to provide an adequate program of therapy.

The therapy services must be provided either by or under the direct supervision of the TPP. Each TPP should be enrolled as a Medicare provider. If a therapist is not enrolled, the services of that therapist must be directly supervised by an enrolled therapist. Direct supervision requires that the supervising private practice therapist be present in the office suite at the time the service is performed. These direct supervision requirements apply only in the private practice setting and only for therapists and their assistants. In other outpatient settings, supervision rules differ. The services of support personnel must be included in the therapist's bill. The supporting personnel, including other therapists, must be W-2 or 1099 employees of the TPP or other qualified employer.

Coverage of outpatient therapy under Part B includes the services of a qualified TPP when furnished in the therapist's office or the beneficiary's home. For this purpose, "home" includes an institution that is used as a home, but not a hospital, CAH or SNF, (**Federal Register** Nov. 2, 1998, pg 58869).

C. Assignment

Reference: Nov. 2, 1998 **Federal Register**, pg. 58863
See also Pub. 100-04 chapter 1, §30.2.

When physicians, NPPs, or TPPs obtain provider numbers, they have the option of accepting assignment (participating) or not accepting assignment (nonparticipating). In contrast, providers, such as outpatient hospitals, SNFs, rehabilitation agencies, and CORFs, do not have the option. For these providers, assignment is mandatory.

If physicians/NPPs, or TPPs accept assignment (are participating), they must accept the Medicare Physician Fee Schedule amount as payment. Medicare pays 80% and the patient is responsible for 20%. In contrast, if they do not accept assignment, Medicare will only pay 95% of the fee schedule amount. However, when these services are not furnished on an assignment-related basis, the limiting charge applies. (See §1848(g)(2)(c) of the Act.)

NOTE: Services furnished by a therapist in the therapist's office under arrangements with hospitals in rural communities and public health agencies (or services provided in

the beneficiary's home under arrangements with a provider of outpatient physical or occupational therapy services) are not covered under this provision. See section 230.6.

230.5 - Physical Therapy, Occupational Therapy and Speech-Language Pathology Services Provided Incident to the Services of Physicians and Non-Physician Practitioners (NPP)

(Rev. 179, Issued: 01-14-14, Effective: 01-07-14, Implementation: 01-07-14)

References: §1861(s)(2)(A) of the Act

42 CFR 410.10(b)

42 CFR 410.26

Pub. 100-02, ch. 15, §60.

The Benefit. Therapy services have their own benefit under §1861 of the Social Security Act and shall be covered when provided according to the standards and conditions of the benefit described in Medicare manuals. *The statute 1862(a)(20)* requires that payment be made for a therapy service billed by a physician/NPP only if the service meets the standards and conditions--other than licensing--that would apply to a therapist. (For example, see coverage requirements in Pub. 100-08, chapter 13, §13.5.1(C), Pub. 100-04, chapter 5, and also the requirements of this *chapter*, §[220](#) and §[230](#).)

Incident to a Therapist. There is no coverage for services provided incident to the services of a therapist. Although PTAs and OTAs work under the supervision of a therapist and their services may be billed by the therapist, their services are covered under the benefit for therapy services and not by the benefit for services incident to a physician/NPP. The services furnished by PTAs and OTAs are not incident to the therapist's service.

Qualifications of Auxiliary Personnel. Therapy services appropriately billed incident to a physician's/NPP's service shall be subject to the same requirements as therapy services that would be furnished by a physical therapist, occupational therapist or speech-language pathologist in any other outpatient setting with one exception. When therapy services are performed incident to a physician's/NPP's service, the qualified personnel who perform the service do not need to have a license to practice therapy, unless it is required by state law. The qualified personnel must meet all the other requirements except licensure. Qualifications for therapists are found in 42CFR484.4 and in section 230.1, 230.2, and 230.3 of this *chapter*. In effect, these rules require that the person who furnishes the service to the patient must, at least, be a graduate of a program of training for one of the therapy services as described above. Regardless of any state licensing that allows other health professionals to provide therapy services, Medicare is authorized to pay only for services provided by those trained specifically in physical therapy, occupational therapy or speech-language pathology. That means that the services of athletic trainers, massage therapists, recreation therapists, kinesiotherapists, low vision specialists or any other profession may not be billed as therapy services.

The services of PTAs and OTAs also may not be billed incident to a physician's/NPP's service. However, if a PT and PTA (or an OT and OTA) are both employed in a physician's office, the services of the PTA, when directly supervised by the PT or the services of the OTA, when directly supervised by the OT may be billed by the physician group as PT or OT services using the PIN/NPI of the enrolled PT (or OT). (See Section 230.4 for private practice rules on billing services performed in a physician's office.) If the PT or OT is not enrolled, Medicare shall not pay for the services of a PTA or OTA billed incident to the physician's service, because they do not meet the qualification standards in 42CFR484.4.

Therapy services provided and billed incident to the services of a physician/NPP also must meet all incident-to requirements in §60 *of this chapter*. Where the policies have different requirements, the more stringent requirement shall be met.

For example, when therapy services are billed as incident to a physician/NPP services, the requirement for direct supervision by the physician/NPP and other incident to requirements must be met, even though the service is provided by a licensed therapist who may perform the services unsupervised in other settings.

The mandatory assignment provision does not apply to therapy services furnished by a physician/NPP or "incident to" a physician's/NPP's service. However, when these services are not furnished on an assignment-related basis; the limiting charge applies.

For emphasis, following are some of the standards that apply to therapy services billed incident-to the services of a physician/NPP in the physician's/NPP's office or the beneficiary's residence.

- A. Therapy services provided to the beneficiary must be covered and payable outpatient rehabilitation services as described, for example, in this section as well as Pub. 100-08, chapter 13, §13.5.1.
- B. Therapy services must be provided by, or under the direct supervision of a physician (a doctor of medicine or osteopathy; *a doctor of podiatry or a doctor of optometry when treating patients within the state scope of practice in the state in which the services are provided*) or NPP who is legally authorized to practice therapy services by the state in which he or she performs such function or action. Direct supervision requirements are the same as in 42CFR410.32(b)(3). The supervisor must be present in the office suite and immediately available to furnish assistance and direction throughout the performance of the procedure. It does not mean that the physician/NPP must be present in the same room in the office where the service is performed.
- C. The services must be of a level of complexity that require that they be performed by a therapist or under the direct supervision of the therapist, physician/NPP who is licensed to perform them. Services that do not require the performance or supervision of the therapist, physician/NPP, are not considered reasonable or

necessary therapy services even if they are performed or supervised by a physician/NPP or other qualified professional.

- D. Services must be furnished under a plan of treatment as in §220.1.2 of this chapter. The services provided must relate directly to the physician/NPP service to which it is incident.

*Medicare Expired Legislative Provisions
Extended and Other Bipartisan Budget Act of
2018 Provisions
(www.CMS.gov)*

Medicare Expired Legislative Provisions Extended and Other Bipartisan Budget Act of 2018 Provisions

On February 9, 2018, President Trump signed into law the Bipartisan Budget Act of 2018. This new law includes several provisions related to Medicare payment.

With regard to payment for outpatient therapy services, the law repeals application of the Medicare outpatient therapy caps but retains the former cap amounts as a threshold above which claims must include the KX modifier as a confirmation that services are medically necessary as justified by appropriate documentation in the medical record; and retains the targeted medical review process, but at a lower threshold amount. It also extends several recently expired Medicare legislative provisions affecting health care providers and beneficiaries, including the Medicare physician fee schedule work geographic adjustment floor, add-on payments for ambulance services and home health rural services, changes to the payment adjustment for low volume hospitals, and the Medicare dependent hospital program.

Please note that this summary does not include all of the Medicare provisions in the new law. For provisions not included below, more information will be forthcoming. In addition, if further implementation information and guidance for some of the provisions described below [including those that may involve provider action] is needed, it will be forthcoming.

For Sections 50201 “*Extension of Work Geographic Practice Cost Index (GPCI) Floor*”, 50202 “*Repeal of Medicare Payment Cap for Therapy Services; Limitation to Ensure Appropriate Therapy*”, and 50203 “*Medicare Ambulance Services*” provision changes, Medicare Administrative Contractors (MAC) will implement these changes no later than February 26, 2018, and will provide additional details on timelines for reprocessing or release of held claims impacted by these changes. The following are brief descriptions of these provisions:

Section 50201 - Extension of Work Geographic Practice Cost Index (GPCI) Floor - The new law extends a provision raising the Work GPCI to 1.000 for all localities that currently have a Work GPCI of less than 1.000. The Work GPCI Floor impacts the fees for all codes paid under the Medicare Physician Fee Schedule (MPFS) for those localities. The Work GPCI floor is extended through December 31, 2019. No new provider action is necessary for implementation.

Section 50202 - Repeal of Medicare Payment Cap for Therapy Services; Limitation to Ensure Appropriate Therapy - The new law requires for services after December 31, 2017:

- Medicare claims are no longer subject to the therapy caps (one for occupational therapy services and another for physical therapy and speech-language pathology combined);
- Claims for therapy services above a certain amount of incurred expenses, which is the same amount as the previous therapy caps, must include the KX modifier indicating that such services are medically necessary as justified by appropriate medical record documentation; and
- Claims for therapy services above certain threshold levels of incurred expenses will be subject to targeted medical review. The medical review thresholds for therapy services in a year before 2028 are \$3,000.
- CMS will begin the process of releasing claims that had been held briefly after expiration of the therapy caps exceptions process. CMS will release for processing the

held claims based on the date the claim was received, i.e., on a first-in, first-out basis, until no claims are being held. This process will be accomplished as quickly as possible while staying within the requirements for the volume of claims that MACs can release on a given day.

Section 50203 - Medicare Ambulance Services - The new law extends the following two expiring ambulance payment provisions: (1) the 3 percent increase in the ambulance fee schedule rates for covered ground ambulance transports that originate in rural areas and the 2 percent increase in the ambulance fee schedule rates for covered ground ambulance transports that originate in urban areas are extended through December 31, 2022; and (2) the increase in the base rate of the fee schedule for covered ground ambulance transports originating in a rural area that is within the lowest 25th percentile of all rural areas arrayed by population density (known as the “super rural” add-on) is extended through December 31, 2022. No new provider action is necessary for implementation.

For the following Medicare provisions in the new law, Medicare claims processing system changes are under development but are anticipated to be included in systems changes effective in the Spring. More information related to these changes will be forthcoming. As system changes are implemented, we will share information related to any necessary claims reprocessing.

Section 50204 - Extension of Increased Inpatient Hospital Payment Adjustment for Certain Low-Volume Hospitals - The new law extends changes to a provision that allows qualifying low-volume hospitals to receive add-on payments based on their number of discharges and their distance from the nearest hospital for fiscal years 2018 through 2022 and makes additional changes to the provision for fiscal years 2019 through 2022. For fiscal year 2018, a hospital must have less than 1,600 Medicare discharges, consistent with the discharge criterion that applied for fiscal years 2011 through 2017. For fiscal years 2019 through 2022, a hospital must have less than 3,800 total discharges. The new law also extends the mileage criterion that applied for fiscal years 2011 through 2017, that the hospital be located more than 15 road miles from the nearest subsection (d) hospital, for fiscal year 2018 through fiscal year 2022. For fiscal year 2018, a qualifying hospital’s add-on payment is calculated using a continuous linear sliding scale ranging from 25 percent for low-volume hospitals with 200 or fewer Medicare discharges to 0 percent for low-volume hospitals with greater than 1,600 Medicare discharges. For fiscal years 2019 through 2022, the add-on payment is calculated using a continuous linear sliding scale ranging from 25 percent for low-volume hospitals with 500 or fewer discharges to 0 percent for low-volume hospitals with greater than 3,800 discharges. For fiscal year 2023 and subsequent fiscal years, the qualifying criteria and payment adjustment revert to the preexisting requirements.

Hospitals that believe they meet the mileage criterion should review, once publically available in Table 14, the Medicare discharges and potential FY 2018 low-volume hospital payment adjustment based on the March 2017 update of the FY 2016 MedPAR file, as these data were the most recent data available at the time of the development of the FY 2018 payment rates and factors established in the FY 2018 IPPS/LTCH PPS final rule, which will be used to determine qualifying low-volume hospitals and their fiscal year 2018 low-volume adjustment, and consistent with past practice should submit to its MAC a written request to continue to receive a low-volume payment adjustment. This written request must state that the hospital meets the mileage and discharge criteria applicable for fiscal year 2018 under the amendments provided by the Bipartisan Budget Act of 2018, and must provide sufficient evidence to document that it meets the discharge and mileage requirements. For hospitals that

qualified for the low-volume adjustment in fiscal year 2017, this written verification could be a brief letter to the MAC stating that the hospital continues to meet the low-volume hospital distance criterion as documented in a prior low-volume hospital status request. A hospital that is seeking to newly qualify to receive a low-volume hospital payment adjustment based on the mileage and discharge criteria applicable for fiscal year 2018 under the amendments provided by the Bipartisan Budget Act of 2018 must submit to its MAC a written request for low-volume hospital status, including documentation that the hospital meets the fiscal year 2018 discharge and mileage criteria. For example, the use of a Web-based mapping tool as part of documenting that the hospital meets the mileage criterion for the low-volume hospital adjustment is acceptable.

CMS will issue further instruction to hospitals for requesting the low-volume hospital adjustment for FY 2018, including the deadline for receipt of written requests to apply the low-volume percentage increase to payments for discharges beginning on or after October 1, 2017 (that is, the beginning of FY 2018). If the request for low-volume hospital status for FY 2018 is received after this deadline, and the MAC determines that the hospital meets the criteria to qualify as a low-volume hospital, the MAC will apply the applicable low-volume adjustment in determining payments for the hospital's FY 2018 discharges prospectively effective within 30 days of the date of the MAC's low-volume status determination..

Section 50205 - Extension of the Medicare-Dependent Hospital (MDH) Program - The MDH program provides enhanced payment to qualifying small rural hospitals for which Medicare patients make up a significant percentage of inpatient days or discharges. This provision extends the MDH program until October 1, 2022. It also provides for an eligible hospital that is located in a state with no rural area to qualify for MDH status under an expanded definition if, in general, the hospital satisfies any of the statutory criteria at section 1886(d)(8)(E)(ii)(I), (II) (as of January 1, 2018), or (III) to be reclassified as rural. Hospitals that qualified as Medicare-dependent hospitals in fiscal year 2017 and did not reclassify as a Sole Community Hospital (SCH) or cancel their rural classification do not need to take further action. Their claims will be reprocessed retroactive to October 1, 2017.

However, former MDHs that classified as an SCH on or after October 1, 2017 would not be automatically reinstated as MDHs. In order to be classified as an MDH, a former MDH that is currently classified as an SCH must first cancel its SCH status according to § 412.92(b)(4), since a hospital cannot be both an SCH and an MDH, and then reapply and be approved for MDH status under § 412.108(b). Additionally, since one of the criteria to be classified as an MDH is that the hospital must be located in a rural area, a former MDH that canceled its rural status on or after October 1, 2017 would also not be automatically reinstated as an MDH. In order to qualify for MDH status, the hospital must again request to be reclassified as rural under § 412.103(b) and must also reapply for MDH status under § 412.108(b). Under § 412.108(b)(3), the Medicare contractor (MAC) will make a determination regarding whether a hospital meets the criteria for MDH status and notify the hospital within 90 days from the date that it receives the hospital's request and all of the required documentation. Under § 412.108(b)(4), a determination of MDH status made by the MAC is effective 30 days after the date the MAC provides written notification to the hospital.

Hospitals seeking to newly qualify for MDH status under the amendments made by the Bipartisan Budget Act of 2018 (including the expanded MDH definition for hospitals in all-urban states), must submit a written request along with qualifying documentation to their MAC as outlined in the current regulations at §412.108(b), as described above.

Section 50208 – Extension of Home Health Rural Add-On (for 2018) - The new law extends a provision through December 31, 2018 allowing a 3 percent payment add-on for home health services provided in rural areas. No new provider action is necessary for implementation.

Section 51005 -- Extension of Blended Site Neutral Payment Rate for Certain Long-Term Care Hospital Discharges; Temporary Adjustment to Site Neutral Payment Rates - This new law extends the blended payment rate for site neutral payment rate long-term care hospital (LTCH) discharges for cost reporting periods beginning in an additional two years (fiscal years 2018 and 2019). In addition, the policy reduces the LTCH IPPS comparable per diem amount used in the site neutral payment rate for fiscal years 2018 through 2026 by 4.6 percent.

For the following Medicare provisions in the new law with future effective dates, Medicare claims processing system changes are under development for implementation of these provisions on their effective dates. More information related to these changes will be forthcoming.

Section 50208 – Extension of Home Health Rural Add-On (beginning in 2019) - Beginning in 2019 and subsequent years, the new law puts in place a home health rural add-on payment that varies by year across three different tiers of rural counties in which home health services are furnished: (1) rural counties in the highest quartile of all counties with respect to the number of Medicare home health episodes furnished per 100 individuals who are entitled to, or enrolled for, benefits under Part A or Part B (but not enrolled in a plan under Part C) (2) rural counties with a population density of 6 or fewer individuals that are not in the above highest quartile of home health utilization and (3) all other rural counties. Implementation of this provision will require notice and comment rulemaking.

Section 53108 – Reduction for Non-Emergency ESRD Ambulance Transports - The new law mandates an increased reduction applied to the ambulance fee schedule payment rates for ambulance services consisting of non-emergency basic life support services involving transports of beneficiaries with ESRD for renal dialysis services furnished other than on an emergency basis by a provider of services or a renal dialysis facility, beginning with dates of service on and after October 1, 2018. The reduction is being increased from 10% to 23%.

In addition, with regard to *Section 53111 – Medicare Payment Update for Skilled Nursing Facilities*, CMS has received questions from stakeholders about the impact of the FY 2019 Skilled Nursing Facility (SNF) update due to section 53111 of the BBA of 2018.

To help answer these questions, we are providing information about the estimated market basket update for FY 2019 based on currently available data. This estimate may be updated in the Notice of Proposed Rulemaking for the FY 2019 SNF Prospective Payment System (PPS).

Section 53111 of the BBA of 2018 specified that the FY 2019 update for the SNF PPS be 2.4 percent. Based on data currently available, CMS is projecting that the FY 2019 SNF PPS update would have been 1.8 percent if section 53111 of the BBA of 2018 had not been enacted. This 1.8 percent is a result of the projected SNF market basket increase factor of 2.6 percent reduced by a 0.8 percent multifactor productivity adjustment. This means that, based on data currently available, SNFs would receive a FY 2019 update of 2.4 percent rather than the currently projected update of 1.8 percent because of the provision in the BBA of 2018.

Frequently Asked Questions
(www.CMS.gov)



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Frequently Asked Questions (FAQs) Regarding Jimmo Settlement Agreement

Q1: What is the *Jimmo* Settlement Agreement (January 2013)?

A1: The *Jimmo* Settlement Agreement clarified that when a beneficiary needs skilled nursing or therapy services under Medicare's skilled nursing facility (SNF), home health (HH), and outpatient therapy (OPT) benefits in order to maintain the patient's current condition or to prevent or slow decline or deterioration (provided all other coverage criteria are met), the Medicare program covers such services and coverage cannot be denied based on the absence of potential for improvement or restoration. In short, what the Settlement Agreement and the resulting revised manual provisions clarify is that Medicare coverage for skilled nursing and therapy services in these settings does not "turn on" the presence or absence of a beneficiary's potential for improvement, *i.e.*, it does not matter whether such care is expected to improve or maintain the patient's clinical condition. In addition, although such maintenance coverage standards do not apply to services furnished in an Inpatient Rehabilitation Facility (IRF) or a comprehensive outpatient rehabilitation facility (CORF), the *Jimmo* Settlement Agreement clarified that for services performed in the IRF setting, coverage should never be denied because a patient cannot be expected to achieve complete independence in the domain of self-care or because a patient cannot be expected to return to his or her prior level of functioning. The *Jimmo* Settlement Agreement provided that these clarifications be included in the Medicare Benefit Policy Manual.

Q2: What is the effect of the *Jimmo* Settlement Agreement on other requirements for receiving Medicare coverage?

A2: The *Jimmo* Settlement Agreement included language specifying that nothing in the settlement agreement modified, contracted, or expanded the existing eligibility requirements for receiving Medicare coverage. While the *Jimmo* Settlement Agreement resulted in clarifications of the coverage criteria for skilled nursing and therapy services in the SNF, HH, OPT, and IRF care settings, it did not affect other existing aspects of Medicare coverage and eligibility for these settings. A few examples of such other requirements would include that the services be reasonable and necessary, comply with therapy caps in the OPT setting, and not exceed the 100-day limit for Part A SNF benefits during a benefit period.

Q3: What are maintenance services addressed by the *Jimmo* Settlement Agreement?

A3: These are nursing or therapy services to maintain the patient's condition or to prevent or slow further deterioration. Even though no improvement is expected, there may be specific instances in the SNF, HH, and OPT settings where the skills of a qualified therapist, registered nurse, or (when provided by regulation) a licensed practical nurse are required to perform nursing/therapy maintenance services that would otherwise be considered unskilled because of the patient's special medical complications or where the needed services are of such complexity that the skills of such a practitioner are required to perform it safely and effectively. The *Jimmo* Settlement Agreement clarified that such skilled maintenance services are Medicare covered services.

Q4: How is coverage of skilled nursing and skilled therapy services under the SNF, HH, and OPT benefits to be determined?

A4: Coverage of skilled nursing and skilled therapy services under these benefits does not turn on the presence or absence of a beneficiary's potential for improvement or restoration, but rather on the beneficiary's need for skilled care. Skilled care may be necessary to improve a patient's current condition, to maintain the patient's current condition, or to prevent or slow further deterioration of the patient's condition. A beneficiary's lack of restoration potential cannot, in itself, serve as the basis for denying coverage under these benefits. An individualized assessment of the beneficiary's medical condition and the reasonableness and necessity of the treatment, care, or services is required to determine coverage. Coverage for skilled care under these benefits is not available where the beneficiary's care needs can be addressed safely and effectively through the use of unskilled personnel or caregivers. Any Medicare coverage or appeals decisions concerning skilled care coverage must reflect these basic principles. Claims for skilled care coverage must include sufficient documentation to substantiate that skilled care is required, that it was in fact provided, and that the services themselves are reasonable and necessary, thereby facilitating accurate and appropriate claims adjudication.

Q5: When are skilled nursing or therapy services to maintain a patient's current condition or prevent or slow further deterioration covered under the SNF, HH, and OPT benefits, assuming all other coverage criteria are met?

A5: As long as all other coverage criteria are met, skilled nursing and therapy services that maintain the patient's current condition or prevent or slow further deterioration are covered under the SNF, HH, and OPT benefits as long as an individualized assessment of the patient's clinical condition demonstrates that the specialized judgment, knowledge, and skills of a qualified therapist, registered nurse or, when provided by regulation, a licensed vocational or practical nurse, are necessary in order for the maintenance services to be safely and effectively provided.

Skilled nursing care is necessary only when the needed services are of such complexity that the skills of a registered nurse, or (when provided by regulation), a licensed practical nurse are required to furnish the services, or the particular patient's special medical complications require the skills of a such a practitioner to perform a type of service that would otherwise be considered non-skilled. However, when the individualized assessment of the patient's clinical condition does not demonstrate such a need for skilled care, including when the services needed do not require skilled nursing care because they could safely and effectively be performed by the patient or unskilled caregivers, such maintenance services are not covered under the SNF or HH benefits.

Skilled therapy is necessary for the performance of a safe and effective maintenance program only when the needed therapy procedures are of such complexity that the skills of a qualified therapist are needed to perform the procedure, or the patient's special medical complications require the skills of a qualified therapist to perform a therapy service that would otherwise be considered non-skilled. However, when the individualized assessment does not demonstrate such a need for skilled care, including when the performance of a maintenance program does not require the skills of a qualified therapist because it could be safely and effectively accomplished by the patient or with the assistance of non-therapists, including unskilled caregivers, such maintenance services are not covered under the SNF, HH, or OPT therapy benefits. To the extent provided by regulation, the establishment or design of a maintenance program by a qualified therapist, the instruction of the beneficiary or appropriate caregiver by a qualified therapist regarding a maintenance program, and the necessary periodic reevaluations by a qualified therapist of the beneficiary and maintenance program are covered to the degree that the specialized knowledge and judgment of a qualified therapist are required.

Q6: How can I find out if skilled nursing or therapy services are covered by Medicare for a particular condition?

A6: Medicare coverage for skilled nursing or therapy services is not determined solely by a patient's specific medical condition. Rather, an individualized assessment of the patient's medical condition, as documented in the patient's medical record, would be necessary in order to determine coverage. For questions regarding specific conditions and whether skilled nursing or therapy services would be covered:

Providers & Suppliers: Contact your local Medicare Administrative Contractor (MAC)

Beneficiaries: Call 1-800-MEDICARE.

Q7: Can a patient change from an improvement course of care to a maintenance course of care, and vice versa?

A7: Yes. The therapy plan of care should indicate the treatment goals based on an individualized assessment or evaluation of the patient. Skilled services would be covered where such skilled services are necessary to maintain the patient's current condition or prevent or slow further deterioration so long as the beneficiary requires skilled care for the services to be safely and effectively provided. The health care provider must continually evaluate the individual's need for skilled care, as well as whether such care meets Medicare's overall requirement for being reasonable and necessary to diagnose or treat the individual's condition, and make such determinations on an ongoing basis, altering – on a prospective and not a retrospective basis – the treatment plan and goals when necessary.

Q8: What is the role of "documentation" in facilitating accurate coverage determinations for claims involving skilled maintenance care?

A8: The revised Medicare Benefit Policy Manual provisions [Chapters 7(SNF), 8(HH), & 15(OPT)] include information on the role of appropriate documentation in facilitating accurate coverage determinations for claims involving skilled care. While the presence of appropriate documentation is not, in and of itself, an element of coverage, such documentation serves as the means by which a provider would be able to establish, and a Medicare contractor would be able to confirm, that skilled care is, in fact, needed and received in a given case. In revising the manual provisions pursuant to the settlement agreement, CMS has provided additional guidance in this area, both generally and as it relates to particular clinical scenarios.

We note that the manual revisions do not require the presence of any particular phraseology or verbal formulation as a prerequisite for coverage (although some areas of the Medicare Benefit Policy Manual do identify certain vague phrases like “patient tolerated treatment well,” “continue with POC,” and “patient remains stable” as being *insufficiently explanatory* to establish coverage). Rather, coverage determinations must consider the *entirety* of the clinical evidence in the file, and our enhanced guidance on documentation is intended to assist providers in their efforts to identify and include the kind of clinical information that can most effectively serve to support a finding that skilled care is needed and received—which, in turn, will help to ensure more accurate and appropriate claims adjudication.

Care must be taken to assure that documentation justifies the necessity of the skilled services provided. Justification for treatment would include, for example, objective evidence or a clinically supportable statement of expectation that, in the case of maintenance therapy, the skills of a qualified therapist are necessary to maintain, prevent, or slow further deterioration of the patient’s functional status, and the services cannot be safely and effectively carried out by the beneficiary personally, or with the assistance of non-therapists, including unskilled caregivers.

Q9: Can a patient receive therapy services from multiple disciplines with differing goals for restoration and maintenance?

A9: Yes. A comprehensive treatment plan does not require all disciplines to have the same goals. Once setting-specific qualifying criteria are met, each individual discipline creates a care plan specific to that discipline. Based on the qualified therapist’s assessment or evaluation and periodic reassessment or re-evaluation findings, each discipline will choose the most appropriate approach for the patient and must provide documentation that supports that decision.

Q10: How does the maintenance coverage standard under the *Jimmo* Settlement apply to skilled observation and assessment of homebound Medicare patients?

A10: As with all skilled nursing services under the HH benefit, skilled observation and assessment of the patient’s condition by a nurse is a Medicare covered service regardless of whether there is an expectation of improvement from the nursing care or whether the services are designed to maintain the patient’s current condition or prevent or slow further deterioration. Observation and assessment are reasonable and necessary skilled services where there is a reasonable potential for change in a patient’s condition that requires skilled nursing personnel to identify and evaluate the patient’s need for possible modification of treatment or initiation of additional medical procedures until the patient’s clinical condition and/or treatment regimen has stabilized.

Q11: If a patient is not improving or is not expected to return to his or her prior level of function from skilled nursing or therapy, does Medicare coverage for skilled nursing or skilled therapy services stop unless the patient deteriorates?

A11: The Medicare program does not require a patient to decline before covering medically necessary skilled nursing or skilled therapy. For a patient who had been expected to improve, but is no longer improving, a determination as to whether skilled care is needed to maintain the patient’s current condition or prevent or slow further deterioration must be made, and if such skilled care is needed, a plan of care to reflect the new maintenance goals must be developed. If, however, a patient is no longer improving and there is no expectation of improvement and skilled care is not needed to maintain the patient’s current condition or to prevent or slow further deterioration, such skilled care services would not be covered.

Q12: If a qualified therapist discontinues a Medicare patient’s outpatient therapy because the patient has stopped improving and the patient is not expected to return to his or her prior level of function, is additional therapy available?

A12: Yes, when the outpatient therapy services no longer meet the criteria for rehabilitative therapy service – whose goal is improvement of an impairment or functional limitation – the patient may be covered to receive skilled therapy services in certain circumstances as maintenance therapy under a maintenance program in order to maintain function or to prevent or slow decline or deterioration. Skilled therapy services are covered when the specialized judgment, knowledge, and skills of a qualified therapist are necessary for performance of a maintenance program, as previously discussed in response to Question 5. The deciding factors are always whether the services are considered reasonable, effective treatments for the patient’s condition and require the skills of a qualified therapist, or whether they can be safely and effectively carried out by non-skilled personnel or caregivers.

Q13: Where can I find examples that demonstrate the coverage requirements for skilled services?

A13: Chapters 7 (HH), 8 (SNF), and 15 (OPT) of the Medicare Benefit Policy Manual (100-02) contain many examples.

Q14: Does the *Jimmo* Settlement Agreement apply to Medicare patients whose health care providers are in Accountable Care Organizations (ACO)?

A14: Yes. Medicare patients who see health care providers that are participating in a Medicare ACO maintain all their Medicare rights, including application of the standards for coverage of skilled care as clarified by the *Jimmo* Settlement Agreement.

Q15: Does the *Jimmo* Settlement Agreement apply to beneficiaries in Medicare Advantage plans?

A15: Yes. Medicare Advantage plans must cover the same Part A and Part B benefits as original Medicare, and must also apply the standards for coverage of skilled care as clarified by the *Jimmo* Settlement Agreement.

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Nondiscrimination Notice

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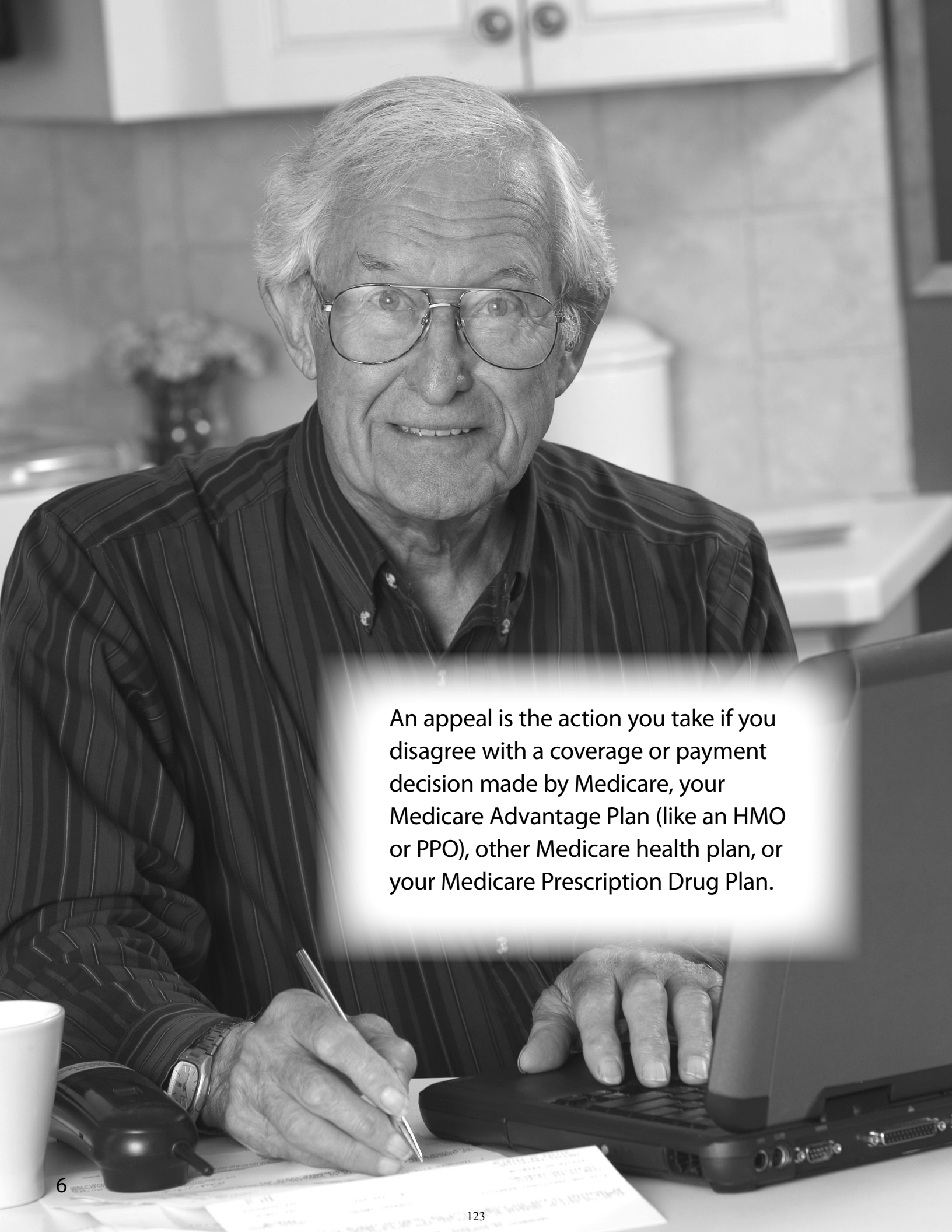
- Calling 1-800-368-1019. TTY users can call 1-800-537-7697.
- Visiting hhs.gov/ocr/civilrights/complaints.

▪ Writing: Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

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Note: Definitions of **red** words are on pages 59–62.



An appeal is the action you take if you disagree with a coverage or payment decision made by Medicare, your Medicare Advantage Plan (like an HMO or PPO), other Medicare health plan, or your Medicare Prescription Drug Plan.

Section 1: What can I appeal?

1

You have the right to **appeal** if you disagree with the decision from **Medicare**, your **Medicare health plan**, or your **Medicare Prescription Drug Plan** for one of these requests:

- A request for a health care service, supply, item, or prescription drug that you think you should be able to get.
- A request for payment of a health care service, supply, item, or prescription drug you already got.
- A request to change the amount you must pay for a health care service, supply, item, or prescription drug.

You can also appeal if Medicare or your plan stops providing or paying for all or part of a health care service, supply, item, or prescription drug you think you still need.

See the sections in this booklet for information on how to file an appeal no matter how you get your Medicare. For more information, visit [Medicare.gov/appeals](https://www.medicare.gov/appeals), or call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

Can someone file an appeal for me?

If you want help filing an appeal, you can appoint a representative. Your representative can help you with the appeals steps explained in this booklet. Your representative can be a family member, friend, advocate, attorney, doctor, or someone else to act on your behalf.

You can appoint your representative in one of these ways:

1. Fill out an “Appointment of Representative” form (CMS Form number 1696). To get a copy, visit [cms.gov/cmsforms/downloads/cms1696.pdf](https://www.cms.gov/cmsforms/downloads/cms1696.pdf), or call 1-800-MEDICARE and ask for a copy.

Words in **red** are defined on pages 59–62.



What can I appeal?

2. Submit a written request that includes:

- Your name, address, phone number, and **Medicare** number (found on your red, white, and blue Medicare card).
- A statement appointing someone as your representative.
- The name, address, and phone number of your representative.
- The professional status of your representative (like a doctor) or their relationship to you.
- A statement authorizing the release of your personal and identifiable health information to your representative.
- A statement explaining why you're being represented and to what extent.
- Your signature and the date you signed the request.
- Your representative's signature and the date they signed the request.

You must send the form or written request to the company that handles **claims** for Medicare or your **Medicare health plan**. If a representative is helping with your **appeal**, send the form or written request with your appeal request. Keep a copy of everything you send to Medicare as part of your appeal.

If you have questions about appointing a representative, call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

In some cases, your doctor can make a request on your behalf without being appointed your representative:

- If you have a **Medicare Advantage Plan** or other **Medicare health plan**:
 - Your treating doctor can request an organization determination or certain reconsiderations on your behalf, and you don't need to submit an "Appointment of Representative" form.
 - If you want your treating doctor to request a higher level of **appeal** on your behalf, you'll need to submit the "Appointment of Representative" form or a written request to appoint a representative as described below.
 - For more information on how to file an appeal if you have a Medicare Advantage Plan or other Medicare health plan, see Section 3.
- If you have a **Medicare Prescription Drug Plan**:
 - Your doctor or other prescriber can request a coverage determination, redetermination, or reconsideration from the Independent Review Entity (IRE) on your behalf, and you don't need to submit an "Appointment of Representative" form.
 - If you want your doctor or other prescriber to request a higher level of appeal on your behalf, you'll need to submit the "Appointment of Representative" form.
 - For more information on how to appeal if you have Medicare prescription drug coverage, see Section 4.



What can I appeal?



If you want help filing an appeal, you can appoint a representative. Your representative can be a family member, friend, advocate, attorney, doctor, or someone else to act on your behalf.

Section 2: How do I appeal if I have Original Medicare?

2

Original Medicare includes Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance). If you have Original Medicare, you get a “Medicare Summary Notice” (MSN) in the mail every 3 months if you get Part A and Part B-covered items and services. If you want to get your MSNs electronically (also called “eMSNs”), visit [MyMedicare.gov](https://www.mymedicare.gov) to sign up.

The MSN shows all your items and services that providers and suppliers billed to Medicare during the 3-month period, what Medicare paid, and what you may owe the provider or supplier. The MSN also shows you if Medicare has fully or partially denied your medical claim. This is the initial determination, and it’s made by the Medicare Administrative Contractor (MAC), which processes Medicare claims.

Read the MSN carefully. If you disagree with a Medicare coverage or payment decision, you can appeal the decision. The MSN contains information about your appeal rights. If you decide to appeal, ask your doctor, other health care provider, or supplier for any information that may help your case. Keep a copy of everything you send to Medicare as part of your appeal.

If you aren’t sure if Medicare was billed for the items and services you got, write or call your doctor, other health care provider, or supplier and ask for an itemized statement. This statement should list all of your items and services that were billed to Medicare. You can also check your MSN to see if Medicare was billed.

Words in red are defined on pages 59–62.

What's the appeals process for Original Medicare?

The **appeals** process has 5 levels:

Level 1: Redetermination by the Medicare Administrative Contractor (MAC)

Level 2: Reconsideration by a Qualified Independent Contractor (QIC)

Level 3: Hearing before an Administrative Law Judge (ALJ)

Level 4: Review by the Medicare Appeals Council (Appeals Council)

Level 5: Judicial review by a federal district court

If you disagree with the decision made at any level of the process, you can generally go to the next level. At each level, you'll get a decision letter with instructions on how to move to the next level of appeal.

Level 1: Redetermination by the Medicare Administrative Contractor (MAC), the company that handles claims for Medicare

Medicare contracts with the MACs to review your appeal request and make a decision. If you disagree with the initial determination on the **MSN**, you can request a redetermination (a second look or review). This is done by the MACs, but by people at the company who weren't involved with the first decision. You have 120 days after you get the MSN to request a redetermination.

How do I request a redetermination?

You can request a redetermination in one of these ways:

1. Read your MSN carefully, and follow the instructions for sending an appeal:
 - Circle the item(s) and/or service(s) you disagree with on the MSN.
 - Explain in writing on the MSN why you disagree with the decision, or write it on a separate piece of paper along with your Medicare number and attach it to the MSN.

How do I appeal if I have Original Medicare?

- Include your name, phone number, and **Medicare** number on the **MSN**, and sign it.
 - Include any other information you have about your **appeal** with the MSN. Ask your doctor, other **health care provider**, or **supplier** for any information that may help your case. Write your Medicare number on all documents you submit with your appeal request.
 - You must send your request for redetermination to the company that handles **claims** for Medicare. The company's address is listed in the "File an Appeal in Writing" section of the MSN.
2. Fill out a "Medicare Redetermination Request" form (CMS Form number 20027). To get a copy, visit cms.gov/cmsforms/downloads/cms20027.pdf, or call 1-800-MEDICARE (1-800-633-4227) and ask for a copy. TTY users can call 1-877-486-2048. Send the completed form, or a copy, to the company that handles claims for Medicare listed on the MSN.
 3. Submit a written request to the MAC. The company's address is listed on the MSN. Your request must include:
 - Your name and Medicare number.
 - The specific item(s) and/or service(s) for which you're requesting a redetermination and specific date(s) of service.
 - An explanation of why you don't agree with the initial determination.
 - Your signature. If you're appointed a representative, include the name and signature of your representative. For more information on appointing a representative, see Section 1.

Words in **red** are defined on pages 59–62.

Keep a copy of everything you send to Medicare as part of your appeal. You'll generally get a decision from the Medicare contractor (either in a letter or a MSN) within 60 days after they get your request. If Medicare covered the item(s) and/or service(s), it will be listed on your next MSN.

How do I appeal if I have Original Medicare?

You can submit additional information or evidence to the MAC after the redetermination request has been filed, but it may take longer than 60 days for the MAC to make a decision. If you submit additional information or evidence after filing the request for redetermination, the contractor will get an extra 14 calendar days to make a decision for each submission.

If you disagree with the redetermination decision made by the MAC in level 1, you have 180 days after you get the “Medicare Redetermination Notice” to request a reconsideration by a Qualified Independent Contractor (QIC), which is level 2.

Level 2: Reconsideration by a Qualified Independent Contractor (QIC)

A QIC is an independent contractor that didn't take part in the level 1 decision. The QIC will review your request for a reconsideration and will make a decision.

How do I request a reconsideration?

Follow the directions on the “Medicare Redetermination Notice” you got in level 1 to file a request for reconsideration. You must send your request to the QIC that will handle your reconsideration. The QIC's address is listed on the redetermination notice. You can request a reconsideration in one of these ways:

1. Fill out a “Medicare Reconsideration Request” form (CMS Form number 20033), which is included with the “Medicare Redetermination Notice.” You can also get a copy by visiting cms.gov/cmsforms/downloads/cms20033.pdf, or calling 1-800-MEDICARE (1-800-633-4227) and asking for a copy. TTY users can call 1-877-486-2048.

How do I appeal if I have Original Medicare?

2. Submit a written request that includes:
 - Your name and **Medicare** number.
 - The specific item(s) or service(s) for which you're requesting a reconsideration and the specific date(s) of service. See your redetermination notice for this information.
 - The name of the company that made the redetermination (the company that handles **claims** for Medicare), which you can find on the **MSN** and on the redetermination notice.
 - An explanation of why you disagree with the redetermination decision.
 - Your signature. If you've appointed a representative, include the name and signature of your representative. For more information on appointing a representative, see Section 1.

No matter how you choose to request a reconsideration, the request should clearly explain why you disagree with the redetermination decision from level 1. Send a copy of the "Medicare Redetermination Notice" with your request for a reconsideration to the QIC. You should also include with your request any information that may help your case. You can submit additional information or evidence after the reconsideration request has been filed, but it may take longer for the QIC to make a decision. Keep a copy of everything you send to Medicare as part of your **appeal**.

In most cases, the QIC will send you a written response called a "Medicare Reconsideration Notice" about 60 days after the QIC gets your appeal request. If the QIC doesn't issue a timely decision, you may ask the QIC to move your case to the next level of appeal.

Words in **red** are defined on pages 59–62.

Note: Some IREs call themselves "Part C QICs."

How do I appeal if I have Original Medicare?

If you disagree with the reconsideration decision in level 2, you have 60 days after you get the “Medicare Reconsideration Notice” to request a hearing by an Administrative Law Judge (ALJ), which is level 3.

Level 3: Hearing before an Administrative Law Judge (ALJ)

A hearing before an ALJ allows you to present your **appeal** to a new person who will independently review the facts of your appeal and listen to your testimony before making a new and impartial decision. An ALJ hearing is usually held by phone or video-teleconference, or in some cases, in person. You can also ask the ALJ to make a decision without a hearing, and the ALJ may also issue a decision without holding a hearing if evidence in the hearing record supports a decision that’s fully in your favor.

To get an ALJ hearing, the amount of your case must meet a minimum dollar amount. For 2017, the required amount is \$160. The “Medicare Reconsideration Notice” will include a statement that tells you if your case meets the minimum dollar amount. However, it’s up to the ALJ to make the final decision. You may be able to combine **claims** to meet the minimum dollar amount.

How do I request a hearing with an ALJ?

Follow the directions on the “Medicare Reconsideration Notice” you got from the QIC in level 2 to request a hearing before an ALJ. You must send your request to the appropriate Office of Medicare Hearings and Appeals (OMHA) Central Operations. The address is listed in the QIC’s reconsideration notice. You can file a request for a hearing in one of these ways:

1. Fill out a “Request for Medicare Hearing by an Administrative Law Judge” form (CMS Form Number 20034 A/B), which is included with the “Medicare Reconsideration Notice.” You can also get a copy by visiting cms.gov/cmsforms/downloads/cms20034ab.pdf, or calling 1-800-MEDICARE (1-800-633-4227) and asking for a copy. TTY users can call 1-877-486-2048.



2. Submit a written request to the OMHA office that will handle your ALJ hearing that includes:
 - Your name, address, and **Medicare** number. If you've appointed a representative, include the name and address of your representative.
 - The **appeal** number included on the QIC reconsideration notice, if any.
 - The dates of service for the items or services you're appealing. See your **MSN** or reconsideration notice for this information.
 - An explanation of why you disagree with the reconsideration decision being appealed.
 - Any information that may help your case. If you can't include this information with your request, include a statement explaining what you plan to submit and when you'll submit it.

Keep a copy of everything you send to Medicare as part of your appeal. For more information about the ALJ hearing process, visit hhs.gov/omha and select "Coverage and Claims Appeals." If you need help filing an appeal with an ALJ, call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

If the ALJ doesn't issue a timely decision, you may ask the ALJ to move your case to the next level of appeal.

If you disagree with the ALJ's decision in level 3, you have 60 days after you get the ALJ's decision to request a review by the Medicare Appeals Council (Appeals Council), which is level 4.

Level 4: Review by the Medicare Appeals Council (Appeals Council)

You can request that the Appeals Council review your case regardless of the dollar amount of your case.

Words in **red** are defined on pages 59–62.

How do I appeal if I have Original Medicare?

How do I request a review?

To request that the Appeals Council review the ALJ's decision in your case, follow the directions in the ALJ's hearing decision you got in level 3. You must send your request to the Appeals Council at the address listed in the ALJ's hearing decision. You can file a request for Appeals Council review in one of these ways:

1. Fill out a "Request for Review of an Administrative Law Judge (ALJ) Medicare Decision/Dismissal" form (DAB-101). To get a copy, visit hhs.gov/dab/divisions/dab101.pdf, or call 1-800-MEDICARE (1-800-633-4227) and ask for a copy. TTY users can call 1-877-486-2048.
2. Submit a written request to the Appeals Council that includes:
 - Your name and **Medicare** number. If you've appointed a representative, include the name of your representative.
 - The specific item(s) and/or service(s) and the specific dates of service you're appealing. See your **MSN** or your ALJ hearing decision for this information.
 - A statement identifying the parts of the ALJ's decision with which you disagree and an explanation of why you disagree.
 - The date of the ALJ decision.
 - Your signature. If you've appointed a representative, include the signature of your representative.
 - If you're requesting that your case be moved from the ALJ to the Appeals Council because the ALJ hasn't issued a timely decision, include the hearing office in which the request for hearing is pending.

Keep a copy of everything you send to Medicare as part of your **appeal**. For more information about the Appeals Council review process, visit hhs.gov/dab and select "Medicare Operations Division." If you need help filing a request for Appeals Council review, call 1-800-MEDICARE.

If the Appeals Council doesn't issue a timely decision, you can ask the Appeals Council to move your case to the next level of appeal.

Words in **red**
are defined on
pages 59–62.

If you disagree with the Appeals Council's decision in level 4, you have 60 days after you get the Appeals Council's decision to request judicial review by a federal district court, which is level 5.

Level 5: Judicial review by a federal district court

If you disagree with the decision issued by the Appeals Council, you can request judicial review in federal district court. To get a review, the amount of your case must meet a minimum dollar amount. For 2017, the minimum dollar amount is \$1,560. You may be able to combine **claims** to meet this dollar amount.

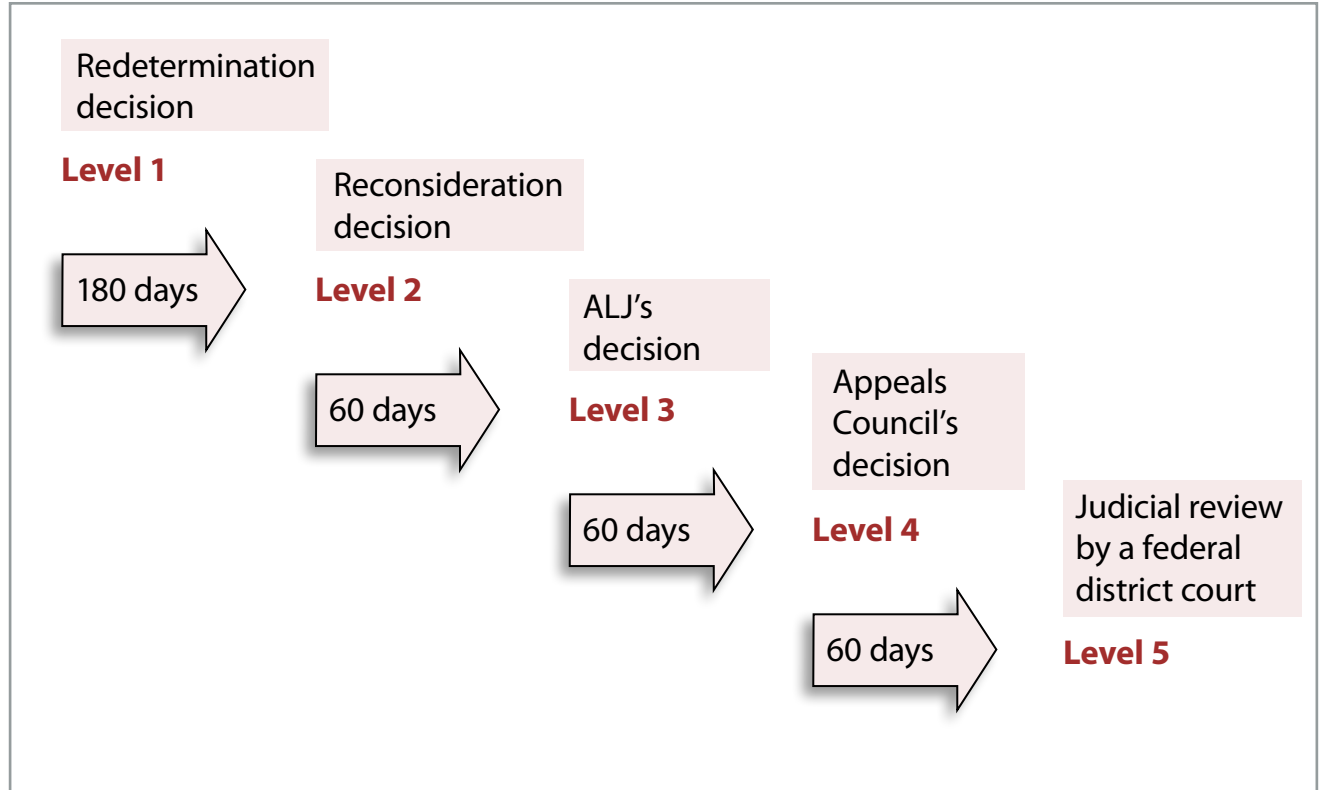
How do I request a review?

Follow the directions in the Appeals Council's decision letter you got in level 4 to file a complaint in federal district court.

For more information on the appeals process

- Visit [Medicare.gov/appeals](https://www.medicare.gov/appeals).
- Call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.
- Visit [Medicare.gov/claims-and-appeals/file-an-appeal/appeals-forms.html](https://www.medicare.gov/claims-and-appeals/file-an-appeal/appeals-forms.html) for appeals forms.
- Call your **State Health Insurance Assistance Program (SHIP)** for free, personalized health insurance counseling, including help with **appeals**. To get the phone number for the SHIP in your state, visit [shiptacenter.org](https://www.shiptacenter.org), or call 1-800-MEDICARE.

How do I appeal if I have Original Medicare?



How do I get an expedited (fast) appeal in a hospital?

When you're admitted as an inpatient to a hospital, you have the right to get the hospital care that's necessary to diagnose and treat your illness or injury. If you think you're being discharged from the hospital too soon, you have the right to ask your **Beneficiary and Family Centered Quality Improvement Organization (BFCC-QIO)** to review your case. To get the BFCC-QIO's phone number, visit [Medicare.gov/contacts](https://www.Medicare.gov/contacts), or call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

Within 2 days of your admission, you should get a notice called "An Important Message from Medicare about Your Rights" (sometimes called the "Important Message from Medicare" or the "IM"). If you don't get this notice, ask for it. This notice lists the BFCC-QIO's contact information and explains:

- Your right to get all **medically necessary** hospital services
- Your right to be involved in any decisions that the hospital, your doctor, or anyone else makes about your hospital services and to know who will pay for them
- Your right to get the services you need after you leave the hospital
- Your right to **appeal** a discharge decision and the steps for appealing the decision
- The circumstances under which you will or won't have to pay for charges for continuing to stay in the hospital
- Information on your right to get a detailed notice about why your covered services are ending

If the hospital gives you the IM more than 2 days before your discharge day, it must either give you a copy of your original, signed IM or provide you with a new one (that you must sign) before you're discharged.

How do I appeal if I have Original Medicare?

How do I ask for a fast appeal?

You may have the right to ask the **BFCC-QIO** for a fast **appeal**. Follow the directions on the IM to request a fast appeal if you think your **Medicare**-covered hospital services are ending too soon. You must ask for a fast appeal no later than the day you're scheduled to be discharged from the hospital.

If you ask for your appeal within this timeframe, you can stay in the hospital without paying for your stay (except for applicable **coinsurance** or **deductibles**) while you wait to get the decision from the BFCC-QIO.

If you miss the deadline for a fast appeal, you can still ask the BFCC-QIO to review your case, but different rules and timeframes apply. For more information, contact the BFCC-QIO.

What will happen during the BFCC-QIO's review?

When the BFCC-QIO gets your request within the fast appeal timeframe, it will notify the hospital. Then, the hospital will give you a "Detailed Notice of Discharge" by noon of the day after the BFCC-QIO notifies the hospital. The notice will include:

1. Why your services are no longer reasonable and necessary, or are no longer covered
2. The applicable Medicare coverage rule or policy, including a citation to the applicable Medicare policy, or information on how you can get a copy of the policy
3. How the applicable coverage rule or policy applies to your specific situation

The BFCC-QIO will look at your medical information provided by the hospital and will also ask you for your opinion. The BFCC-QIO will decide if you're ready to be discharged within one day of getting the requested information.

How do I appeal if I have Original Medicare?

If the **BFCC-QIO** decides that you're being discharged too soon, **Medicare** will continue to cover your hospital stay as long as **medically necessary** (except for applicable **coinsurance** or **deductibles**).

If the **BFCC-QIO** decides that you're ready to be discharged and you met the deadline for requesting a fast **appeal**, you won't be responsible for paying the hospital charges (except for applicable coinsurance or deductibles) until noon of the day after the **BFCC-QIO** gives you its decision. If you get any inpatient hospital services after noon of that day, you may have to pay for them.

If you have any questions about fast appeals in hospitals, call the **BFCC-QIO** at the phone number listed on the notice the hospital gives you. You can also visit [Medicare.gov/contacts](https://www.Medicare.gov/contacts) or call 1-800-MEDICARE (1-800-633-4227) to get the **BFCC-QIO's** phone number. TTY users can call 1-877-486-2048.

How do I get an expedited (fast) appeal in a setting other than a hospital?

You have the right to a fast appeal if you think your Medicare-covered **skilled nursing facility** (SNF), **home health agency** (HHA), **comprehensive outpatient rehabilitation facility** (CORF), or **hospice** services are ending too soon.

While you're getting SNF, HHA, CORF, or hospice services, you should get a notice called the "Notice of Medicare Non-Coverage" at least 2 days before covered services end. If you don't get this notice, ask for it. This notice explains:

- The date that your covered services will end
- That you may have to pay for services you get after the coverage end date given on your notice
- Information on your right to get a detailed notice about why your covered services are ending
- Your right to a fast appeal and information on how to contact your **BFCC-QIO** to request a fast appeal

Words in red are defined on pages 59–62.

How do I appeal if I have Original Medicare?

How do I ask for a fast appeal?

Ask the **BFCC-QIO** for a fast **appeal** no later than noon of the day after you get the “Notice of Medicare Non-Coverage.” Follow the instructions on the notice to do this.

If you miss the deadline for requesting a fast appeal, you can still ask the BFCC-QIO to review your case, but different rules and timeframes apply. For more information, contact the BFCC-QIO. To get the BFCC-QIO’s phone number, visit [Medicare.gov/contacts](https://www.Medicare.gov/contacts), or call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

What will happen during the BFCC-QIO’s review?

When the BFCC-QIO gets your request, it will notify the provider. Then, by the end of the day that the provider gets the notice from the BFCC-QIO, the provider will give you a “Detailed Explanation of Non-Coverage.” The notice will include:

- Why your **Medicare** services are no longer reasonable and necessary, or are no longer covered
- The applicable Medicare coverage rule or policy, including a citation to the applicable Medicare policy, or information on how you can get a copy of the policy
- How the applicable Medicare coverage rule or policy applies to your situation

If the BFCC-QIO decides that your services are ending too soon, Medicare may continue to cover your **SNF, HHA, CORF, or hospice** services (except for applicable **coinsurance or deductibles**).

If the BFCC-QIO decides that your services should end, you won’t be responsible for paying for any SNF, HHA, CORF, or hospice services provided before the termination date on the “Notice of Medicare Non-Coverage.” If you continue to get services after the coverage end date, you may have to pay for those services.

How do I appeal if I have Original Medicare?

If you have questions about your rights regarding **SNF, HHA, CORF, or hospice services**, including appealing the **BFCC-QIO's** decision, getting notices, or learning about your rights after missing the filing deadline, call the BFCC-QIO at the phone number listed on the notice the provider gives you. You can also visit [Medicare.gov/contacts](https://www.Medicare.gov/contacts), or call 1-800-MEDICARE (1-800-633-4227) to get the BFCC-QIO's phone number. TTY users can call 1-877-486-2048.

What's an "Advance Beneficiary Notice of Noncoverage" (ABN)?

If you have **Original Medicare** and your doctor, other **health care provider**, or **supplier** thinks that **Medicare** probably (or certainly) won't pay for items or services, he or she may give you a written notice called an ABN. This notice is used by doctors, suppliers, and certain health care providers, like independent physical and occupational therapists, laboratories, and outpatient hospitals.

The ABN lists the items or services that Medicare isn't expected to pay for, an estimate of the costs for the items and services, and the reasons why Medicare may not pay. The ABN gives you information to make an informed choice about whether or not to get items or services, **understanding that you may have to accept responsibility for payment.**

You'll be asked to choose an option box and sign the notice to say that you read and understood it. You must choose one of these options:

- **Option 1**—You want the items or services that may not be paid for by Medicare. Your provider or supplier may ask you to pay for them now, but you also want them to submit a **claim** to Medicare for the items or services. If Medicare denies payment, you're responsible for paying, but since a claim was submitted, you can **appeal** to Medicare.
- **Option 2**—You want the items or services that may not be paid for by Medicare, but you don't want your provider or supplier to bill Medicare. You may be asked to pay for the items or services now, but because you request your provider or supplier to not submit a claim to Medicare, you can't file an appeal.

Words in **red** are defined on pages 59–62.

How do I appeal if I have Original Medicare?

- **Option 3**—You don’t want the items or services that may not be paid for by **Medicare**, and you aren’t responsible for any payments. A **claim** isn’t submitted to Medicare, and you can’t file an **appeal**.

An ABN isn’t an official denial of coverage by Medicare. If payment is denied when a claim is submitted, you have the right to file an appeal.

Other types of ABNs

1. “Skilled Nursing Facility Advance Beneficiary Notice” (SNFABN)

A **skilled nursing facility** (SNF) will issue you a SNFABN if there’s reason to believe that Medicare may not cover or continue to cover your care or stay because it isn’t reasonable or necessary, or is considered **custodial care**.

The SNFABN lets you know Medicare will likely no longer pay for your services. If you choose to get the services that may not be covered under **Part A**, you don’t have to pay for these services until a claim is submitted and Medicare officially denies payment. However, while the claim is processed, you have to continue paying costs that you would normally have to pay, like the daily **coinsurance** and costs for services and supplies Medicare generally doesn’t cover.

The SNF may use the ABN and collect money from you now for **Part B** items or services. If Medicare pays, the SNF will refund any payments you made, except **copayments** or **deductibles**.

2. “Hospital Issued Notice of Noncoverage” (HINN)

Hospitals use a HINN when all or part of your inpatient hospital care may not be covered by Medicare. This notice will tell you why the hospital thinks Medicare won’t pay, and what you may have to pay if you keep getting these services.

How do I appeal if I have Original Medicare?

Services & supplies Medicare generally doesn't cover

Doctors, other **health care providers**, and **suppliers** don't have to (but still may) give you an ABN for services that **Medicare** generally doesn't cover, like:

- Dental services
- Hearing aids
- Routine eye exams
- Routine foot care

What notices are given by home health agencies?

Home health agencies are required to give people with **Original Medicare** written notices in these situations:

1. “Home Health Change of Care Notice” (HHCCN)

The HHCCN is a written notice that your home health agency should give you when your home health plan of care is changing because of one of these:

- The home health agency makes a business decision to reduce or stop giving you some or all of your home health services or supplies.
- Your doctor changed your orders, which may reduce or stop giving you certain home health services or supplies.

The HHCCN lists the services or supplies that will be changed, and it gives you instructions on what you can do if you don't agree with the change.

The home health agency isn't required to give you a HHCCN when the “Notice of Medicare Non-Coverage” (NOMNC) is issued. See page 28 for more information.

Words in **red**
are defined on
pages 59–62.

How do I appeal if I have Original Medicare?

2. “Advance Beneficiary Notice of Noncoverage” (ABN)

When the **home health agency** believes that **Medicare** may not pay for certain home health items and services or all of your home health care, the agency should give you an ABN. See page 25 for more information on ABNs.

Home health agencies are required to give you an ABN if care is reduced or terminated, or before you get any items or services that may not be paid for by Medicare because of any of these reasons:

- They’re not considered medically reasonable and necessary.
- The care is **custodial**.
- You aren’t confined to your home.
- You don’t need intermittent skilled nursing care.

Note: “The Home Health Advance Beneficiary Notice” (HHABN) has been discontinued. It was replaced by the HHCCN and the ABN in 2013.

3. “Notice of Medicare Non-Coverage” (NOMNC)

Your home health agency will give you a NOMNC when all of your Medicare-covered services are ending. This notice will tell you when the services will end and how to **appeal** if you think the services are ending too soon. The NOMNC tells you how to contact your **BFCC-QIO** to ask for a fast appeal. If you don’t get this notice, ask for it.

If you decide to ask for a fast appeal, you should call the BFCC-QIO within the timeframe listed on the notice. After you request a fast appeal, you’ll get a second notice with more information about why your care is ending. The BFCC-QIO may ask you questions about your care. To help your case, ask your doctor for information, which you can submit to the BFCC-QIO.

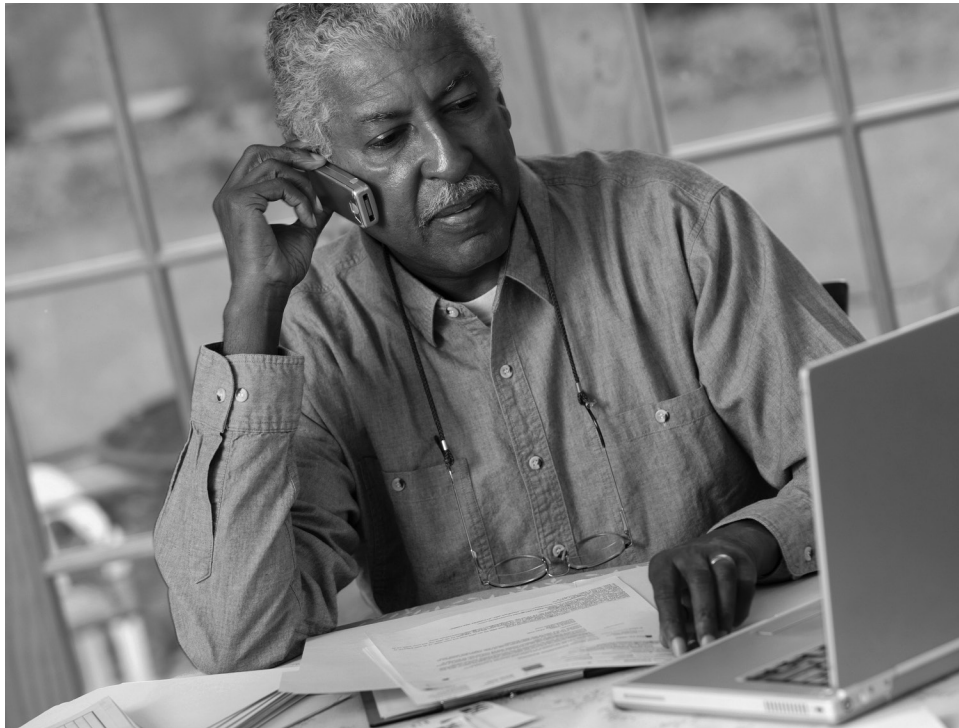
How do I appeal if I have Original Medicare?

4. “Detailed Explanation of Non-Coverage” (DENC)

Your **home health agency** will give you a DENC when it’s informed by the **BFCC-QIO** that you’ve requested a BFCC-QIO review of your case. The DENC will explain why your home health agency believes that **Medicare** will no longer pay for your home health care.

Words in **red**
are defined on
pages 59–62.

How do I appeal if I have Original Medicare?



Section 3: How do I appeal if I have a Medicare Advantage Plan or other Medicare health plan?

3

Medicare Advantage Plans (like HMOs or PPOs) and Medicare Cost Plans are health plan options that are approved by **Medicare** and run by private companies. When you join a Medicare Advantage Plan or other **Medicare health plan**, you're still in the Medicare Program. Your Medicare Advantage Plan or other Medicare health plan will send you information that explains your rights. Call your plan if you have questions.

Medicare Cost Plans are types of HMOs that are available in certain areas of the country. You may be covered by a Medicare Cost Plan, even if you only have **Part B**. If you have a Medicare Cost Plan and go to a non-network provider, the services are covered under **Original Medicare**. You can either get your Medicare prescription drug coverage from the Cost Plan (if offered), or you can buy a **Medicare Prescription Drug Plan** to add prescription drug coverage. If you have a Medicare Cost Plan and want to **appeal** services you got outside of the plan's network, you'll need to follow the Original Medicare appeals process. See Section 2.

If you're in a PACE (Program of All-inclusive Care for the Elderly) program, your appeal rights are different. The PACE organization will provide you with written information about your appeal rights.

Words in **red** are defined on pages 59–62.

If you have a Medicare Advantage Plan or other Medicare health plan, you have the right to request an appeal to resolve differences with your plan. You have the right to ask your plan to provide or pay for items or services you think should be covered, provided, or continued.

If you decide to appeal, ask your doctor, other **health care provider**, or **supplier** for any information that may help your case. Keep a copy of everything you send to your plan as part of your appeal.

What's the appeals process for Medicare Advantage Plans or other Medicare health plans?

Request an organization determination

You have the right to ask your plan to provide or pay for items or services you think should be covered, provided, or continued. This is called an “organization determination.” You, your representative, or your doctor can request an organization determination from your plan in advance to make sure that the services are covered or after payment of the services is denied.

If you think your health could be seriously harmed by waiting the standard 14 days for a decision, ask your plan for a fast decision. The plan must notify you of its decision within 72 hours if it determines, or your doctor tells your plan, that waiting for a standard decision may seriously jeopardize your life, health, or ability to regain maximum function.

If the plan won't cover the items or services you asked for, you'll get a notice explaining why your plan fully or partially denied your request and instructions on how to **appeal** your plan's decision by requesting a reconsideration. If you appeal the plan's decision, you may want to ask for a copy of your file containing medical and other information about your case. Your plan may charge you for this copy.

If you disagree with your plan's initial decision (also known as the organization determination), you can file an appeal. The appeals process has 5 levels:

Level 1: Reconsideration from your plan

Level 2: Review by an Independent Review Entity (IRE)

Level 3: Hearing before an Administrative Law Judge (ALJ)

Level 4: Review by the Medicare Appeals Council (Appeals Council)

Level 5: Judicial review by a federal district court

If you disagree with the decision made at any level of the process, you can generally go to the next level. At each level, you'll get instructions on how to move to the next level of appeal.

How do I appeal if I have a Medicare Advantage Plan or other Medicare health plan?

Words in **red** are defined on pages 59–62.

Level 1: Reconsideration from your plan

If you disagree with your plan's initial decision (also known as the organization determination), you or your representative can request a reconsideration (a second look or review). If your **appeal** is for a service you haven't gotten yet, your doctor can request a reconsideration on your behalf and must notify you about it.

You must request the reconsideration within 60 days of the date of the notice of the organization determination.

How do I request a reconsideration?

You, your representative, or your doctor must file a written standard or expedited (fast) request unless your plan allows you to file a request over the phone, by fax, or by email. You can find your plan's address in your plan materials and on the organization determination notice.

Follow the directions in the "Notice of Denial of Medical Coverage" or the "Notice of Denial of Payment" you got with your unfavorable decision to request a reconsideration from your plan. Your written reconsideration request should include:

- Your name, address, and **Medicare** number.
- The items or services for which you're requesting a reconsideration, the dates of service, and the reason(s) why you're appealing.
- If you've appointed a representative, include the name of your representative and proof of representation. For more information on appointing a representative, see Section 1.

You should also include any other information that may help your case. Keep a copy of everything you send to your plan as part of your appeal.

Your plan must respond to your request for an appeal within these timeframes:

- Expedited (fast) request—72 hours
- Standard service request—30 days
- Payment request—60 days

How do I appeal if I have a Medicare Advantage Plan or other Medicare health plan?

Your request will be a fast request if your plan determines, or your doctor tells your plan, that waiting for a standard service decision may seriously jeopardize your life, health, or ability to regain maximum function.

The timeframe for completing standard service and fast service requests may be extended by up to 14 days. The timeframe may be extended if, for example, your plan needs more information from a non-contract provider to make a decision about the case and the extension is in your best interest. Your plan will notify you in writing if it decided to take an extension. Your plan will notify you of the reasons for the delay and inform you of your right to file an expedited (fast) **grievance** if you disagree with the plan's decision to take an extension.

If the plan decides against you (fully or partially), your **appeal is automatically sent to an Independent Review Entity (IRE), which is level 2.**

Level 2: Review by an Independent Review Entity (IRE)

You'll get a written notice from your plan about all appeal decisions. If your plan decides against you, your appeal is automatically sent to level 2. If this happens, the notice from your plan will give you the specific reason(s) for any full or partial denial.

You may send the IRE information about your case. They must get this information within 10 days after the date you get the notice telling you your case file has been sent to the IRE. The IRE's address is on the notice.

Generally, the IRE will send you its decision in a written "Reconsideration Determination" within these timeframes:

- Expedited (fast) request—72 hours
- Standard service request—30 days
- Payment request—60 days

You'll get a fast decision if the IRE determines that your life or health may be at risk by waiting for a standard decision.

Note: Some IREs call themselves "Part D QICs."

How do I appeal if I have a Medicare Advantage Plan or other Medicare health plan?

If you disagree with the IRE's decision in level 2, you have 60 days from the date of the IRE's decision to request an Administrative Law Judge (ALJ) hearing, which is level 3.

Level 3: Hearing before an Administrative Law Judge (ALJ)

A hearing before an ALJ allows you to present your **appeal** to a new person who will review the facts of your appeal independently before making a new and impartial decision. An ALJ hearing is usually held by phone or video-teleconference, or in some cases, in person. You can also ask the ALJ to make a decision without a hearing.

To get an ALJ hearing, the amount of your case must meet a minimum dollar amount. For 2017, the required minimum amount is \$160. The ALJ will decide if your case meets the minimum dollar amount. You may be able to combine **claims** to meet the minimum dollar amount.

Words in **red** are defined on pages 59–62.

How do I request a hearing?

Follow the directions in the IRE's reconsidered determination to ask for a hearing before an ALJ, or submit a written request with the information listed below within 60 days of the IRE's reconsidered determination. Note that if any of the required information is missing from your request, it can cause delays in the processing of your appeal. Your written request must include:

- Your name, address, and **Medicare** number. If you've appointed a representative, include the name and address of your representative.
- The document control number assigned by the IRE, if any.
- The dates of service for the items or services you're appealing.
- An explanation of why you disagree with the IRE's reconsideration or other determination being appealed.
- Any other information that may help your case. If you can't include this information with your request, include a statement explaining what you plan to submit and when you'll submit it.

How do I appeal if I have a Medicare Advantage Plan or other Medicare health plan?

Keep a copy of everything you send to your plan as part of your **appeal**. To request an ALJ hearing, follow the instructions in the IRE's reconsideration decision. Your request for an ALJ hearing must be filed with the IRE and the IRE will forward your request and the case file to the ALJ. To learn more about the ALJ hearing process, visit hhs.gov/omha and select "Coverage and Claims Appeals." If you need help filing an appeal with an ALJ, call your plan.

If the ALJ decides in your favor, the plan has the right to appeal this decision by asking the Medicare Appeals Council (Appeals Council) for a review.

If you disagree with the ALJ's decision in level 3, you have 60 days after you get the ALJ's decision to request a review by the Appeals Council, which is level 4.

Level 4: Review by the Medicare Appeals Council (Appeals Council)

You can request that the Appeals Council review your case regardless of the dollar amount of your case.

How do I request a review?

To request that the Appeals Council review the ALJ's decision in your case, follow the directions in the ALJ's hearing decision you got in level 3. You must send your request to the Appeals Council at the address listed in the ALJ's hearing decision. You can file a request for Appeals Council review in one of these ways:

1. Fill out a "Request for Review of an Administrative Law Judge (ALJ) Medicare Decision/Dismissal" form (DAB-101). To get a copy, visit hhs.gov/dab/divisions/dab101.pdf, or call your plan or 1-800-MEDICARE (1-800-633-4227) and ask for a copy. TTY users can call 1-877-486-2048.
2. Submit a written request to the Appeals Council that includes:
 - Your name and **Medicare** number. If you've appointed a representative, include the name of your representative.

How do I appeal if I have a Medicare Advantage Plan or other Medicare health plan?

- The specific item(s) and/or service(s) you're appealing and the specific dates of service. See your reconsideration or ALJ hearing decision for this information.
- A statement identifying the parts of the ALJ's decision with which you disagree and an explanation of why you disagree.
- The date of the ALJ decision.
- Your signature. If you've appointed a representative, include the signature of your representative.
- If you're requesting that your case be moved from the ALJ to the Appeals Council because the ALJ hasn't issued a timely decision, include the hearing office in which the request for hearing is pending.

Keep a copy of everything you send to your plan as part of your **appeal**. For more information about the Appeals Council review process, visit hhs.gov/dab and select "Medicare Operations Division." If you need help filing a request for Appeals Council review, call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

If the Appeals Council doesn't issue a timely decision, you can ask the Appeals Council to move your case to the next level of appeal.

If you disagree with the Appeals Council's decision in level 4, you have 60 days after you get the Appeals Council's decision to request judicial review by a federal district court, which is level 5.

Level 5: Judicial review by a federal district court

If you disagree with the decision issued by the Appeals Council (or if the Appeals Council denied your request for review), you can request judicial review in federal district court. To get a review, the amount of your case must meet a minimum dollar amount. For 2017, the required minimum **claim** amount is \$1,560. You may be able to combine claims to meet this dollar amount.

Words in **red** are defined on pages 59–62.

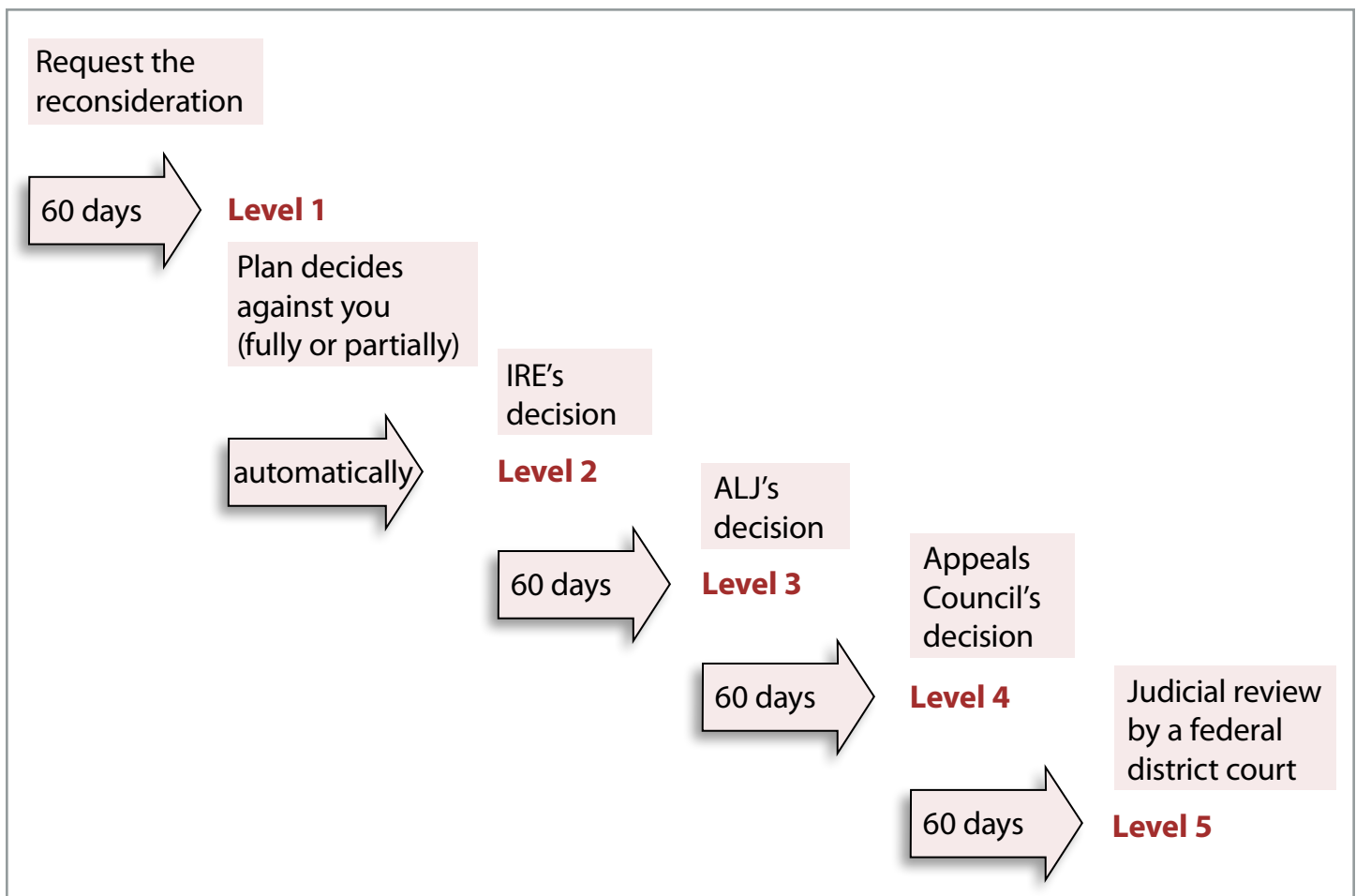
How do I appeal if I have a Medicare Advantage Plan or other Medicare health plan?

How do I request a review?

Follow the directions in the Appeals Council's decision letter you got in level 4 to file a complaint in federal district court.

For more information on the appeals process

- Visit [Medicare.gov/appeals](https://www.medicare.gov/appeals).
- Call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.
- Visit [Medicare.gov/claims-and-appeals/file-an-appeal/appeals-forms.html](https://www.medicare.gov/claims-and-appeals/file-an-appeal/appeals-forms.html) for **appeal** forms.
- Call your **State Health Insurance Assistance Program (SHIP)** for free, personalized health insurance counseling, including help with appeals. To get the phone number for the SHIP in your state, visit shiptacenter.org, or call 1-800-MEDICARE.



How do I appeal if I have a Medicare Advantage Plan or other Medicare health plan?

How do I get an expedited (fast) appeal in a hospital?

When you're admitted as an inpatient to a hospital, you have the right to get the hospital care that's necessary to diagnose and treat your illness or injury. If you think you're being discharged from the hospital too soon, you have the right to ask your **Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO)** to review your case. To get the BFCC-QIO's phone number, visit [Medicare.gov/contacts](https://www.medicare.gov/contacts), or call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

During your hospital stay, you should get a notice called "An Important Message from Medicare about Your Rights" (sometimes called the "Important Message from Medicare" or the "IM"). If you don't get this notice, ask for it. This notice lists the BFCC-QIO's contact information and explains:

- Your right to get all **medically necessary** hospital services
- Your right to be involved in any decisions that the hospital, your doctor, or anyone else makes about your hospital services, and who will pay for them
- Your right to get services you need after you leave the hospital
- Your right to **appeal** a discharge decision and the steps for appealing the decision
- The circumstances under which you will or won't have to pay for charges for continuing to stay in the hospital
- Information on your right to get a detailed notice about why your covered services are ending

You should get the IM within 2 days of your hospital admission. If the hospital gives you the notice more than 2 days before your discharge day, it must either give you a copy of your original, signed IM or provide you with a new one (that you must sign) before you're discharged.

Words in **red** are defined on pages 59–62.

How do I appeal if I have a Medicare Advantage Plan or other Medicare health plan?

How do I ask for a fast appeal?

You have the right to a fast **appeal** if you think you're being discharged too soon. Ask the **BFCC-QIO** for a fast appeal. Follow the directions on the IM to do this. You must ask for a fast appeal no later than the day you're being discharged from the hospital.

If you meet this deadline, you can stay in the hospital after your discharge date without paying for it (except for applicable **coinsurance** or **deductibles**) while you wait to get the decision from the BFCC-QIO.

If you miss the deadline for a fast appeal, you can request an expedited (fast) reconsideration from your plan, but your **Medicare health plan** will only cover hospital services if there's a decision issued in your favor.

To ask for a fast appeal, contact your **State Health Insurance Assistance Program (SHIP)**. To get the phone number for your SHIP, visit shiptacenter.org, or call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

What will happen during the BFCC-QIO's review?

When the BFCC-QIO gets your request, it will notify the plan and the hospital. Once your plan and the hospital are notified by the BFCC-QIO, you plan or the hospital will provide you a "Detailed Notice of Discharge" by noon on that day that includes:

- Why your services are no longer reasonable and necessary, or are no longer covered
- The applicable **Medicare** coverage rule or policy, including a citation to the applicable Medicare policy, or information on how you can get a copy of the policy
- How the applicable coverage rule or policy applies to your specific situation

You can also ask your plan for copies of any of the materials that your plan sent to the BFCC-QIO about your hospital discharge. The BFCC-QIO will look at your medical information provided by the plan and the hospital and will also ask you for your opinion. Within one day of getting that information, the BFCC-QIO will decide if you're ready to be discharged.

Words in **red** are defined on pages 59–62.

How do I appeal if I have a Medicare Advantage Plan or other Medicare health plan?

If the BFCC-QIO decides that you're being discharged too soon, the plan will continue to provide for your Medicare-covered hospital stay as long as **medically necessary** (except for applicable **coinsurance** or **deductibles**) if your plan previously authorized coverage of the inpatient admission or the inpatient admission was for emergency or urgently needed care. If your plan never authorized the inpatient admission and it wasn't for emergency or urgently needed care, you may need to **appeal** the denial of coverage for your plan to pay.

If the BFCC-QIO decides that you're ready to be discharged and you met the deadline for requesting a fast appeal, you won't be responsible for paying the hospital charges (except for applicable coinsurance or deductibles) incurred through noon of the day after the BFCC-QIO gives you its decision. If you get any inpatient hospital services after noon on the day that the BFCC-QIO gives you its decision, you might have to pay for them.

If you have any questions about fast appeals in hospitals, you can call the BFCC-QIO at the phone number listed on the notice the hospital gives you. You can also visit [Medicare.gov/contacts](https://www.Medicare.gov/contacts), or call 1-800-MEDICARE (1-800-633-4227) to get the BFCC-QIO's phone number. TTY users can call 1-877-486-2048.

How do I get an expedited (fast) appeal in a setting other than a hospital?

You have the right to a fast appeal if you think your services from a Medicare-covered **skilled nursing facility (SNF)**, **home health agency (HHA)**, or **comprehensive outpatient rehabilitation facility (CORF)** are ending too soon. During a fast appeal, the BFCC-QIO looks at your case and decides if your health care services need to continue.

How do I appeal if I have a Medicare Advantage Plan or other Medicare health plan?

While you're getting **SNF**, **HHA**, or **CORF** services, you should get a notice called "Notice of Medicare Non-Coverage" at least 2 days before covered services end. If you don't get this notice, ask for it. This notice explains:

- The date that your covered services will end
- That you may have to pay for services you got after the coverage end date indicated on your notice
- Information on your right to get a detailed notice about why your covered services are ending
- Your right to a fast **appeal** and information on how to contact your **BFCC-QIO** to request a fast appeal

How do I ask for a fast appeal?

Ask the BFCC-QIO for a fast appeal no later than noon of the first day after the day you get the "Notice of Medicare Non-Coverage." Follow the instructions on the termination notice.

If you miss the deadline for requesting a fast appeal from the BFCC-QIO, you can request an expedited (fast) reconsideration from your plan, but services will only be covered if there's a decision issued in your favor.

Words in **red** are defined on pages 59–62.

What will happen during the BFCC-QIO's review?

When the BFCC-QIO gets your request, it will notify the plan and the provider. You'll get a "Detailed Explanation of Non-Coverage" by the end of the day. The notice will include:

- Why your plan intends to stop covering your services
- The applicable **Medicare** coverage rule or policy, including citation to the applicable Medicare policy, or information on how you can get a copy of the policy your plan is using to explain why your coverage is ending
- Any applicable plan policy, contract provision, or reason on which your discharge decision was based

How do I appeal if I have a Medicare Advantage Plan or other Medicare health plan?

The **BFCC-QIO** will:

- Ask you why you believe coverage for the services should continue.
- Look at your medical records and the information provided by the plan.
- Make a decision by close of business the day after it gets the information it needs to make a decision.

If the BFCC-QIO decides that your services are ending too soon, your plan will continue to provide for your **Medicare**-covered **SNF**, **HHA**, or **CORF** services (except for applicable **coinsurance** or **deductibles**).

If the BFCC-QIO decides that your services should end, you won't be responsible for paying for any SNF, HHA, or CORF services provided before the termination date on the "Notice of Medicare Non-Coverage." If you continue to get services after the coverage end date, you may have to pay for those services.

If you have questions about your rights regarding SNF, HHA, or CORF services, including appealing the BFCC-QIO's decision, getting notices, or learning about your additional **appeal** rights after missing the filing deadline, call the BFCC-QIO at the phone number listed on the notice the provider gives you, or call your health plan (their phone number is in your plan materials). You can also visit [Medicare.gov/contacts](https://www.Medicare.gov/contacts) or call 1-800-MEDICARE (1-800-633-4227) to get the BFCC-QIO's phone number. TTY users can call 1-877-486-2048.

How do I file a grievance?

If you have concerns or problems with your **Medicare Advantage Plan** or other **Medicare health plan** that don't involve requests to provide or pay for items or services, you can file a "**grievance**."

- If your complaint involves the quality of care you got or are getting, you can file a grievance with your plan and/or your BFCC-QIO. For the phone number of the BFCC-QIO, visit [Medicare.gov/contacts](https://www.Medicare.gov/contacts), or call 1-800-MEDICARE.

How do I appeal if I have a Medicare Advantage Plan or other Medicare health plan?

- You may file a **grievance** with your **Medicare health plan** if:
 - You believe your plan's customer service hours of operation should be different.
 - You believe there aren't enough specialists in the plan to meet your needs.
 - The company offering your plan is sending you materials that you didn't ask to get and aren't related to your plan.
 - The plan didn't make a decision about a reconsideration within the required timeframe. See the level 1 **appeal** on page 33.
 - The plan didn't send your case to the IRE. See level 2 on page 34.
 - You disagree with the plan's decision not to grant your request for a fast appeal or you disagree with the plan's decision to extend the timeframe for making its decision.
 - The plan didn't provide the required notices.
 - The plan's notices don't follow **Medicare** rules.

When you join a **Medicare Advantage Plan** or other Medicare health plan, the plan will send you information about how to file grievances in its membership materials. Read the information carefully, and keep it where you can find it if you need it. Call your plan if you have questions.

Section 4: How do I appeal if I have Medicare prescription drug coverage?

4

If you have Medicare prescription drug coverage through a **Medicare Prescription Drug Plan** (PDP), a **Medicare Advantage Plan** with prescription drug coverage (MA-PD), or other **Medicare** plan, your plan will send you information that explains your rights (called an “Evidence of Coverage”). Call your plan if you have questions about your “Evidence of Coverage.”

You have the right to ask your plan to provide or pay for a drug you think should be covered, provided, or continued. You have the right to request an **appeal** if you disagree with your plan’s decision about whether to provide or pay for a drug.

If you decide to appeal, ask your doctor or other **health care provider** for any information that may help your case. Keep a copy of everything you send to your plan as part of your appeal.

What if my plan won’t cover a drug I think I need?

If your pharmacist tells you that your Medicare drug plan won’t cover a drug you think should be covered, or it will cover the drug at a higher cost than you think you should have to pay, you have these options:

1. **Talk to your prescriber.**

Ask your prescriber if you meet prior authorization or step therapy requirements. For more information on these requirements, visit Medicare.gov, or call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048. You can also ask your prescriber if there are generic, over-the-counter, or less expensive brand-name drugs that could work just as well as the ones you’re taking now.

Words in **red** are defined on pages 59–62.

How do I appeal if I have Medicare prescription drug coverage?

2. Request a coverage determination (including an “exception”).

You, your representative, your doctor, or other prescriber can request (orally or in writing) that your plan cover the prescription you need. You can request a coverage determination if your pharmacist or plan tells you one of these:

- A drug you believe should be covered isn’t covered.
- A drug is covered at a higher cost than you think you should have to pay.
- You have to meet a plan coverage rule (like prior authorization) before you can get the drug you requested.
- It won’t cover a drug on the **formulary** because the plan believes you don’t need the drug.

You, your representative, your doctor, or other prescriber can request a coverage determination called an “exception” if:

- You think your plan should cover a drug that’s not on its formulary because the other treatment options on your plan’s formulary won’t work for you.
- Your doctor or other prescriber believes you can’t meet one of your plan’s coverage rules, like prior authorization, step therapy, or quantity or dosage limits.
- You think your plan should charge a lower amount for a drug you’re taking on the plan’s non-preferred drug tier because the other treatment options in your plan’s preferred drug tier won’t work for you.

If you request an exception, your doctor or other prescriber will need to give a supporting statement to your plan explaining why you need the drug you’re requesting. Check with your plan to find out if the supporting statement is required to be made in writing. The plan’s decision-making time period begins once your plan gets the supporting statement.

How do I appeal if I have Medicare prescription drug coverage?

You can either request a coverage determination before you pay for or get your prescriptions, or you can decide to pay for the prescription, save your receipt, and request that the plan pay you back by requesting a coverage determination. Check the “Evidence of Coverage” you get from your plan for more information on getting reimbursed for out-of-pocket costs.

You can file a standard request for any coverage determination, or if you haven’t already paid for the drug yourself, you can file an expedited (fast) request. See timeframes below.

How do I file a standard coverage determination?

You, your representative, your doctor, or other prescriber can request a coverage determination (including an exception) by following the instructions that your plan sends you. Once your plan has gotten your request, it has 72 hours to notify you of its decision with respect to requests for drug benefits, and 14 calendar days for requests for payment.

You can call your plan, write them a letter, or send them a completed “Model Coverage Determination Request” form to ask your plan for a coverage determination or exception. This form is available at cms.gov/medprescriptdrugapplgriev/13_forms.asp, or call your plan and ask for a copy. Your plan must accept any written request for a coverage determination from you, your representative, your doctor, or your other prescriber.

How do I file an expedited (fast) coverage determination?

You, your representative, your doctor, or other prescriber can call or write your plan to request that a fast decision be made within 24 hours of your request. You’ll get a fast decision if your plan determines, or your doctor or other prescriber tells your plan, that waiting 72 hours for a decision may seriously jeopardize your life, health, or ability to regain maximum function. You can’t request (and won’t get) a fast decision if you’ve already paid for and gotten the drug.

Words in **red** are defined on pages 59–62.

How do I appeal if I have Medicare prescription drug coverage?

You can call your plan, write them a letter, or send them a completed “Model Coverage Determination Request” form to ask your plan for a fast coverage determination or exception. This form is available at cms.gov/medprescriptdrugapplgriev/13_forms.asp, or call your plan and ask for a copy.

What if I disagree with the decision?

Your **Medicare drug plan** will send you a written decision. If you disagree with this decision, you have the right to **appeal**.

What’s the appeals process for Medicare prescription drug coverage?

The appeals process has 5 levels:

Level 1: Redetermination from your plan

Level 2: Reconsideration by an Independent Review Entity (IRE)

Level 3: Hearing before an Administrative Law Judge (ALJ)

Level 4: Review by the Medicare Appeals Council (Appeals Council)

Level 5: Judicial review by a federal district court

If you disagree with the decision made at any level of the process, you can generally go to the next level. At each level, you’ll get instructions on how to move to the next level of appeal.

Level 1: Redetermination from your plan

If you disagree with your plan’s initial denial (coverage determination), you can request a redetermination.

You must request the redetermination within 60 days from the date of the coverage determination.

How do I appeal if I have Medicare prescription drug coverage?

How do I request a redetermination?

Follow the directions in the plan's initial denial notice and plan materials. You, your representative, your doctor, or other prescriber can request a standard or expedited (fast) redetermination.

You can't request a fast redetermination if it's an **appeal** about payment for a drug you already got. Standard requests must be made in writing, unless your plan allows you to file a standard request orally, like by phone. You'll get a fast decision if your plan determines, or your doctor or other prescriber tells your plan, that waiting for a standard decision may seriously jeopardize your life, health, or ability to regain maximum function.

Your plan must accept any written request for a redetermination from you, your representative, your doctor, or other prescriber.

A written request to appeal should include:

- Your name, address, and **Medicare** number or member number.
- The name of the drug you want your plan to cover.
- Reason(s) why you're appealing.
- If you've appointed a representative, include the name of your representative and proof of representation. For more information on appointing a representative, see Section 1.

Send your request along with any other information that may help your case, including medical records. Your plan's address and phone number is in your plan materials and will also be in any written plan decision you get.

Your plan will respond in a "Redetermination Notice" within these timeframes:

- Expedited (fast) redetermination decision—as quickly as your health condition requires, but no later than 72 hours
- Standard redetermination decision—7 days

If you disagree with the plan's redetermination decision in level 1, you can request a reconsideration by an Independent Review Entity (IRE), which is level 2, within 60 days from the date of the redetermination decision.

Words in **red** are defined on pages 59–62.

How do I appeal if I have Medicare prescription drug coverage?

Level 2: Reconsideration by an Independent Review Entity (IRE)

If your **Medicare drug plan** decides against you in level 1, it will send you a written decision. If you disagree with the plan's redetermination, you, your representative, or your doctor or other prescriber can request a standard or expedited (fast) reconsideration by an IRE. You can't request a fast redetermination if it's an **appeal** about payment for a drug you already got.

How do I request a reconsideration?

To request a reconsideration by an IRE, follow the directions in the plan's "Redetermination Notice." If your plan issues an unfavorable redetermination, it should also send you a "Request for Reconsideration" form that you can use to ask for a reconsideration. If you don't get this form, call your plan and ask for a copy. This form is also available at [cms.gov/medprescriptdrugapplgriev/13_forms.asp](https://www.cms.gov/medprescriptdrugapplgriev/13_forms.asp).

Send your request to the IRE at the address or fax number listed in the plan's redetermination decision letter that's mailed to you. You'll get a fast reconsideration decision if the IRE determines, or your prescriber tells the IRE, that waiting for a standard decision may seriously jeopardize your life, health, or ability to regain maximum function.

Once the IRE gets the request for review, it will send you its decision in a "Reconsideration Notice" within these timeframes:

- Expedited (fast) reconsideration decision—as quickly as your health condition requires, but no later than 72 hours
- Standard reconsideration decision—7 days

Note: Some IREs call themselves "Part D QICs."

If you disagree with the IRE's decision in level 2, you have 60 days after you receive the IRE's decision to request an Administrative Law Judge (ALJ) hearing, which is level 3.

How do I appeal if I have Medicare prescription drug coverage?

Level 3: Hearing before an Administrative Law Judge (ALJ)

A hearing before an ALJ allows you to present your **appeal** to a new person who will review the facts of your appeal independently and listen to your testimony before making a new and impartial decision. An ALJ hearing is usually held by phone or video-teleconference, or in some cases, in person. You can also ask the ALJ to make a decision without a hearing, and the ALJ may also issue a decision without holding a hearing if the evidence in the hearing record supports a decision that's fully in your favor.

At the ALJ hearing, you'll have the chance to explain why your **Medicare drug plan** should cover your drug or pay you back. You can also ask your doctor or other prescriber to join the hearing and explain why he or she believes the drug should be covered.

To get an ALJ hearing, the amount of your case must meet a minimum dollar amount. For 2017, the required minimum amount is \$160. The ALJ will decide if your case meets the minimum dollar amount. You may be able to combine **claims** to meet the minimum dollar amount.

Words in **red** are defined on pages 59–62.

How do I request a hearing?

Follow the directions on the IRE's reconsideration notice to request an ALJ hearing. Your request must be sent to the Office of Medicare Hearings and Appeals (OMHA) address listed in the IRE's reconsideration notice. Only you or your representative can file a request in one of these ways:

1. Fill out a "Request for Hearing by an Administrative Law Judge" form (CMS Form number 20034 A/B). To get a copy visit cms.gov/cmsforms/downloads/cms20034ab.pdf, or call 1-800-MEDICARE (1-800-633-4227) and ask for a copy. TTY users can call 1-877-486-2048.

How do I appeal if I have Medicare prescription drug coverage?

2. Submit a written request to the OMHA office. Your letter must include:
 - Your name, address, phone number, **Medicare** number, and the name of your **Medicare Prescription Drug Plan**. If you've appointed a representative, include the name, address, and phone number of your representative.
 - The **appeal** case number included on the reconsideration notice.
 - The prescription drug in dispute. See your redetermination or reconsideration notice for this information.
 - The reason why you disagree with the reconsideration decision.
 - Any other information that may help your case. If you can't include this information with your request, include a statement explaining what you plan to submit and when you'll submit it.
 - If you're requesting an expedited (fast) decision, include a statement that indicates this.
3. If you're requesting an expedited (fast) hearing, you can make an oral request. Follow the instructions in the IRE's decision notice to do this. The ALJ will give you a fast decision if your doctor or other prescriber indicates, or the ALJ determines, that waiting 90 days for a decision may seriously jeopardize your life, health, or ability to regain maximum function. You can't request (and won't get) a fast decision if you already got the drug.

Once the ALJ gets the request for review, you'll get a decision. If you request an expedited (fast) ALJ decision, you'll get a decision as quickly as your health condition requires, but generally no later than 10 days beginning on the day your request for hearing is received by the appropriate OMHA field office, unless that time period is extended.

To learn more about the ALJ hearing process, visit hhs.gov/omha and select "Coverage and Claims Appeals." If you need help filing an appeal with an ALJ, call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

How do I appeal if I have Medicare prescription drug coverage?

If you disagree with the ALJ's decision in level 3, you have 60 days after you get the ALJ's decision to request a review by the Medicare Appeals Council (Appeals Council), which is level 4.

Words in red are defined on pages 59–62.

Level 4: Review by the Medicare Appeals Council (Appeals Council)

You can request that the Appeals Council review your case, regardless of the dollar amount of your case.

How do I request a review?

To request that the Appeals Council review the ALJ's decision in your case, follow the directions in the ALJ's hearing decision you got in level 3. Your request must be sent to the Appeals Council at the address listed in the ALJ's hearing decision. You or your representative can file a request for Appeals Council review in one of these ways:

1. Fill out a “Request for Review of an Administrative Law Judge (ALJ) Medicare Decision/Dismissal” form (DAB-101). To get a copy, visit hhs.gov/dab/divisions/dab101.pdf, or call 1-800-MEDICARE (1-800-633-4227) and ask for a copy. TTY users can call 1-877-486-2048.
2. Submit a written request to the Appeals Council that includes:
 - Your name, address, phone number, Medicare number, and the name of your Medicare Prescription Drug Plan. If you've appointed a representative, include the name and address of your representative.
 - The prescription drug in dispute. See your IRE reconsideration notice or your ALJ hearing decision for this information.
 - A statement identifying the parts of the ALJ's decision with which you disagree and an explanation of why you disagree.
 - The ALJ appeal case number.

How do I appeal if I have Medicare prescription drug coverage?

- If you're requesting an expedited (fast) decision, include a statement that indicates this.
 - Your signature. If you've appointed a representative, include the signature of your representative.
3. If you're requesting an expedited (fast) review, you can make an oral request. Follow the instructions in the ALJ's decision notice to do this. The Appeals Council will give you a fast decision if your doctor or other prescriber indicates, or the Appeals Council determines, that waiting 90 days for a decision may seriously jeopardize your life, health, or ability to regain maximum function. You can't request (and won't get) a fast decision if you already got the drug.

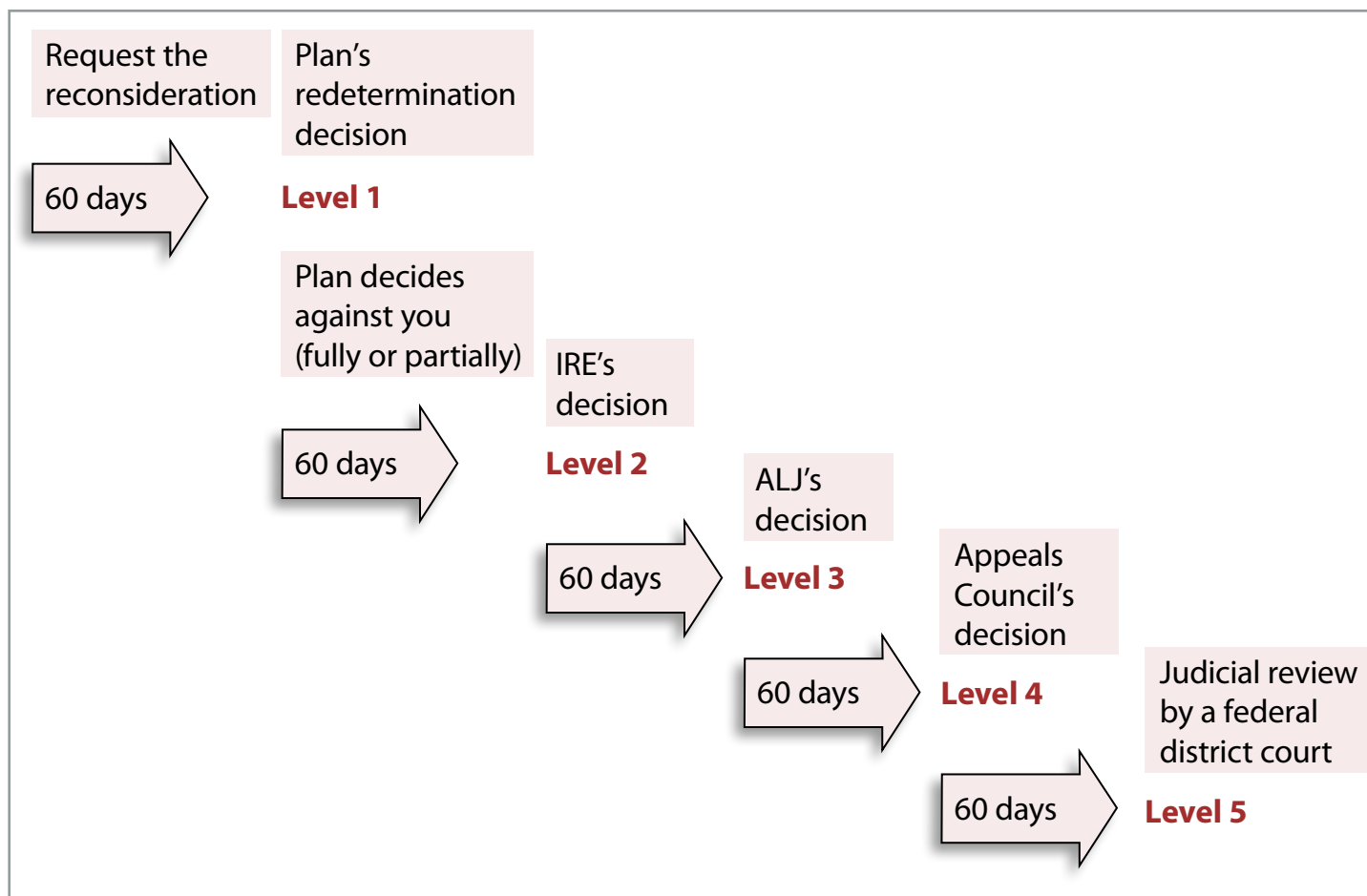
Once the Appeals Council gets the request for review, you'll get a decision. Expedited (fast) Appeals Council decision, you'll get a decision as quickly as your health condition requires, but generally no later than 10 days beginning on the day the Appeals Council receives the request for review, unless that time period is extended.

To learn more about the Appeals Council review process, visit hhs.gov/dab and select "Medicare Appeals Council." If you need help filing a request for Appeals Council review, call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

Words in **red** are defined on pages 59–62.

If you disagree with the Appeals Council's decision in level 4, you have 60 days after you get the Appeals Council's decision to request judicial review by a federal district court, which is level 5.

How do I appeal if I have Medicare prescription drug coverage?



Level 5: Judicial review by a federal district court

If you disagree with the decision issued by the Appeals Council, you can request judicial review in federal district court. To get a review, the amount of your case must meet a minimum dollar amount. For 2017, the minimum dollar amount is \$1,560. You may be able to combine **claims** to meet this dollar amount.

How do I request a review?

Follow the directions in the Appeals Council's decision letter you got in level 4 to file a complaint in federal district court. You should check with the clerk's office of the federal district court for instructions about how to file the **appeal**. The court location is on the Appeals Council's decision notice.

How do I appeal if I have Medicare prescription drug coverage?

Words in **red** are defined on pages 59–62.

For more information on the appeals process:

- Visit [Medicare.gov/appeals](https://www.medicare.gov/appeals).
- Call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.
- Visit [Medicare.gov/claims-and-appeals/file-an-appeal/appeals-forms.html](https://www.medicare.gov/claims-and-appeals/file-an-appeal/appeals-forms.html).
- Call your **State Health Insurance Assistance Program (SHIP)** for free, personalized health insurance counseling, including help with **appeals**. To get the phone number for the SHIP in your state, visit shiptacenter.org, or call 1-800-MEDICARE.

How do I file a grievance or complaint?

If you have a concern or a problem with your plan that isn't a request for coverage or reimbursement for a drug, you have the right to file a complaint (also called a "**grievance**").

Some examples of why you might file a complaint include:

- You believe your plan's customer service hours of operation should be different.
- You have to wait too long for your prescription.
- The company offering your plan is sending you materials that you didn't ask to get and aren't related to the drug plan.
- The plan didn't make a timely decision about a coverage determination in level 1 and didn't send your case to the IRE.
- You disagree with the plan's decision not to grant your request for an expedited (fast) coverage determination or first-level appeal (called a "redetermination").
- The plan didn't provide the required notices.
- The plan's notices don't follow **Medicare** rules.

How do I appeal if I have Medicare prescription drug coverage?

If your complaint involves the quality of care you got or are getting, you can file a **grievance** with your plan and/or your **Beneficiary and Family Centered Quality Improvement Organization (BFCC-QIO)**. For the phone number of your BFCC-QIO, visit [Medicare.gov/contacts](https://www.medicare.gov/contacts), or call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

If you want to file a complaint:

- You must file your complaint within 60 days from the date of the event that led to the complaint.
- You can file your complaint with the plan over the phone or in writing.
- You must be notified of the plan's decision generally no later than 30 days after the plan gets the complaint.
- If the complaint relates to a plan's refusal to make an expedited (fast) coverage determination or redetermination and you haven't yet purchased or received the drug, the plan must notify you of its decision within 24 hours after it gets the complaint.

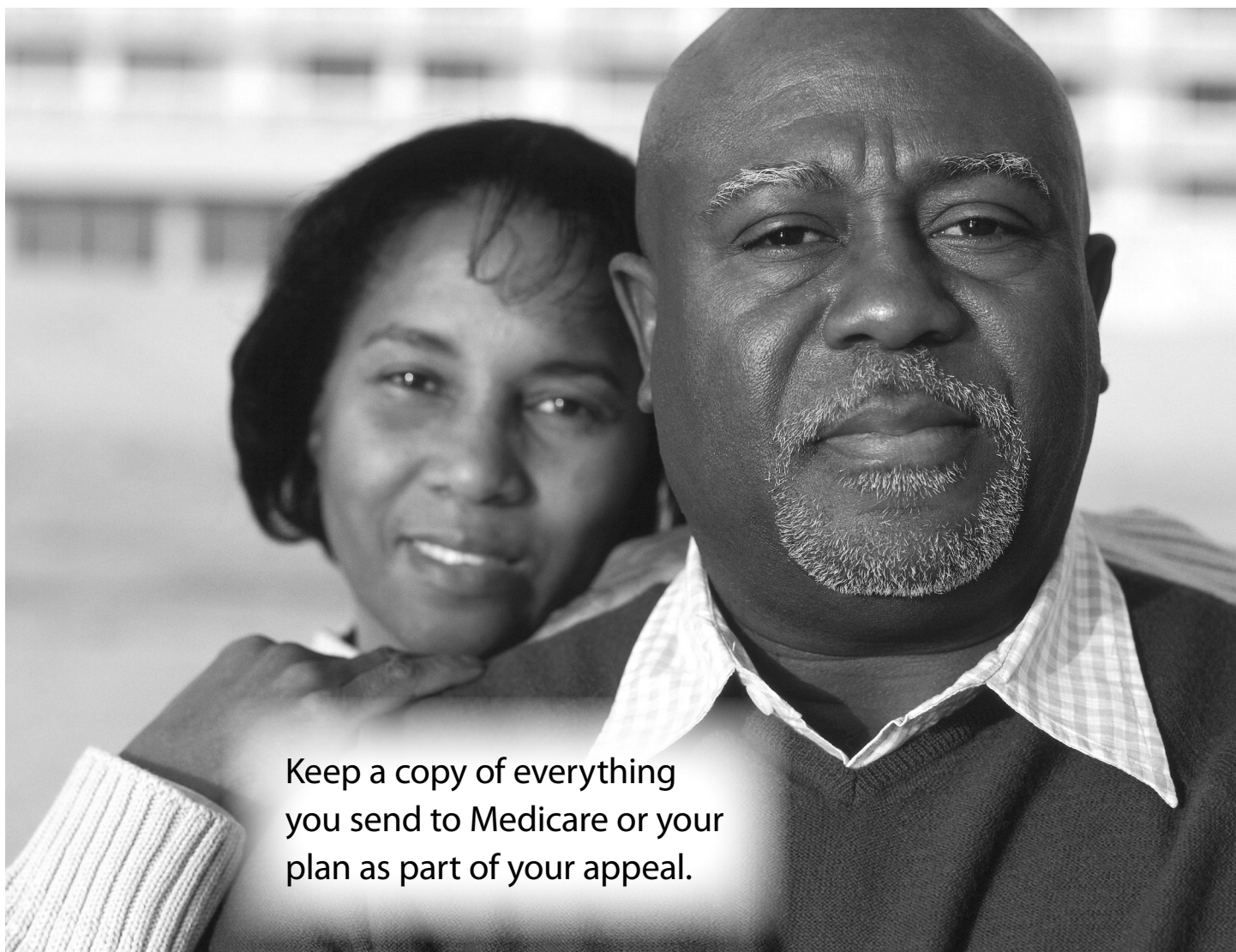
If the plan doesn't address your complaint, call 1-800-MEDICARE.

More information on filing a complaint

- Visit [Medicare.gov/appeals](https://www.Medicare.gov/appeals).
- Call your **SHIP** for free, personalized counseling and help filing a complaint. To get the phone number of the SHIP in your state, visit [shiptacenter.org](https://www.shiptacenter.org), or call 1-800-MEDICARE.

4

How do I appeal if I have Medicare prescription drug coverage?



Keep a copy of everything
you send to Medicare or your
plan as part of your appeal.

Appeal—An appeal is the action you can take if you disagree with a coverage or payment decision made by Medicare, your Medicare health plan, or your Medicare Prescription Drug Plan. You can appeal if Medicare or your plan denies one of these:

- Your request for a health care service, supply, item, or prescription drug that you think you should be able to get
- Your request for payment for a health care service, supply, item, or prescription drug you already got
- Your request to change the amount you must pay for a health care service, supply, item or prescription drug

You can also appeal if Medicare or your plan stops providing or paying for all or part of a health care service, supply, item, or prescription drug you think you still need.

Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO)—A type of QIO (a group of doctors and other health care experts under contract with Medicare) that uses doctors and other health care experts to review complaints and quality of care for people with Medicare. The BFCC-QIO makes sure there is consistency in the case review process while taking into consideration local factors and local needs, including general quality of care and medical necessity.

Claim—A request for payment that you submit to Medicare or other health insurance when you receive items and services that you think are covered.

Coinsurance—An amount you may be required to pay as your share of the cost for services after you pay any deductibles. Coinsurance is usually a percentage (for example, 20%).

Comprehensive outpatient rehabilitation facility (CORF)—A facility that provides a variety of services on an outpatient basis, including physicians' services, physical therapy, social or psychological services, and rehabilitation.

Copayment—An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit, or a prescription drug. A copayment is usually a set amount, rather than a percentage. For example, you might pay \$10 or \$20 for a doctor's visit or prescription drug.

Custodial care—Nonskilled personal care, such as help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around, and using the bathroom. It may also include the kind of health-related care that most people do themselves, like using eye drops. In most cases, Medicare doesn't pay for custodial care.

Deductible—The amount you must pay for health care or prescriptions, before Original Medicare, your prescription drug plan, or your other insurance begins to pay.

Formulary—A list of prescription drugs covered by a prescription drug plan or another insurance plan offering prescription drug benefits. Also called a drug list.

Grievance—A complaint about the way your Medicare health plan or Medicare drug plan is giving care. For example, you may file a grievance if you have a problem calling the plan or if you're unhappy with the way a staff person at the plan has behaved towards you. However, if you have a complaint about a plan's refusal to cover a service, supply, or prescription, you file an appeal.

Health care provider—A person or organization that is licensed to give health care. Doctors, nurses, and hospitals are examples of health care providers.

Home health agency (HHA)—An organization that provides home health care.

Hospice—A special way of caring for people who are terminally ill. Hospice care involves a team-oriented approach that addresses the medical, physical, social, emotional, and spiritual needs of the patient. Hospice also provides support to the patient’s family or caregiver.

Medically necessary—Health care services or supplies needed to diagnose or treat an illness, injury, condition, disease, or its symptoms and that meet accepted standards of medicine.

Medicare—The federal health insurance program for people who are 65 or older, certain younger people with disabilities, and people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant, sometimes called ESRD).

Medicare Advantage Plan (Part C)—A type of Medicare health plan offered by a private company that contracts with Medicare to provide you with all your Part A and Part B benefits. Medicare Advantage Plans include Health Maintenance Organizations, Preferred Provider Organizations, Private Fee-for-Service Plans, Special Needs Plans, and Medicare Medical Savings Account Plans. If you’re enrolled in a Medicare Advantage Plan, Medicare services are covered through the plan and aren’t paid for under Original Medicare. Most Medicare Advantage Plans offer prescription drug coverage.

Medicare health plan—Generally, a plan offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the plan. Medicare health plans include all Medicare Advantage Plans, Medicare Cost Plans, and Demonstration/Pilot Programs. Programs of All-inclusive Care for the Elderly (PACE) organizations are special types of Medicare health plans that can be offered by public or private entities and provide Part D and other benefits in addition to Part A and Part B benefits.

Medicare Part A (Hospital Insurance)—Part A covers inpatient hospital stays, care in a skilled nursing facility, hospice care, and some home health care.

Medicare Part B (Medical Insurance)—Part B covers certain doctors' services, outpatient care, medical supplies, and preventive services.

Medicare Prescription Drug Plan (Part D)—Part D adds prescription drug coverage to Original Medicare, some Medicare Cost Plans, some Medicare Private-Fee-for-Service Plans, and Medicare Medical Savings Account Plans. These plans are offered by insurance companies and other private companies approved by Medicare. Medicare Advantage Plans may also offer prescription drug coverage that follows the same rules as Medicare Prescription Drug Plans.

Medicare Summary Notice (MSN)—A notice you get after the doctor, other health care provider, or supplier files a claim for Part A or Part B services in Original Medicare. It explains what the doctor, other health care provider, or supplier billed for, the Medicare-approved amount, how much Medicare paid, and what you must pay.

Original Medicare—Original Medicare is a fee-for-service health plan that has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance). After you pay a deductible, Medicare pays its share of the Medicare-approved amount, and you pay your share (coinsurance and deductibles).

Skilled nursing facility (SNF)—A nursing facility with the staff and equipment to give skilled nursing care and, in most cases, skilled rehabilitative services and other related health services.

State Health Insurance Assistance Program (SHIP)—A state program that gets money from the federal government to give free local health insurance counseling to people with Medicare.

Supplier—any company, person, or agency that gives you a medical item or service, except when you're an inpatient in a hospital or skilled nursing facility.

**U.S. DEPARTMENT OF HEALTH
AND HUMAN SERVICES**

Centers for Medicare & Medicaid Services
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Baltimore, MD 21244-1850

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This booklet is available in Spanish. To get a free copy, call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

¿Necesita usted una copia en español?
Para obtener su copia GRATIS, llame al
1-800-MEDICARE (1-800-633-4227).

Frequently Asked Questions
(www.MedicareAdvocacy.org)

Frequently Asked Questions (FAQs) Regarding the Jimmo v. Sebelius “Improvement Standard” Settlement

[medicareadvocacy.org/jimmo-v-sebelius-the-improvement-standard-case-faqs/](https://www.medicareadvocacy.org/jimmo-v-sebelius-the-improvement-standard-case-faqs/)

General

1. **Question:** Are professional therapy services available under Medicare only for patients who are improving or who are expected to improve?

Answer: No. The *Jimmo* Settlement confirms that services by a physical therapist, occupational therapist, and speech and language pathologist are covered by Medicare, Parts A and B, and by Medicare Advantage Plans in skilled nursing facilities, home health, and outpatient therapy, when the services are necessary to maintain a patient’s current condition or to prevent or slow a patient’s further decline or deterioration.

2. **Question:** Is it fraud for a skilled nursing facility, home health agency, or outpatient therapy provider to continue to provide skilled nursing or skilled therapy services to a patient who is not improving?

Answer: No. As long as the *Jimmo* Settlement is followed, the patient continues to need professional nursing or professional therapy services to maintain the patient’s condition or to prevent or slow the patient’s decline or deterioration, and all relevant coverage criteria for the particular health care setting are met, Medicare covers the services and the health care provider is not committing fraud.

3. **Question:** Does *Jimmo* apply only to specified medical conditions, such as multiple sclerosis and Parkinson’s Disease?

Answer: No. The Settlement is not limited to any particular condition or disease. It applies to any Medicare patient who requires skilled nursing or skilled therapy to maintain the patient’s current condition or to prevent or slow the patient’s further decline or deterioration, regardless of the patient’s underlying illness, disability, or injury. The Settlement is not limited to people with chronic conditions and applies equally, for example, to patients who had a stroke. The fundamental issue for coverage under the standard clarified by *Jimmo* is whether the patient needs professional services to maintain function or to prevent or slow decline or deterioration.

4. **Question:** Are there time limits for the coverage of skilled nursing and skilled therapy services?

Answer: The *Jimmo* Settlement does not include any time limits for Medicare coverage.

The rules for the health care settings covered by *Jimmo* vary.

For **home health**, as long as the skilled nursing or skilled therapy services are necessary to maintain the patient's functioning or to prevent or slow the patient's decline or deterioration, there are no time limits to home health care. Medicare beneficiaries are entitled to ongoing coverage, which may last years, as long as all coverage criteria are met.

There are similarly no time limits for **outpatient therapy**. Medicare has therapy "caps" for payment for covered services, but there is an exceptions process that authorizes coverage for medically necessary therapy services that exceed the caps. The exceptions process is applicable to maintenance therapy as well as to therapy that is provided with an expectation of improvement.

Coverage for a stay in a **skilled nursing facility** under Medicare Part A is limited to 100 days in a benefit period for residents needing therapy services five days a week. (Under Part A, Medicare covers room and board, nursing services, therapy services, and medications.) However, if a skilled nursing facility resident has used all 100 days in a benefit period or if the resident needs fewer than five days a week of skilled therapy services, these services can be covered by Medicare Part B. The coverage standards for therapy under Parts A and B are the same. However, Part B payments can continue indefinitely, if coverage standards are met.

5. **Question:** Does the *Jimmo* Settlement apply only in the state of Vermont?

Answer: No. The Settlement applies to the entire country. The federal district court judge certified a nationwide class of Medicare beneficiaries.

6. **Question:** If a patient has plateaued, does Medicare coverage for skilled nursing or skilled therapy services stop, unless the patient deteriorates?

Answer: No. The Medicare program does not require a patient to decline before covering medically necessary skilled nursing or skilled therapy. If a patient is no longer improving and the basis of Medicare coverage is expected to shift to maintenance, the nurse or therapist must assess the patient and develop a plan of care to reflect the new maintenance goals. The nurse or therapist must document the maintenance goals in the plan of care and in the nursing or therapy notes.

7. **Question:** Does the *Jimmo* Settlement apply to patients who have dementia?

Answer: Yes. Dementia is not a disqualifying condition for Medicare coverage. If the patient needs skilled therapy to maintain the patient's current condition or to prevent or slow the patient's decline or deterioration, Medicare covers the therapy services, as long as all other coverage criteria are met. Skilled professional therapists are trained to work with patients who have dementia.

8. **Question:** What are some appropriate goals for maintenance therapy?

Answer: Maintenance therapy goals include preventing unnecessary, avoidable complications from a chronic condition, such as deconditioning, muscle weakness from lack of mobility, and muscle contractures. Maintenance therapy goals also include reducing fatigue, promoting safety, and maintaining strength and flexibility.

For a patient with a progressive neurologic condition, appropriate maintenance therapy goals include maintaining joint flexibility, preventing contractures, reducing the risk for skin breakdown, and ensuring appropriate positioning.

9. **Question:** Does the *Jimmo* Settlement apply to Medicare patients whose health care providers are in Accountable Care Organizations (ACO)?

Answer: Yes. Medicare patients who see health care providers that are participating in a Medicare ACO maintain all their Medicare rights, including application of the clarified standard for coverage of skilled care under *Jimmo*. Just as with any other Medicare patient, no “rules of thumb” should be used to determine coverage. An individualized assessment of the patient’s medical condition and of the reasonableness and necessity of the treatment is required.

Example: After a hospitalization, a patient receives skilled physical and occupational therapy in a skilled nursing facility for 14 days. While she is no longer improving, she still requires daily skilled therapy to maintain and prevent deterioration, and otherwise meets all coverage requirements. It is appropriate for her to continue to receive Medicare coverage in the skilled nursing facility, regardless of whether her providers are in an ACO. Just as for any other person in Medicare, there is no arbitrary cut-off for coverage in a skilled nursing facility for patients in ACOs. An individualized assessment is necessary, and coverage may continue as long as the patient has a continuing need for skilled therapy or nursing. Note that the maximum of 100 days per benefit period still applies, and that the medical record must support the fact that the patient requires skilled care.

10. **Question:** Does the *Jimmo* Settlement apply to beneficiaries in Medicare Advantage plans?

Answer: Yes. Medicare Advantage plans must cover the same Part A and Part B benefits as original Medicare, and must also apply the clarified standard for coverage of skilled care under *Jimmo*. Just as with any other Medicare patient, no “rules of thumb” should be used to determine coverage. An individualized assessment of the patient’s medical condition and of the reasonableness and necessity of the treatment is required.

Example: After an acute episode a patient in a Medicare Advantage plan is receiving skilled nursing home visits and home health aides covered by her plan. She has congestive heart failure, diabetes, leg and foot ulcers, and, after three weeks, is deemed to be “chronic.” The training and judgment of a skilled nurse are still necessary to monitor, manage, and assess

her multiple serious conditions, which have the reasonable potential to change and result in an adverse event. It is appropriate for her plan to continue coverage. The fact that she is “chronic” or in a Medicare Advantage plan is not relevant. Note that all other coverage criteria, such as being “homebound,” must also continue to be met, and the documentation should reflect the reasons why the skilled nursing visits continue to be reasonable and necessary.

Therapy Services (All Settings)

11. **Question:** Do maintenance therapy patients have goals?

Answer: Yes. A patient who is receiving skilled therapy, as outlined in the law, regulations, and Medicare Benefit Policy Manual, requires a discipline-specific, patient-centered care plan. One component of this care plan is goal statements, developed by the qualified therapist and based on an assessment of the patient. The goals reflect the intent and scope of the skilled therapy.

12. **Question:** What qualifies a patient for therapist-provided maintenance services under the Medicare benefit?

Answer: Since maintenance services are considered skilled care, the patient must meet the setting-specific qualifying criteria outlined in the law, regulations, and Medicare Benefit Policy Manual. Once those criteria have been confirmed, the qualified therapist will, after completion of a thorough assessment of the patient, select the focus of care in collaboration with the physician. If the patient is currently at a point where material improvement is not expected and decline is probable without skilled therapy care, a maintenance course of care may be developed and implemented.

13. **Question:** What qualifies a patient for discharge when receiving maintenance therapy?

Answer: A patient receiving therapy as outlined in the law, regulations, and Medicare Benefit Policy Manual, is appropriate for discharge from skilled service when the patient no longer requires the skills of an occupational therapist, physical therapist, and/or speech-language pathologist. “Skilled” services are those that can only be provided by a qualified therapist, due to the complex nature of the needed therapy procedures and/or the patient’s special medical complications that require the skills of a qualified therapist to perform a therapy service that would otherwise be considered non-skilled.

14. **Question:** What diagnoses qualify a patient for maintenance therapy?

Answer: There are no specific diagnoses that qualify a patient for maintenance therapy in and of themselves. While patients with progressive neurological conditions, such as Parkinson’s Disease, multiple sclerosis, or amyotrophic lateral sclerosis (ALS), are “logical” maintenance therapy candidates, Medicare coverage is not limited to patients with these

conditions. Coverage decisions cannot be based on only one piece of information, such as diagnosis. The qualified therapist must consider all relevant information, such as identified impairments and functional limitations, and determine if skilled interventions are essential to stabilize the situation. Per the Medicare Benefit Policy Manual Chapter 7 – Home Health Services; 40.4 – Skilled Therapy Services: “a patient's diagnosis or prognosis should never be the sole factor in deciding that a service is or is not skilled. The key issue is whether the skills of a therapist are needed to treat the illness or injury, or whether the services can be carried out by unskilled personnel.”

15. **Question:** Do maintenance therapy patients have to be reassessed?

Answer: Yes. Periodic reassessment of both the patient and the plan of care is expected to determine if the course of care is effective in situations where improvement is expected and when it is not. There are setting-specific time frames associated with formal requirements for performing reassessments. These time frames should be considered the minimum standard, as determining effectiveness should be occurring over the entire course of care.

16. **Question:** Are objective tests and measures appropriate for use with maintenance therapy patients?

Answer: Yes. Patients determined to be appropriate for maintenance therapy service(s) require assessment by a qualified therapist. This assessment, as with patients receiving therapy services under an improvement (restorative or rehabilitative) focus of care, should include a baseline quantification of impairments. When available and appropriate, the inclusion of objective tests and measures should be utilized to quantify impairments. Objective tests and measures provide valid and reliable findings that demonstrate the effectiveness of therapy and support clinical decision-making regarding continuation or discharge from therapy service(s).

The presence or absence of change in objective tests and measures from baseline to subsequent assessments may vary, depending on whether the patient is on an improvement (restorative/rehabilitative) or maintenance (stabilization) course of care.

17. **Question:** If a patient is receiving maintenance services from one discipline, must all other disciplines also provide maintenance care?

Answer: No. A maintenance focus of care does not require all disciplines to take the same approach. Once setting-specific qualifying criteria are met, each individual discipline creates a care plan specific to that discipline. Based on the assessment and periodic reassessment findings, each discipline will choose the most appropriate approach for the patient and must provide documentation that clearly supports that decision.

18. **Question:** Can a patient change from an improvement course of care to a maintenance course of care?

Answer: Yes. When it is determined by the qualified therapist that a patient requires continued skilled service and the expectation of improvement is no longer indicated, however, it may be appropriate to transition from an improvement approach to a maintenance course of care. This decision would be based on a reassessment of the patient by the qualified therapist at that point, with expectation that modification and/or updates to the existing therapy care plan, in coordination with the physician, occur prior to that transition.

19. **Question:** Can a patient change from a maintenance course of care to an improvement course of care?

Answer: Yes. A patient may need maintenance therapy to maintain strength and flexibility and to prevent deconditioning while, for example, recovering from surgery or healing from an amputation. Following the recovery or healing, the patient may then become able to participate in additional therapy, with the goal of improving. A patient who is not weight-bearing may need maintenance therapy to maintain strength and flexibility and to prevent deconditioning, but once the patient becomes weight-bearing, she may need additional therapy to regain her ability to walk.

20. **Question:** If the patient has a progressive condition, such as Parkinson's Disease, multiple sclerosis, or amyotrophic lateral sclerosis (ALS), is it expected that the patient show "progress" when receiving maintenance services?

Answer: Yes. "Progress" is not synonymous with "improvement." Progress in maintenance therapy would be the *responsiveness* of the patient to the established course of care.

Maintenance therapy is intended to stabilize or slow the natural course of deterioration with a progressive condition, or to prevent potential sequelae that may occur due to the presence of that progressive condition, such as soft tissue contracture due to limb paralysis.

Progress, or responsiveness to therapy, would be determined by the patient's capacity to function at an optimal level, consistent with the stage or severity of the underlying progressive condition.

21. **Question:** If a patient is receiving maintenance therapy through home health care, can an aide be included in the Plan of Care?

Answer: Yes, if the patient is under a home health plan of care and at least one qualifying professional service is being provided, aide services can be included as indicated, whether the focus of care is improvement or maintenance.

22. **Question:** If a patient is on a maintenance therapy program, should the patient's "rehab potential" be considered "poor?"

Answer: No. “Rehab potential” is not a *prognosis* of the patient’s underlying condition(s), but rather the qualified therapist’s clinical assessment of the patient’s ability to progress/be responsive to the maintenance therapy program (see answer #20 above). A patient with a progressive condition, such as multiple sclerosis or amyotrophic lateral sclerosis (ALS), would be expected to be responsive to the individualized, patient-centered maintenance therapy care plan developed by the qualified therapist following assessment.

23. **Question:** Once a patient can walk a specified number of feet, does skilled physical therapy end in skilled nursing facilities, home health, or outpatient therapy?

Answer: No. The ability to walk a specified distance is not the sole goal of physical therapy. Physical therapy ensures that the patient can safely navigate the patient’s own actual and personal environment. Mobility and maintenance goals are tied to the patient’s environment. Relevant factors for therapy in home care, for example, may include whether the patient needs to climb stairs to enter the home, whether the patient’s home has one floor or more, and whether the patient needs to navigate curbs and different surfaces.

Home Health Care

24. **Question:** Are there time limits in how long skilled nursing or skilled therapy can be provided in home care?

Answer: No. As long as the skilled nursing or skilled therapy services are necessary to maintain the patient’s functioning or to prevent or slow the patient’s decline or deterioration, there are no time limits to home care. Medicare patients are entitled to ongoing coverage, which may last years, as long as all coverage criteria are met.

25. **Question:** How does the maintenance coverage standard under the *Jimmo* Settlement apply to skilled observation and assessment of homebound Medicare patients?

Answer: Observation and assessment of the patient’s condition are covered where such skilled nursing services are necessary to maintain the patient’s current condition or prevent or slow further deterioration so long as the patient requires skilled care for the services to be safely and effectively performed. Depending on the unique condition of the patient, these services may continue to be reasonable and necessary for a patient for so long as there is a reasonable potential for complications, and all other coverage requirements are met.

Coverage does not depend on the patient’s restoration potential, and changes to the treatment plan or the patient’s condition are not required. A patient may appear to be chronic or stable, but because of a reasonable potential for complications, the patient may continue to require skilled care to maintain his or her condition, or to prevent or slow his or her deterioration.

The determination of coverage for maintenance nursing should be made based on the individualized assessment of the patient’s overall medical condition, and the reasonableness

and necessity of the treatment, care, or services in question.

Example: A homebound, non-ambulatory patient has non-healing leg ulcers. On occasion, the patient has been hospitalized due to infection stemming from the site. Although the patient's family performs some wound care, the treating physician has ordered a home health nurse to observe and assess the wounds and the patient once or twice each month, to timely identify clinical issues that warrant either a change or addition to the ordered treatment, education, or other appropriate intervention.

Outpatient Therapy

26. **Question:** If a physical therapist discontinues a Medicare patient's outpatient therapy because the patient's improvement has plateaued and the patient is not expected to return to his or her prior level of function, can the physician prescribe additional therapy?

Answer: Yes. The *Jimmo* Settlement allows patients who are engaged in an outpatient therapy program to continue receiving coverage for those services, even if there is no improvement and if the patient will not return to his or her prior level of function if skilled therapy continues to be needed to maintain the individual's condition or slow decline.

In addition, even though it may appear that the skills of a therapist are not ordinarily required to perform the specific procedures, skilled therapy is covered if the patient's special medical complication requires the skills of a therapist to ensure proper healing and non-skilled individuals could not safely and effectively carry out the procedures.

The *Jimmo* Settlement specifically states that skilled therapy services are covered when the specialized judgment, knowledge, and skills of a qualified therapist are necessary for performance of a maintenance program. If the non-skilled personnel cannot ensure the maintenance of the patient's condition, therapy is reasonable and necessary.

27. **Question:** If a Medicare patient exceeds the therapy cap for outpatient therapy services and requires those services to maintain his or her current function, can Medicare coverage continue?

Answer: Yes. The *Jimmo* Settlement allows patients to receive Medicare coverage for necessary outpatient therapy maintenance programs by skilled providers. Medicare is available when the therapy is required to maintain the patient's functioning and requires a qualified therapist to be safe and effective. In such circumstances, the provider should seek an "exception" to the therapy cap to continue therapy services. In addition, patients who exceed the \$1920 therapy cap or the \$3,700 threshold of manual medical review (in 2017) for therapy expenditures can seek a further review to determine whether the outpatient therapy services continue to be reasonable and necessary.

Example: A patient with Parkinson's Disease who maintains his current function through regular outpatient physical therapy and speech language pathology should seek an exception to the therapy cap (through his provider) once the cap is reached.

28. **Question:** Can a one-time consultation with a skilled therapist regarding instructions for self-care be covered by Medicare?

Answer: Yes. The *Jimmo* Settlement states that the establishment of a maintenance program by a qualified therapist and the instruction of the patient regarding a maintenance program is covered to the extent the specialized knowledge and judgment of the therapist is required. As there may be certain exercises and treatments the patient can learn through the skills of the therapist, a one-time consultation would be covered.

Example: A patient with arthritis that causes difficulty with ambulation may require an outpatient therapy session to learn targeted exercises he can do on his own to improve his walking.

29. **Question:** Can Medicare coverage continue for outpatient therapy if a physician prescribes the therapy to a Medicare patient to prevent or slow further deterioration, even if the patient continues to deteriorate?

Answer: Yes. Under the *Jimmo* Settlement, Medicare coverage for outpatient therapy depends on the patient's need for skilled care by a qualified therapist. The beneficiary's potential for improvement is not the determining factor for coverage. Therapy to maintain a patient's condition or to prevent or slow further deterioration is covered if the therapeutic procedures require a qualified therapist to be safe and effective. The issue to determine coverage is not whether the patient improves, but whether the patient requires skilled services. Slowing a patient's decline or deterioration is an appropriate goal of maintenance therapy.

Example: A patient with diabetic neuropathy and a recent lower limb amputation who receives outpatient therapy to prevent further decline in her mobility but still experiences a decline following initiation of the therapy services is still covered for the care under Medicare if, without the therapy, the patient's mobility would decline more markedly or rapidly.

30. **Question:** Can an evaluation of an already-established maintenance plan be covered for a Medicare patient who needs to be assessed for assistive equipment and other therapies in order to prevent deterioration?

Answer: Yes. Under the *Jimmo* Settlement, necessary periodic reevaluations of maintenance programs by a qualified therapist are covered to the degree that the specialized knowledge and judgment of the therapist are required. A reevaluation of a maintenance program to assess for the need for assistive devices and to prevent deterioration is a skill that requires the specialized knowledge of a therapist. If the therapist determines that the program needs revision, based on the patient's new developments, the

establishment of a new maintenance program would also be covered.

Example: A patient with functional and cognitive deficits following a traumatic brain injury who carries out therapy on his own as part of a maintenance plan may have his therapy plan reevaluated either (1) on a periodic basis to ensure that it is properly addressing his needs or (2) following some change in his condition that may necessitate corresponding changes to the therapy program.

Skilled Nursing Facilities

31. **Question:** Are there time limits in how long skilled therapy can be provided in a skilled nursing facility?

Answer: Medicare covers a maximum of 100 days in a Part A benefit period. If a skilled nursing facility resident has used all 100 days or if the resident needs fewer than five days a week of skilled therapy services (and does not need skilled nursing seven days per week) and if the resident, in either situation, continues to need skilled therapy services, these services can be covered by Medicare Part B. While the coverage standards for Parts A and B are the same, Part B payments for skilled therapy can continue indefinitely, if coverage standards are met.

32. **Question:** Is maintenance therapy available for patients who are not weight-bearing?

Answer: Yes. The physician may order therapy to maintain a patient's strength and flexibility, and to prevent deconditioning, until such time as the patient becomes weight-bearing and can safely participate in additional therapy. Similarly, a patient who needs to learn to use a prosthesis may receive maintenance therapy at the beginning of his or her stay in a skilled nursing facility in order to maintain upper body strength while the site of the amputation heals. Maintenance therapy may be provided first in these situations, followed by therapy to improve the patient's functioning, once the patient becomes weight-bearing or the patient's site of amputation has healed.

Inpatient Rehabilitation Hospitals

33. **Question:** Can an inpatient rehabilitation hospital (IRH) stay be covered if a patient is not able to return to his or her prior level of functioning but can achieve some improvement in function through IRH care?

Answer: Yes. Under the *Jimmo* Settlement, a Medicare patient's claim for inpatient rehabilitation hospital care cannot be denied simply because the patient is not expected to return to his or her prior level of functioning. While the IRH regulations do include a modified improvement standard, the patient must only be reasonably expected to make measurable improvement that will be of practical value to improve the patient's functional capacity or adaptation to impairments. The expected improvement is to be accomplished within a

reasonable period of time. Therefore, as long as there is a reasonable expectation that the patient can make some improvement in functional status, it is not required that the patient be able to return to his or her prior level of functioning.

Example: If a patient who required amputation of a lower limb is not expected to be able to return to her pre-amputation functional status, IRH care may still be reasonable and necessary if the rehabilitation physician believes that she will make measurable improvement of practical value and all other coverage criteria are met.

34. **Question:** Can inpatient rehabilitation be covered for a Medicare beneficiary who is currently making improvement, but will never be able to independently care for him- or herself?

Answer: Yes. The *Jimmo* Settlement states that inpatient rehabilitation claims cannot be denied based simply on the fact that a patient can never achieve complete independence with self-care. In an IRH, a patient's medical record only needs to demonstrate a reasonable expectation that a measurable improvement will be possible within a reasonable period of time. The patient's medical record must indicate the nature and degree of expected improvement and the expected length of time to achieve the improvement in order to properly track whether an inpatient rehabilitation stay is reasonable and necessary.

Example: If it is clear that a Medicare patient who has experienced a traumatic brain injury will not be able to be fully independent with self-care at the conclusion of therapy services, an IRH stay may still be medically reasonable and necessary, and covered by Medicare, if measurable improvement of practical value to the individual can be reasonably expected.

35. **Question:** Are there different Medicare coverage standards for the amount of therapy an IRH can provide for a patient with one of the qualifying conditions under the "60% Rule" and for patients with conditions not on the 60% Rule list?

Answer: No. There are no distinctions between Medicare IRH coverage criteria applicable to patients with one of the 13 qualifying conditions for IRH classification versus other patients. *Jimmo* does not apply only to a particular set of diagnoses, conditions, injuries or illnesses.

Example: A patient with cancer of the spine (which is not one of the 60% qualifying conditions) may need inpatient rehabilitation, and Medicare coverage, to address deteriorating function in conjunction with his health issues. The premise of the *Jimmo* Settlement applies equally to such a patient as to patients who have a condition on the 60% list. The 13 qualifying conditions are intended to determine whether a hospital or unit qualifies for classification as an IRH, not whether IRH care for a particular patient qualifies for Medicare coverage.

36. **Question:** Can an IRH continue to treat a patient if the patient has shown no improvement but the physician continues to believe there is a reasonable expectation

that the patient will demonstrate measurable improvement?

Answer: Yes. In order for the patient to receive a Medicare-covered inpatient rehabilitation stay, the patient's medical record must demonstrate ongoing and sustainable improvement that is of practical value to the patient. However, if the expectation for measurable improvement existed at the time of the patient's admission and can realistically be documented in the medical record even after no initial improvement, it is possible the IRH stay may be covered.

Example: If a formerly independent, debilitated patient does not make measurable improvement within the first seven days of an IRH stay but the physician documents the continued expectation for measurable improvement of practical value, with support from the medical record, Medicare coverage can continue.

37. **Question:** If the patient does not improve at all over the entire period of his or her stay, must the entire stay be denied as a covered Medicare service?

Answer: No. The entire stay should not necessarily be denied coverage as long as, when the patient was admitted, the medical record demonstrated a reasonable expectation that there would be a measurable, practical improvement in the patient's functional condition over a predetermined and reasonable period of time. If the patient does not achieve a measurable improvement by the expected period of time, and the physician no longer has an expectation that the patient would improve, any further inpatient care would no longer be covered. However, as long as there was an expectation of improvement during the inpatient stay, regardless of whether there was actual improvement at any time, the stay can be covered as necessary and reasonable.

Example: If a patient who had a stroke was initially determined to be appropriate for IRH care but then did not progress during the stay and was determined by the physician at the first team meeting to no longer have a reasonable expectation of improvement, subsequent days, but not the prior period, (following a reasonable amount of time to arrange for transfer or discharge) would no longer be covered.

38. **Question:** Can inpatient rehabilitation continue to be covered for a Medicare patient if he or she has achieved an improvement in functionality, will soon be discharged, but is undergoing instruction and observation over the last few days of the patient's stay?

Answer: Yes. The *Jimmo* Settlement states that daily physical improvement is not required to retain covered services. This is true even in an inpatient rehabilitation setting, as the requirements for improvement are only measured over a prescribed period of time. During a long stay, many treatment plans will move from traditional therapeutic services to patient education, equipment training, and other similar instruction to prepare patients for the return

home. The counseling and instruction towards getting the patient ready to go home are considered part of the therapy and meet the end goal of enabling the patient to safely live at home.

Example: If a patient who had a stroke and was admitted to an IRH for treatment improves to the point of being medically and functionally ready for discharge, she may receive Medicare for several more days in the IRH if those days are necessary to counsel and instruct the patient (and her caregivers) regarding safely returning to home and home exercise programs or use of mobility equipment.

39. **Question:** Can an IRH admit a functionally impaired patient whose function is deteriorating in order to prevent further deterioration and teach the patient new skills?

Answer: Yes. Pursuant to the *Jimmo* Settlement, Medicare coverage for IRH care should not be denied because a patient is not expected to achieve complete independence in the domain of self-care or because a patient is not expected to return to his or her prior level of functioning. In addition, the IRH regulations state that Medicare will only cover an IRH claim if the patient is expected to make a measurable improvement that will be of practical value to improve the patient's functional capacity or adaptation to impairments. Even though the IRH regulations require an expected measurable improvement, if the stay is for the purpose of the prevention of deterioration, the expected prevention of deterioration itself is a measurable improvement over what the patient's function would have been if he or she had not been admitted for an inpatient stay. In addition, Medicare coverage can be available if the patient makes an expected, measurable improvement to improve his or her adaptation to impairments. Therefore, assuming the other coverage criteria are met, the stay can be covered by Medicare.

Example: A medically compromised patient with a long-term spinal cord injury who starts to have increased difficulty performing activities of daily living despite a maintenance therapy program may be appropriate for IRH care if his physician has a reasonable expectation that inpatient therapy will prevent the patient's further deterioration, thereby achieving measurable improvement of practical value for the patient.

*Self-Help Packet for Outpatient Therapy
Denials*
(www.MedicareAdvocacy.org)



Self-Help Packet for Outpatient Therapy Denials Including “Improvement Standard” Denials

 medicareadvocacy.org/self-help-packet-for-outpatient-therapy-denials

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1. Introduction

Dear Medicare Patient:

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.acl.gov/Default.aspx>.

2. Checklist for Outpatient Therapy Discharges

Note: Detailed information is available by clicking links included in the checklist below, or scrolling down the page to the detailed description.

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

If your current therapy services are being cut or stopped and you wish them to continue:

☐ 1. Determine the reason for the end of services:

1. Physician's Orders expired; or
2. Therapist says services aren't coverable because you won't improve; or
3. Services are deemed no longer medically reasonable and necessary.

☐ 2. Take the appropriate steps:

- If your physician's orders have expired and you believe you need more therapy, contact your physician and ask him or her to order more care.
 - If your therapist thinks that more therapy won't be covered due to Medicare guidelines on improvement, then see <http://www.medicareadvocacy.org/medicare-info/improvement-standard/>. Suggest the therapist read CMS publications at: <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/Jimmo-FactSheet.pdf>; www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2013-Transmittals-Items/R176BP.html?DLPage=1&DLSortDir=descending; and www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8458.pdf.
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3. Checklist for Outpatient Therapy Appeals

There are several levels of appeal. The process begins when you receive the "Medicare Summary Notice." If you have been held financially responsible, you should certainly appeal. If the provider has been held financially responsible, and you want to get more therapy of a similar kind, you should also appeal.

☐ 1. After you receive the "Medicare Summary Notice," request a Redetermination. Follow the instructions on the last page of the MSN for how to file the appeal.

- You have 120 days to appeal the denial.
- Ask that the physician who ordered the care or your primary care physician write a statement explaining why the therapy was medically necessary.
- Ask your physician to give you copies of published articles or treatment guidelines supporting your argument.
- If possible also include a letter supporting the claim from the treating therapist.
- Send a copy of the letter and any other documentation in support of coverage along with your appeal

☐ 2. Receive the Redetermination decision.

☐ 3. If the Redetermination decision is unfavorable, request a Reconsideration. Follow the instructions in the decision on how to do this.

- You have 180 days to request the Reconsideration.
- Include in your appeal request that you are a beneficiary appealing the denial because your therapy was medically reasonable and necessary.
- Send copies of any additional documentation in support of coverage along with your request.

☐ 4. Receive the Reconsideration decision.

☐ 5. If the Reconsideration decision is unfavorable, request an Administrative Law Judge (ALJ) Hearing. Follow the instructions in the decision on how to do this.

- You have 60 days to request an ALJ hearing.
- Write on your appeal request and on the outside of the envelope that you are a "**BENEFICIARY-APPELLANT**."
- Write in the appeal that the therapy should be covered because it was medically reasonable and necessary.
- Indicate that you would like the hearing to be held by Video-teleconference.
- Send copies of any documentation in support of coverage along with your request.

☐ 6. Receive and respond to the written Notice of Hearing from the Office of Medicare Hearings and Appeals (OMHA). Follow the instructions in the Notice of Hearing on how to respond.

- Be sure the notice states a Video-Teleconference (VTC) is scheduled. If the hearing is not VTC, call OMHA and request VTC.
- In the response letter, request a copy of the exhibit list and case file for your records.
- Be sure to note in the response if you will have someone testify at the hearing on your behalf.

☐ 7. Receive the hearing file. Be sure it includes all records you have obtained and submitted during your appeal. If it does not, send the missing records to the ALJ.

☐ 8. Attend the hearing and argue your case. Explain in detail to the ALJ why your therapy was erroneously denied by Medicare.

- Be sure the ALJ has the additional records you submitted.

☐ 9. Receive the ALJ decision.

☐ 10. If the ALJ Decision is unfavorable, follow the instructions in the decision on how to appeal to the Medicare Appeals Council.

4. Quick Screen: Medicare Coverage for Outpatient Therapy

Coverage Criteria:

Physical, speech, and occupational therapy should be covered by Medicare Part B if the therapy meets the following criteria:

1. The patient's treating physician orders and periodically reviews the patient's therapy regimen.
2. The therapy is "medically necessary." This means that the ordered therapy is considered a specific and effective treatment for the patient's condition under accepted standards of medical practice.
3. The therapy required can be safely and effectively performed only by, or under the supervision of, a qualified therapist because of the complexity of the therapy or medical condition of the patient.

Other Important Points:

1. Many Medicare denials are based on a belief that the patient's medical condition will not significantly improve within a reasonable and predictable period of time. However, "restoration potential" is *not* required by law and a *maintenance therapy program can be covered* if therapy performed by a skilled professional is necessary to prevent further deterioration or to preserve current capabilities.
2. Therapy that can ordinarily be performed by a nonskilled person can still be covered by Medicare if the individual patient's condition is so medically complex that it requires a skilled therapist to perform or supervise the care.

Billing Information:

1. Prior to the Bipartisan Budget Act of 2018, physical, speech, and occupational therapy performed in an outpatient setting were subject to an annual Medicare payment cap.
 2. The Act, which was signed into law in February 2018, repealed outpatient therapy caps. Patients no longer need to seek additional coverage through an "exceptions process" for services provided after December 31, 2017.
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5. Outpatient Therapy Appeal Details

Typical Scenario: You are a Medicare beneficiary receiving therapy. Medicare Part B is paying for this care because it is provided by a skilled professional (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.” You believe you continue to need and will continue to benefit from the provided skilled care.

Action Steps: Medicare is an insurance program; it only pays for care that has been provided, it does not pay for 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 step is to keep the care in place. The best way to keep therapy in place is by understanding the rules about when Medicare should cover therapy and enlisting the assistance of your physician.

There are many reasons why a therapist might discharge you. However, the following two are the most common:

1. The expiration of physician orders;
2. The therapist no longer believes the therapy meets Medicare’s coverage criteria.

Often these discharges are inappropriate, done too early, and may endanger your long term health or limit your independence. If you understand the law and advocate for yourself you may be able to keep your medically reasonable and necessary care in place.

1. Expiration of Orders

Therapists work under the orders of physicians. If the physician ordered three therapy sessions, the therapist will discharge you after three therapy sessions. **If you do not think you are ready for the discharge, contact your physician and ask him or her to order more care.**

2. Reasonable and Necessary

Medicare will only pay for therapy if it is medically reasonable and necessary. Unfortunately, for a long time, many believed that Medicare would only cover therapy if the patient would improve significantly in a short period of time. The use of this illegal standard, known as the “Improvement Standard” caused patients with chronic conditions such as Multiple Sclerosis, Alzheimer's disease, ALS, Parkinson's disease, and paralysis to lose access to reasonable and necessary medical care.

Because of the devastating effect of the improvement standard on the lives of people living with chronic conditions, the lawsuit *Jimmo v. Sebelius* was brought on behalf of a nationwide class of Medicare beneficiaries. On January 24, 2013, a settlement agreement was filed. In that settlement, all parties agree, Medicare coverage does not require actual or even the possibility of improvement. You can read the agreement on the Center’s webpage at

<http://www.medicareadvocacy.org/medicare-info/improvement-standard/>. If you cannot access the settlement via the web, please call the Center at 860-456-7790 and we will send you a copy.

Since the Settlement was finalized, the Center for Medicare and Medicaid Services (CMS) published the following, clarifying that maintenance therapy is covered by Medicare:

1. <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/Jimmo-FactSheet.pdf>
2. www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2013-Transmittals-Items/R176BP.html?DLPage=1&DLSortDir=descending
3. www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8458.pdf

If your therapy is ending because your therapist believes you will not improve or not improve quickly enough, but also thinks that continued care is necessary to maintain your condition or slow deterioration, give him or her a copy of this settlement. Also encourage the therapist to read the CMS publications listed above. In addition, ask your physician to give your therapist copies of published research or clinical guidelines from professional sources supporting the medical benefit of maintenance therapy for your medical condition. This information, in combination with the *Jimmo* settlement, should convince your therapist to continue maintenance therapy and bill Medicare.

If the steps above do not succeed, Medicare denies coverage, and you continue therapy, paid by you or another agency, the denial can be appealed through the Medicare Part B appeals process.

1. Review your Medicare Summary Notices

- Medicare beneficiaries receive Medicare Summary Notices (MSN) in the mail on a quarterly basis.
- It is important to review these notices because they reflect what providers have billed Medicare for the beneficiary's care.
- If some of that care has been denied coverage, it will be reflected on the Medicare Summary Notice.
- **Beneficiaries have only 120 days to appeal these denials.**

2. If Outpatient Therapy is Denied Medicare Coverage, Consider Appealing

- If your Medicare Summary Notice (MSN) indicates that your care has been denied coverage, look to see whether you or the provider has been held financially responsible.
- If you have been held financially responsible, you should certainly appeal.
- If the therapy provider has been held financially responsible, and you want to get more therapy of a similar kind, you should also appeal.

3. Ask Your Physician for Support

- Ask your physician to write a letter explaining why your outpatient therapy was medically reasonable and necessary, including information about possible medical harm that might have occurred had you not received the therapy.
- Ask your physician to give you copies of published articles or treatment guidelines from professional organizations that support the argument that the outpatient therapy you received was medically reasonable and necessary.
- If possible also include a letter supporting the claim from the treating therapist.

4. Request a Redetermination

- Follow the instructions on the MSN regarding how to request a Redetermination.
- Circle the denial of payment for your outpatient therapy.
- Write that you are appealing the denial because the therapy was medically reasonable and necessary.
- Attach a copy of your physician's letter of support and other supporting documents.

5. Request a Reconsideration

- You will receive a "Redetermination" in the mail.
- If it is unfavorable, do not feel distressed, you can and should appeal to the next level, called a "Reconsideration."
- **You will have 180 days to request this level of appeal**
- Follow the directions on the "Redetermination" for requesting a "Reconsideration."
- Indicate that you are appealing the decision because the outpatient therapy was medically reasonable and necessary.
- Attach a copy of your physician's letter of support and other supporting documents.

6. Request an ALJ Hearing

- You should receive the "Reconsideration" decision in the mail.
- If this is a denial, again don't feel distressed, **you will have 60 days to appeal.**
- Follow the directions on the form for requesting an administrative law judge (ALJ) hearing.
- Write on the request that you are appealing because the outpatient therapy at issue was medically reasonable and necessary and should be covered by Medicare.
- Note on your request and on the outside of the envelope that you are a **BENEFICIARY-APPELLANT.**
- Indicate that you would like the hearing scheduled via video teleconference (VTC) rather than by telephone.
- Attach a copy of the letter of support from your physician and published articles or treatment guidelines that support your position.

7. Respond to the Notice of Hearing

- You will receive a written notice of hearing in the mail.
- Respond to the notice as directed.

- **Make sure that the notice states that a video teleconference is scheduled.** If it does not, contact the ALJ's legal assistant and request that the hearing be rescheduled as a video teleconference.
- Also ask the legal assistant to send you a copy of the exhibit list and hearing file.

8. Prepare for the Hearing

- When you receive the hearing file, make sure that it contains the provider's documentation regarding the care you received. If it does not, alert the legal assistant and supplement the file.
- Also make sure that it contains the letter of support from your physician and the supportive medical literature.
- Contact your therapist and see if he or she will testify at the hearing on your behalf. If he or she will, let the ALJ's legal assistant know.

9. Argue your Case

- Attend the hearing.
- Ask the ALJ to review the letter from your physician and the medical literature supporting your argument that the outpatient therapy you received was medically reasonable and necessary.
- Have the therapist explain to the ALJ why your care was medically reasonable and necessary.
- Ask the ALJ to grant Medicare Part B coverage for the care at issue.

10. The ALJ Decision

- You will receive the administrative law judge's decision in the mail.
- If it is favorable, send a copy to the provider.
- If it is unfavorable, follow the directions on the hearing decision for filing a Medicare Appeals Council request.

Conclusion

The best way to keep Medicare covered outpatient therapy in place is to know your rights and have the support of your physician. You should not lose access to therapy because you will not improve or because you have reached the financial cap. If coverage is denied, with the support of your therapist and your physician, you **can** win a Medicare appeal.

6. Additional Information

- [A Brief Summary of Medicare Coverage for Outpatient Therapy and the Improvement Myth](#)
 - [Congress DID Repeal Outpatient Therapy Caps Despite Lack of Information on Medicare.gov](#)
 - [Federal Regulations – Outpatient Physical Therapy Coverage](#) (external link)
 - [Federal Regulations – Outpatient Occupational Therapy Coverage](#) (external link)
 - [Federal Regulations – Outpatient Speech- language Pathology Coverage](#) (external link)
 - [Federal Regulations – Medicare Appeals](#) (external link)
 - [Centers for Medicare & Medicaid Services \(CMS\) Manual Provisions](#) (external link)
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A Brief Summary of Medicare Coverage for Outpatient Therapy 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 eligible. 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. 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 vs. Sebelius*, (D. VT, 1/24/2013). In *Jimmo* the judge approved a Settlement stating that Medicare coverage for outpatient therapy 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.

As of December 6, 2013, the Center’s for Medicare and Medicaid Services (CMS) Policy Manuals have been updated to reflect the settlement. The manuals now make it clear that improvement is not necessary for coverage of physical, occupational, and speech therapy.

Medicare Coverage for Outpatient Therapy

Physical therapy, occupational therapy, and speech therapy services can be covered by Medicare Part B for people residing in the community, and for those with continuing hospital or nursing home stays that are not otherwise covered by Medicare, if they meet certain criteria.

Physical therapy services involve the evaluation and treatment of various diagnoses that change a person’s ability to function. A physical therapist evaluates components of movement such as strength, range of motion, balance, endurance and mobility. Physical therapists also

provide a treatment program to help people move, reduce pain, restore function, and prevent disability.

Occupational therapy services involve the evaluation and treatment of various diagnoses that limit a person's functional independence. An occupational therapist helps a person perform activities of daily living by, for example, teaching people how to use adaptive equipment such as devices to help with bathing, dressing, or eating.

Speech-Language Pathology services involve the evaluation and treatment of speech and language disorders, which result in communication disabilities and for the diagnosis and treatment of swallowing disorders (dysphagia), regardless of the presence of a communication disability.

Medicare covers items and services that are reasonable and necessary under § 1862(a)(1)A of the Social Security Act. In addition to being medically reasonable and necessary, outpatient physical, occupational, and speech-language pathology services must meet the following criteria in order for Medicare to cover the services.

1. The therapy services are furnished while the beneficiary is under the care of a physician. 42 CFR §§ 410.59(a)(1), 410.60(a)(1) and 410.62(a)(1).
2. The services are furnished under a written plan of care that is established by a physician or a therapist before treatment is begun. 42 CFR §§ 410.59(a)(2), 410.60(a)(2), 410.62(a)(2), and 410.61(b). The written plan of care must prescribe the type, amount, frequency and duration of the therapy services, and must indicate the diagnosis and anticipated goals. 42 CFR § 410.61(c).
3. The services must be performed by, or under the direct supervision of, a therapist. All services not performed personally by the physical or occupational therapist must be performed by employees of the practice, supervised by the therapist, and included in the fee for the therapist's services. 42 CFR §§ 410.59(c)(2) and 410.60(c)(2). Services of speech-language pathology assistants are not recognized for Medicare coverage. Medicare Benefit Policy Manual (CMS Pub 100-02), Chapter 15, § 230.3C.
4. The services must be medically reasonable and necessary, which means that the services provided are considered specific and effective treatment for the patient's condition under accepted standards of medical practice. Medicare Benefit Policy Manual (CMS Pub 100-02), Chapter 15, § 220.2B.
5. The services must be sufficiently complex, or the condition of the patient is such, that the services required can be safely and effectively performed only by a therapist, or in the case of physical and occupational therapy by or under the supervision of a therapist. (Services that do not require the performance or supervision of a skilled therapist are not coverable, even if they are in fact performed or supervised by a skilled therapist). Medicare Benefit Policy Manual (CMS Pub 100-02), Chapter 15, § 220.2B.
6. The amount, frequency, and duration of the services must be reasonable under accepted standards of practice. Medicare Benefit Policy Manual (CMS Pub 100-02), Chapter 15, § 220.2B.

Important Advocacy Tips

1. Each person should get an individualized assessment regarding Medicare coverage based on his/her unique medical condition and need for care.
2. 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 multiple sclerosis, traumatic brain injury, Alzheimer's disease, Parkinson's disease, or because they need therapy "only" to maintain their condition. These are **not** legitimate reasons for Medicare denials.
3. A beneficiary's diagnosis or prognosis should never be the sole factor in deciding that a service is or is not skilled. The fact that full or partial recovery is not possible does not necessarily mean that skilled therapy is not needed to improve the patient's condition. The deciding factors are always whether the services are considered reasonable, effective treatments for the patient's condition and require the skills of a therapist.
4. Medicare recognizes that skilled services can be required to maintain an individual's condition or functioning, or to slow or prevent deterioration, including therapy to maintain the individual's condition or function.
5. Services that can ordinarily be performed by non-skilled personnel should be considered skilled services if, because of medical complications, a skilled therapist is required to perform or supervise the services.
6. 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 the skilled care and other services are required. If possible, also get a supportive statement from the physical therapist.*

The question to ask is does the patient meet the qualifying criteria listed above and need skilled therapy – not does the patient have a particular disease or will she or he improve.

Congress DID Repeal Outpatient Therapy Caps Despite Lack of Information on Medicare.gov

The Bipartisan Budget Act of 2018 became law on February 9, 2018. The Act repealed the Medicare outpatient therapy caps, which functioned as a barrier to care for those receiving outpatient therapy services. Section 50202 of the Act, “Repeal of Medicare Payment Cap for Therapy Services; Limitation to Ensure Appropriate Therapy,” states that the repeal of the therapy caps is retroactive.^[1] This means that **therapy caps have been removed for all physical therapy, occupational therapy, and speech-language pathology services provided “after December 31, 2017.”**^[2]

To date, the Centers for Medicare & Medicaid Services (CMS) has not updated the relevant CMS.Gov or Medicare.Gov webpages to account for the repeal of outpatient therapy caps. However, CMS did issue a special edition *Medicare Learning Network (MLN) Connects* newsletter to highlight the key aspects of the Act dealing with the repeal. The newsletter emphasizes that “Medicare claims are no longer subject to the therapy caps (one for occupational therapy services and another for physical therapy and speech-language pathology combined).”^[3]

Thus, Medicare beneficiaries and providers are no longer required to seek additional coverage beyond a set dollar amount through the former “exceptions process.” However, claims above the former cap threshold must still “include the KX modifier as a confirmation that services are medically necessary as justified by appropriate documentation in the medical record.” ^[4]

Together with the Settlement Agreement in *Jimmo v. Sebelius*, No. 11-cv-17 (D. VT), Medicare beneficiaries should now be able to continue receiving outpatient therapy to improve or maintain their current conditions, or to slow or prevent the further deterioration of their conditions, without having to overcome arbitrary payment caps as barriers to care.

- To read the Bipartisan Budget Act of 2018, please visit: <https://www.gpo.gov/fdsys/pkg/BILLS-115hr1892enr/pdf/BILLS-115hr1892enr.pdf>
- To read CMS’s Medicare Learning Network Connects newsletter, please visit: <https://www.cms.gov/Center/Provider-Type/All-Fee-For-Service-Providers/Downloads/Medicare-Expired-Legislative-Provisions-Extended.pdf>
- For more information on the *Jimmo* Settlement Agreement, please visit: <http://www.medicareadvocacy.org/medicare-info/improvement-standard/>

Medicare beneficiaries who are told they cannot continue therapy because they have reached a therapy cap should direct their physicians and therapists, or any Medicare contractors reviewing their claim, to the repeal language in the Bipartisan Budget Act of 2018 and the MLN Connects newsletter.

^[1] Bipartisan Budget Act of 2018, H.R. 1892, 115th Cong. 50202 (2018) (to be codified at 42 U.S.C. § 1395l(g)).

^[2] *Id.*

[3] *Medicare Expired Legislative Provisions Extended and Other Bipartisan Budget Act of 2018 Provisions*, MLN Connects, CMS.Gov, <https://www.cms.gov/Center/Provider-Type/All-Fee-For-Service-Providers/Downloads/Medicare-Expired-Legislative-Provisions-Extended.pdf> (last visited 02/28/2018).

[4] *Id.*

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Sample Letters

Date

Re: Need for ongoing Physical Therapy

To Whom it May Concern:

Mr. _____ is a _____ year old man who has been under my care for _____ years. He has **(be specific about history: what happened?)**. Prior to the stroke _____ lived a completely independent life.

Since he has been admitted to _____ Nursing Home for rehabilitation on _____, he has been progressing nicely and working towards returning to independent living. I feel that _____ would continue to benefit from therapy because it would allow him to further strengthen and achieve more functionality to transfer to his wheelchair, to use his walker, to gain access to the toilet, and to ultimately return to independent living (PLEASE PUT IN YOUR OWN WORDS).

In addition, his symptoms which include _____ require further skilled physical therapy and occupational therapy services to prevent decline of physical and functional status in order to maintain clinical status and to return safely home or to an assisted living facility.

It is my medical and professional opinion that the skilled physical therapy services of ----- -----exercises are necessary to continue to maintain Stanley's current functional status, prevent falling _____ and _____ (PLEASE PUT IN YOUR OWN WORDS) He has no caregiver at home that can perform this exercise program with him. I am convinced that termination of these services would be detrimental to _____ health, safety, wellbeing and may put him at risk for re-hospitalization.

_____ has a track-record of superb performance with rehabilitation; he is highly motivated and eager to return to his life. I have no doubt that with continued assistance, at this time, he will be able to return to his life.

I would request that therapy be continued on an ongoing daily basis while in the nursing home and then when he returns to independent living, to secure his functional abilities.

Thank you for your prompt attention and consideration of this matter. If you have any questions please feel free to contact me at _____.

Sincerely,

M D

August 5, 2013

Re:

Issue: Need for ongoing Physical Therapy

Mrs. is a 91 year old woman under my care for over a decade. She has congestive heart failure and longstanding anxiety, but has been in independent living until falling and sustaining a hip fracture June 14, 2013 requiring ORIF.

Since that time she has been receiving physical therapy in her assisted living facility. She had been progressing nicely and working towards return to independent living.

Therapy has been discontinued under Medicare guidelines, but I feel that she would continue to benefit from therapy to allow her to strengthen and achieve more functionality to transfer to her wheelchair, to use her walker, to gain access to the toilet, and to ultimately return to independent living.

Mrs. has a track-record of superb performance with rehabilitation, having undergone extensive rehab in 2012 after a severe motor vehicle accident. Even after a prolonged hospitalization and multiple orthopedic injuries, she was able to resume independent living with the help of physical therapy to assist until she was able to function on her own. I have no doubt that with continued assistance, at this time, she will be able to do the same.

I would request that therapy be continued on an ongoing basis while in the and then when she returns to independent living, to secure her functional abilities.

MD

February 11, 2016

Re:
Address:

DOB:
Control ID:

To Whom It May Concern:

is a patient under my care for the treatment of multiple sclerosis (MS) since 2008. Her advanced MS symptoms include motor weakness, spasticity, inability to ambulate, pathological fatigue and poor endurance. Ms. is wheelchair-bound and homebound because of her symptoms.

M requires skilled physical therapy and occupational therapy services at home to prevent decline of physical and functional status in order to maintain clinical status and safety at home. She is also in need of home health aide services to assist with activities of daily living and personal care including bathing, dressing, and meal preparation.

It is my medical and professional opinion that the skilled Physical Therapy services of stretching and strengthening exercises continue to maintain Ms.' current functional status, prevent falling and prevent regression. is unable to perform self-range of motion and stretching to lower extremities secondary to severe MS symptoms. She has no caregiver at home that can perform this home exercise program once the home health aid from VNA is terminated. Termination of these services would be detrimental to her health, safety, wellbeing and may put her at risk for re-hospitalization.

Thank you for your prompt attention and consideration of this matter.

If you have any questions please feel free to contact me.

Sincerely,



, MD