

—Toolkit—

**Medicare Skilled Nursing Facility Coverage  
And *Jimmo v. Sebelius***

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**1. Introduction**

*Jimmo v. Sebelius*, No. 11-cv-17 (D. VT), is a nationwide class-action lawsuit brought on behalf of Medicare beneficiaries who received care in skilled nursing facilities, home health care, and outpatient therapy and who were denied Medicare coverage on the basis that they were not improving or did not demonstrate a potential for improvement (known as the “Improvement Standard”). On January 24, 2013, the U.S. District Court for the District of Vermont approved a Settlement in *Jimmo* between attorneys for the *Jimmo* plaintiffs (the Center for Medicare Advocacy and Vermont Legal Aid) and the Centers for Medicare & Medicaid Services (CMS).

The *Jimmo* Settlement required CMS to undertake the following to remedy the practice of erroneously denying Medicare coverage based on an “Improvement Standard:”

1. Revise the Medicare Benefit Policy Manual to eliminate any suggestion that a beneficiary must show a potential for improvement, and to confirm that a need for skilled care is the determinative factor, regardless of whether the skilled care is needed to improve or maintain the individual’s condition.
2. Engage in a nationwide Educational Campaign, using written materials, interactive forums, and national calls, to communicate the correct maintenance coverage standards to Medicare providers, contractors, and adjudicators.

After receiving input from the Center for Medicare Advocacy and Vermont Legal Aid, the Secretary of the U.S. Department of Health and Human Services (HHS) published the revised Medicare Benefit Policy Manual on December 6, 2013. The revised Manual emphasizes that coverage for **skilled nursing facility** (and home health or outpatient therapy) cannot be based on a beneficiary’s ability to improve. (CMS Transmittal 179, Pub 100-02, 1/14/2014).

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).

On February 2, 2017, the *Jimmo* Court found that CMS had not properly implemented the Educational Campaign required by the Settlement and ordered the Medicare agency to carry out a Corrective Action Plan to remedy the problems. As urged by the *Jimmo* attorneys, the Court ruled that CMS failed to explain that consideration of the need for skilled care, not the potential for improvement, should govern Medicare coverage determinations for **skilled nursing facilities** (home health, and outpatient therapy). As a result, the Corrective Action Plan required the creation of a new CMS webpage dedicated to *Jimmo*, including a Corrective Statement disavowing the Improvement Standard, *Frequently Asked Questions*, and new training for Medicare contractors who make coverage decisions.

## **2. Unfair Medicare Denials Still Happen**

Unfortunately, the Center still regularly hears from Medicare beneficiaries and their families about coverage denials for skilled care services based on some variation of an 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 and home health nursing to care for her multiple on-going 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 provides all Medicare beneficiaries with long-term and debilitating conditions with protection. The Settlement means that no Medicare beneficiary should be denied coverage for maintenance nursing or therapy provided in a **skilled nursing facility** (by a home health agency, or outpatient therapy entity) when skilled personnel must provide or supervise the care for it to be safe and effective treatment. 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 having a prior 3-day inpatient hospital stay for skilled nursing facility coverage). 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 and their families respond to unfair Medicare denials. The Toolkit includes self-help materials to advocate for coverage of skilled nursing facility care that has 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 Medicare SNF 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's Skilled Nursing Facility Benefit Policy Manual* – Chapter 8 of the Medicare Benefit Policy Manual (“Coverage of Extended Care [Skilled Nursing Facility] Services Under Hospital Insurance”)
5. *Frequently Asked Questions*, from Medicare’s website, CMS.gov
6. *Medicare Appeals Booklet* from Medicare.gov

**B. Information from the Center for Medicare Advocacy**

1. Center for Medicare Advocacy’s *Frequently Asked Questions*
2. *Self-Help Packet for Skilled Nursing Facility Appeals* (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 are entitled to under the law – and the care they need.

Let us know if we can provide further guidance.

Center for Medicare Advocacy  
January 2018

*Important Message about the Jimmo Settlement*  
([www.CMS.gov](http://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](http://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](http://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](http://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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*Counsel for Defendant*

*Jimmo* Fact Sheet  
([www.CMS.gov](http://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 Skilled Nursing Facility Benefit  
Policy Manual  
([www.CMS.gov](http://www.CMS.gov))*

# **Medicare Benefit Policy Manual**

## **Chapter 8 - Coverage of Extended Care (SNF) Services Under Hospital Insurance**

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

*30.2.2.1 – Documentation to Support Skilled Care Determinations*

30.4. - Direct Skilled *Therapy* Services to Patients

### 30 - Skilled Nursing Facility Level of Care - General

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

A3-3132, SNF-214

**Care in a SNF is covered if all of the following four factors are met:**

- The patient requires skilled nursing services or skilled rehabilitation services, i.e., services that must be performed by or under the supervision of professional or technical personnel (see [§§30.2 - 30.4](#)); are ordered by a physician and the services are rendered for a condition for which the patient received inpatient hospital services or for a condition that arose while receiving care in a SNF for a condition for which he received inpatient hospital services;
- The patient requires these skilled services on a daily basis (see [§30.6](#)); and
- As a practical matter, considering economy and efficiency, the daily skilled services can be provided only on an inpatient basis in a SNF. (See [§30.7](#).)
- The services *delivered are* reasonable and necessary for the treatment of a patient's illness or injury, i.e., *are* consistent with the nature and severity of the individual's illness or injury, the individual's particular medical needs, and accepted standards of medical practice. The services must also be reasonable in terms of duration and quantity.

If any one of these four factors is not met, a stay in a SNF, even though it might include the delivery of *some* skilled services, is not covered. For example, payment for a SNF level of care could not be made if a patient needs an intermittent rather than daily skilled service.

In reviewing *claims for* SNF services to determine whether the level of care requirements are met, the intermediary *or Medicare Administrative Contractor (MAC)* first considers whether a patient needs skilled care. If a need for a skilled service does not exist, then the "daily" and "practical matter" requirements are not addressed. *See section 30.2.2.1 for a discussion of the role of appropriate documentation in facilitating accurate coverage determinations for claims involving skilled care. Additional material on documentation appears in the various clinical scenarios that are presented throughout these level of care guidelines.*

*Coverage of nursing care and/or therapy to perform a maintenance program does not turn on the presence or absence of an individual's potential for improvement from the nursing care and/or therapy, but rather on the beneficiary's need for skilled care.*

Eligibility for SNF Medicare A coverage has not changed with the inception of PPS. However, the skilled criteria and the medical review process have changed slightly. For Medicare to render payment for skilled services provided to a beneficiary during a SNF Part A stay, the facility must complete an MDS.

**EXAMPLE:** Even though the irrigation of a suprapubic catheter may be a skilled nursing service, daily irrigation may not be “reasonable and necessary” for the treatment of a patient’s illness or injury.

### **30.2.1 - Skilled Services Defined**

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

Skilled nursing and/or skilled rehabilitation services are those services, furnished pursuant to physician orders, that:

- Require the skills of qualified technical or professional health personnel such as registered nurses, licensed practical (vocational) nurses, physical therapists, occupational therapists, and speech-language pathologists or audiologists; and
- Must be provided directly by or under the general supervision of these skilled nursing or skilled rehabilitation personnel to assure the safety of the patient and to achieve the medically desired result.

**NOTE:** “General supervision” requires initial direction and periodic inspection of the actual activity. However, the supervisor need not always be physically present or on the premises when the assistant is performing services.

*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.*

### **30.2.2 - Principles for Determining Whether a Service is Skilled**

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

**A3-3132.1.B, SNF-214.1.B**

- If the inherent complexity of a service prescribed for a patient is such that it can be performed safely and/or effectively only by or under the general supervision of skilled nursing or skilled rehabilitation personnel, the service is a skilled service; e.g., the administration of intravenous feedings and intramuscular injections; the insertion of suprapubic catheters; and ultrasound, shortwave, and microwave therapy treatments.
- The intermediary *or MAC* considers the nature of the service and the skills required for safe and effective delivery of that service in deciding whether a service is a skilled service. While a patient’s particular medical condition is a valid factor in deciding if skilled services are needed, a patient’s diagnosis or prognosis should never be the sole factor in deciding that a service is not skilled.

**EXAMPLE:** When rehabilitation services are the primary services, the key issue is whether the skills of a therapist are needed. The deciding factor is not the patient’s

potential for recovery, but whether the services needed require the skills of a therapist or whether they can be provided by nonskilled personnel. (See [§30.5](#).)

- A service that is ordinarily considered nonskilled could be considered a skilled service in cases in which, because of special medical complications, skilled nursing or skilled rehabilitation personnel are required to perform or supervise it or to observe the patient. In these cases, the complications and special services involved must be documented by physicians' orders and *notes as well as* nursing or therapy notes.

**EXAMPLE:**

Whirlpool baths do not ordinarily require the skills of a qualified physical therapist. However, the skills, knowledge, and judgment of a qualified physical therapist might be required where the patient's condition is complicated by circulatory deficiency, areas of desensitization, or open wounds. *The documentation needs to support the severity of the circulatory condition that requires skilled care (see section 30.2.2.1).*

- In determining whether services rendered in a SNF constitute covered care, it is necessary to determine whether individual services are skilled, and whether, in light of the patient's total condition, skilled management of the services provided is needed even though many or all of the specific services were unskilled.

**EXAMPLE:**

An 81-year-old woman who is aphasic and confused, suffers from hemiplegia, congestive heart failure, and atrial fibrillation, has suffered a cerebrovascular accident, is incontinent, has a Stage 1 decubitus ulcer, and is unable to communicate and make her needs known. Even though no specific service provided is skilled, the patient's condition requires daily skilled nursing involvement to manage a plan for the total care needed, to observe the patient's progress, and to evaluate the need for changes in the treatment plan. *As discussed in section 30.2.2.1 below, the medical condition of the patient must be described and documented to support the goals for the patient and the need for skilled nursing services.*

- The importance of a particular service to an individual patient, or the frequency with which it must be performed, does not, by itself, make it a skilled service.

**EXAMPLE:**

A primary need of a nonambulatory patient may be frequent changes of position in order to avoid development of decubitus ulcers. However, since such changing of position does not ordinarily require skilled nursing or skilled rehabilitation personnel, it would not constitute a skilled service, even though such services are obviously necessary.

- The possibility of adverse effects from the improper performance of an otherwise unskilled service does not make it a skilled service unless there is documentation to support the need for skilled nursing or skilled rehabilitation personnel. Although the act of turning a patient normally is not a skilled service, for some patients the skills of a nurse may be necessary to assure proper body alignment in order to avoid contractures and deformities. In all such cases, the reasons why skilled nursing or skilled rehabilitation personnel are essential must be documented in the patient's record.

### **30.2.2.1 – Documentation to Support Skilled Care Determinations** (Rev. 179, Issued: 01-14-14, Effective: 01-07-14, Implementation: 01-07-14)

*Claims for skilled care coverage need to include sufficient documentation to enable a reviewer to determine whether—*

- *Skilled involvement is required in order for the services in question to be furnished safely and effectively; and*
- *The services themselves are, in fact, reasonable and necessary for the treatment of a patient's illness or injury, i.e., are consistent with the nature and severity of the individual's illness or injury, the individual's particular medical needs, and accepted standards of medical practice. The documentation must also show that the services are appropriate in terms of duration and quantity, and that the services promote the documented therapeutic goals.*

*Such determinations would be made from the perspective of the patient's condition when the services were ordered and what was, at that time, reasonably expected to be appropriate treatment for the illness or injury. Thus, when a service appears reasonable and necessary from that perspective, it would not then be appropriate to deny the service retrospectively merely because the goals of treatment have not yet been achieved. However, if it becomes apparent at some point that the goal set for the patient is no longer a reasonable one, then the treatment goal itself should be promptly and appropriately modified to reflect this, and the patient should then be reassessed to determine whether the treatment goal as revised continues to require the provision of skilled services. By the same token, the **treatment goal itself** cannot be modified retrospectively, e.g., when it becomes apparent that the initial treatment goal of restoration is no longer a reasonable one, the provider cannot retroactively alter the initial goal of treatment from restoration to maintenance. Instead, it would make such a change on a prospective basis only.*

*Although 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 contractor would be able to confirm that skilled care is, in fact, needed and received in a given case.*



*It is expected that the documentation in the patient's medical record will reflect the need for the skilled services provided. The patient's medical record is also expected to provide important communication among all members of the care team regarding the development, course, and outcomes of the skilled observations, assessments, treatment, and training performed. Taken as a whole, then, the documentation in the patient's medical record should illustrate the degree to which the patient is accomplishing the goals as outlined in the care plan. In this way, the documentation will serve to demonstrate why a skilled service is needed.*

*Thorough and timely documentation with respect to treatment goals can help clearly demonstrate a beneficiary's need for skilled care in situations where such need might not otherwise be readily apparent, as when the treatment's purpose changes (for example, from restoration to maintenance), as well as in establishing the efficacy of care that serves to prevent or slow decline—where, by definition, there would be no “improvement” to evaluate. For example, when skilled services are necessary to maintain the patient's current condition, the documentation would need to substantiate that the services of skilled personnel are, in fact, required to achieve this goal. Similarly, establishing that a maintenance program's services are reasonable and necessary would involve regularly documenting the degree to which the program's treatment goals are being accomplished. In situations where the maintenance program is performed to maintain the patient's current condition, such documentation would serve to demonstrate the program's effectiveness in achieving this goal. When the maintenance program is intended to slow further deterioration of the patient's condition, the efficacy of the services could be established by documenting that the natural progression of the patient's medical or functional decline has been interrupted. Assessments of all goals must be performed in a frequent and regular manner so that the resulting documentation provides a sufficient basis for determining the appropriateness of coverage.*

*Therefore the patient's medical record must document as appropriate:*

- *The history and physical exam pertinent to the patient's care, (including the response or changes in behavior to previously administered skilled services);*
- *The skilled services provided;*
- *The patient's response to the skilled services provided during the current visit;*
- *The plan for future care based on the rationale of prior results.*
- *A detailed rationale that explains the need for the skilled service in light of the patient's overall medical condition and experiences;*
- *The complexity of the service to be performed;*
- *Any other pertinent characteristics of the beneficiary.*

*The documentation in the patient's medical record must be accurate, and avoid vague or subjective descriptions of the patient's care that would not be sufficient to indicate the need for skilled care. For example, the following terminology does not sufficiently describe the reaction of the patient to his/her skilled care:*

- *Patient tolerated treatment well*
- *Continue with POC*
- *Patient remains stable*

*Such phraseology does not provide a clear picture of the results of the treatment, nor the "next steps" that are planned. Objective measurements of physical outcomes of treatment should be provided and/or a clear description of the changed behaviors due to education programs should be recorded so that all concerned can follow the results of the provided services.*

### **30.2.3 - Specific Examples of Some Skilled Nursing or Skilled Rehabilitation Services**

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

**A3-3132.1.C, SNF-214.1.C**

*The following sections describe specific examples of skilled nursing or skilled rehabilitation services.*

#### **30.2.3.1 - Management and Evaluation of a Patient Care Plan**

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

**A3-3132.1.C.1, SNF-214.1.C.1**

The development, management, and evaluation of a patient care plan, based on the physician's orders *and supporting documentation*, constitute skilled nursing services when, in terms of the patient's physical or mental condition, these services require the involvement of skilled nursing personnel to meet the patient's medical needs, promote recovery, and ensure medical safety. However, the planning and management of a treatment plan that does not involve the furnishing of skilled services may not require skilled nursing personnel; e.g., a care plan for a patient with organic brain syndrome who requires only oral medication and a protective environment. The sum total of nonskilled services would only add up to the need for skilled management and evaluation when the condition of the beneficiary is such that there is an expectation that a change in condition is likely without that intervention.

*The patient's clinical record may not always specifically identify "skilled planning and management activities" as such. Therefore, in this limited context, if the documentation of the patient's overall condition substantiates a finding that the patient's medical needs and safety can be addressed only if the total care, skilled or not, is planned and managed by skilled nursing personnel, it is appropriate to infer that skilled management is being provided, but only if the record as a whole clearly establishes that there was a likely*

*potential for serious complications without skilled management, as illustrated in the following Examples.*

#### **EXAMPLE 1:**

An aged patient with a history of diabetes mellitus and angina pectoris is recovering from an open reduction of the neck of the femur. He requires, among other services, careful skin care, appropriate oral medications, a diabetic diet, a therapeutic exercise program to preserve muscle tone and body condition, and observation to notice signs of deterioration in his condition or complications resulting from his restricted (but increasing) mobility. Although any of the required services could be performed by a properly instructed person, that person would not have the capability to understand the relationship among the services and their effect on each other. Since the nature of the patient's condition, his age and his immobility create a high potential for serious complications, such an understanding is essential to assure the patient's recovery and safety. The management of this plan of care requires skilled nursing personnel until *such time as skilled care is no longer required in coordinating* the patient's treatment regimen, even though the individual services involved are supportive in nature and do not require skilled nursing personnel. *The documentation in the medical record as a whole is essential for this determination and must illustrate the complexity of the unskilled services that are a necessary part of the medical treatment and which require the involvement of skilled nursing personnel to promote the stabilization of the patient's medical condition and safety.*

#### **EXAMPLE 2:**

An aged patient is recovering from pneumonia, is lethargic, is disoriented, has residual chest congestion, is confined to bed as a result of his debilitated condition, and requires restraints at times. To decrease the chest congestion, the physician has prescribed frequent changes in position, coughing, and deep breathing. While the residual chest congestion alone would not represent a high risk factor, the patient's immobility and confusion represent complicating factors which, when coupled with the chest congestion, could create high probability of a relapse. In this situation, skilled overseeing of the nonskilled services would be reasonable and necessary, pending the elimination of the chest congestion, to assure the patient's medical safety. *The documentation in the medical record as a whole is essential for this determination and must illustrate the complexity of the unskilled services that are a necessary part of the medical treatment and which require the involvement of skilled nursing personnel to promote the patient's recovery and medical safety in view of the patient's overall condition.*

### **30.2.3.2 - Observation and Assessment of Patient's Condition**

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

**A3-3132.1.C.2, SNF-214.1.C.2**

Observation and assessment are skilled services when the likelihood of change in a patient's condition requires skilled nursing or skilled rehabilitation personnel to identify

and evaluate the patient's need for possible modification of treatment or initiation of additional medical procedures, until the patient's *condition* is essentially stabilized.

**EXAMPLE 1:**

A patient with arteriosclerotic heart disease with congestive heart failure requires close observation by skilled nursing personnel for signs of decompensation, abnormal fluid balance, or adverse effects resulting from prescribed medication. Skilled observation is needed to determine whether the digitalis dosage should be reviewed or whether other therapeutic measures should be considered, until the patient's treatment regimen is essentially stabilized. *The medical documentation must describe the skilled services that require the involvement of nursing personnel to promote the stabilization of the patient's medical condition and safety.*

**EXAMPLE 2:**

A patient has undergone peripheral vascular disease treatment including revascularization procedures (bypass) with open or necrotic areas of skin on the involved extremity. Skilled observation and monitoring of the vascular supply of the legs is required. *The medical documentation must describe the skilled services that require the involvement of nursing personnel to promote the patient's recovery and medical safety in view of the patient's overall condition.*

**EXAMPLE 3:**

A patient has undergone hip surgery and has been transferred to a SNF. Skilled observation and monitoring of the patient for possible adverse reaction to the operative procedure, development of phlebitis, *or* skin breakdown, is both reasonable and necessary. *The medical documentation must describe the skilled services that require the involvement of nursing personnel to promote the patient's recovery and medical safety in view of the patient's overall condition.*

**EXAMPLE 4:**

A patient has been hospitalized following a heart attack, and following treatment but before mobilization, is transferred to the SNF. Because it is unknown whether exertion will exacerbate the heart disease, skilled observation is reasonable and necessary as mobilization is initiated, until the patient's treatment regimen is essentially stabilized. *The medical documentation must describe the skilled services that require the involvement of nursing personnel to promote the stabilization of the patient's medical condition and safety.*

**EXAMPLE 5:**

A frail 85-year-old man was hospitalized for pneumonia. The infection was resolved, but the patient, who had previously maintained adequate nutrition, will not eat or eats poorly.

The patient is transferred to a SNF for monitoring of fluid and nutrient intake, assessment of the need for tube feeding and forced feeding if required. Observation and monitoring by skilled nursing personnel of the patient's oral intake is required to prevent dehydration. *The medical documentation must describe the skilled services that require the involvement of nursing personnel to promote the patient's recovery and medical safety in view of the patient's overall condition.*

#### **EXAMPLE 6:**

*A patient with congestive heart failure may require continuous close observation to detect signs of decompensation, abnormal fluid balance, or adverse effects resulting from prescribed medication(s) that serve as indicators for adjusting therapeutic measures. The medical documentation must describe the skilled services that require the involvement of nursing personnel to promote the patient's recovery and medical safety in view of the patient's overall condition, to maintain the patient's current condition, or to prevent or slow further deterioration in the patient's condition.*

If a patient was admitted for skilled observation but did not develop a further acute episode or complication, the skilled observation services still are covered so long as there was a reasonable probability for such a complication or further acute episode. "Reasonable probability" means that a potential complication or further acute episode was a likely possibility.

*Information from the patient's medical record must document that there is a reasonable potential for a future complication or acute episode sufficient to justify the need for continued skilled observation and assessment.*

*Such signs and symptoms as abnormal/fluctuating vital signs, weight changes, edema, symptoms of drug toxicity, abnormal/fluctuating lab values, and respiratory changes on auscultation may justify skilled observation and assessment. Where these signs and symptoms are such that there is a reasonable potential that skilled observation and assessment by a licensed nurse will result in changes to the treatment of the patient, then the services are reasonable and necessary. However, observation and assessment by a nurse is not reasonable and necessary to the treatment of the illness or injury where these characteristics are part of a longstanding pattern of the patient's waxing and waning condition which by themselves do not require skilled services and there is no attempt to change the treatment to resolve them.*

Skilled observation and assessment may also be required for patients whose primary condition and needs are psychiatric in nature or for patients who, in addition to their physical problems, have a secondary psychiatric diagnosis. These patients may exhibit acute psychological symptoms such as depression, anxiety or agitation, which require skilled observation and assessment such as observing for indications of suicidal or hostile behavior. However, these conditions often require considerably more specialized, sophisticated nursing techniques and physician attention than is available in most participating SNFs. (SNFs that are primarily engaged in treating psychiatric disorders are

precluded by law from participating in Medicare.) Therefore, these cases must be carefully documented.

### **30.2.3.3 - Teaching and Training Activities**

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

**A3-3132.1.C.3, SNF-214.1.C.3**

Teaching and training activities, which require skilled nursing or skilled rehabilitation personnel to teach a patient how to manage their treatment regimen, would constitute skilled services. Some examples are:

- Teaching self-administration of injectable medications or a complex range of medications;
- Teaching a newly diagnosed diabetic to administer insulin injections, to prepare and follow a diabetic diet, and to observe foot-care precautions;
- Teaching self-administration of medical gases to a patient;
- Gait training and teaching of prosthesis care for a patient who has had a recent leg amputation;
- Teaching patients how to care for a recent colostomy or ileostomy;
- Teaching patients how to perform self-catheterization and self-administration of gastrostomy feedings;
- Teaching patients how to care for and maintain central venous lines, such as Hickman catheters;
- Teaching patients the use and care of braces, splints and orthotics, and any associated skin care; and
- Teaching patients the proper care of any specialized dressings or skin treatments.

*The documentation must thoroughly describe all efforts that have been made to educate the patient/caregiver, and their responses to the training. The medical record should also describe the reason for the failure of any educational attempts, if applicable.*

#### **EXAMPLE:**

*A newly diagnosed diabetic patient is seen in order to learn to self-administer insulin injections, to prepare and follow a diabetic diet, and to observe foot-care precautions. Even though the patient voices understanding of the nutritional principles of his diabetic diet, he expresses dissatisfaction with his food choices and refuses to comply with the education he is receiving. This refusal continues, notwithstanding efforts to counsel the*

*patient on the potentially adverse consequences of the refusal and to suggest alternative dietary choices that could help to avoid or alleviate those consequences. The patient's response to the recommended treatment plan as well as to all educational attempts is documented in the medical record.*

### **30.3 - Direct Skilled Nursing Services to Patients**

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

**A3-3132.2, SNF-214.2**

*Nursing services are considered skilled when they are so inherently complex that they can be safely and effectively performed only by, or under the supervision of, a registered nurse or, when provided by regulation, a licensed practical (vocational) nurse. (See 42CFR §409.32) If all other requirements for coverage under the SNF benefit are met, 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 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, and all other requirements for coverage under the SNF benefit are met. Coverage does not turn on the presence or absence of an individual's potential for improvement from nursing care, but rather on the beneficiary's need for skilled care.*

*A condition that would not ordinarily require skilled nursing services may nevertheless require them under certain circumstances. In such instances, 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.*

*A service is not considered a skilled nursing service merely because it is performed by or under the direct supervision of a nurse. If a service can be safely and effectively performed (or self-administered) by an unskilled person, the service cannot be regarded as a skilled nursing service although a nurse actually provides the service. Similarly, the unavailability of a competent person to provide a nonskilled service, regardless of the importance of the service to the patient, does not make it a skilled service when a nurse provides the service.*

Some examples of direct skilled nursing services are:

- Intravenous or intramuscular injections and intravenous feeding;
- Enteral feeding that comprises at least 26 percent of daily calorie requirements and provides at least 501 milliliters of fluid per day;



- Naso-pharyngeal and tracheotomy aspiration;
- Insertion, sterile irrigation, and replacement of suprapubic catheters;
- Application of dressings involving prescription medications and aseptic techniques (see §30.5 for exception);
- Treatment of decubitus ulcers, of a severity rated at Stage 3 or worse, or a widespread skin disorder (see §30.5 for exception);
- Heat treatments which have been specifically ordered by a physician as part of active treatment and which require observation by skilled nursing personnel to evaluate the patient's progress adequately (see §30.5 for exception);
- Rehabilitation nursing procedures, including the related teaching and adaptive aspects of nursing, that are part of active treatment and require the presence of skilled nursing personnel; e.g., the institution and supervision of bowel and bladder training programs;
- Initial phases of a regimen involving administration of medical gases such as bronchodilator therapy; and
- Care of a colostomy during the early post-operative period in the presence of associated complications. The need for skilled nursing care during this period must be justified and documented in the patient's medical record.

#### **30.4 - Direct Skilled *Therapy* Services to Patients**

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

**A3-3132.1.C, SNF-214.1.C**

*The following sections contain examples and guidelines concerning direct skilled therapy services to patients, including skilled physical therapy, occupational therapy, and speech/language pathology therapy.*

*Coverage for such skilled therapy services does not turn on the presence or absence of a beneficiary's potential for improvement from therapy services, but rather on the beneficiary's need for skilled care. Therapy services are considered skilled when they are so inherently complex that they can be safely and effectively performed only by, or under the supervision of, a qualified therapist. (See 42CFR §409.32) These skilled services may be necessary to improve the patient's current condition, to maintain the patient's current condition, or to prevent or slow further deterioration of the patient's condition.*

*If all other requirements for coverage under the SNF benefit are met, such 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 the rehabilitation services.*

### **30.4.1.1 - General**

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

Skilled physical therapy services must meet all of the following conditions:

- The services must be directly and specifically related to an active written treatment plan that is based upon an initial evaluation performed by a qualified physical therapist after admission to the SNF and prior to the start of physical therapy services in the SNF that is approved by the physician after any needed consultation with the qualified physical therapist. In those cases where a beneficiary is discharged during the SNF stay and later readmitted, an initial evaluation must be performed upon readmission to the SNF, prior to the start of physical therapy services in the SNF;
- The services must be of a level of complexity and sophistication, or the condition of the patient must be of a nature that requires the judgment, knowledge, and skills of a qualified physical therapist;
- The services must be provided with the expectation, based on the assessment made by the physician of the patient's restoration potential, that the condition of the patient will improve materially in a reasonable and generally predictable period of time; *or, the services must be necessary for the **establishment** of a safe and effective maintenance program; or, the services must require the skills of a qualified therapist for the **performance** of a safe and effective maintenance program. NOTE: See Section E. Maintenance Therapy for more guidance regarding when skilled therapy services are necessary for the performance of a safe and effective maintenance program.*
- The services must be considered under accepted standards of medical practice to be specific and effective treatment for the patient's condition; and,
- The services must be reasonable and necessary for the treatment of the patient's condition; this includes the requirement that the amount, frequency, and duration of the services must be reasonable.

#### **EXAMPLE 1:**

An 80-year old, previously ambulatory, post-surgical patient has been bed-bound for 1 week, and, as a result, had developed muscle atrophy, orthostatic hypotension, joint stiffness and lower extremity edema. To the extent that the patient requires a brief period of daily skilled physical therapy to restore lost functions, those services are reasonable and necessary *and must be documented in the medical record (see §30.2.2.1).*

## EXAMPLE 2:

A patient with congestive heart failure also has diabetes and previously had both legs amputated above the knees. Consequently, the patient does not have a reasonable potential to achieve ambulation, but still requires daily skilled physical therapy to learn bed mobility and transferring skills, as well as functional activities at the wheelchair level. If the patient has a reasonable potential for achieving those functions in a reasonable period of time in view of the patient's total condition, the physical therapy services are reasonable and necessary *and must be documented in the medical record (see §30.2.2.1).*

*Physical therapy services are not reasonable and necessary and would not be covered if the expected results are insignificant in relation to the extent and duration of physical therapy services that would be required to achieve those results.*

*Some* SNF inpatients do not require skilled physical therapy services but do require services, which are routine in nature. *When* services can be *safely and effectively* performed by supportive personnel, *such as* aides or nursing personnel, without the supervision of a physical therapist, *they do not constitute skilled physical therapy. Additionally*, services involving activities for the general good and welfare of the patient (e.g., general exercises to promote overall fitness and flexibility and activities to provide diversion or general motivation) do not constitute skilled physical therapy.

### 30.4.1.2 - Application of Guidelines

*(Rev. 179, Issued: 01-14-14, Effective: 01-07-14, Implementation: 01-07-14)*  
A3-3132.3.A.2, SNF-214.3.A.2

Some of the more common skilled physical therapy modalities and procedures are:

#### A. Assessment

The skills of a physical therapist are required for the ongoing assessment of a patient's rehabilitation needs and potential. Skilled rehabilitation services concurrent with the management of a patient's care plan include tests and measurements of range of motion, strength, balance, coordination, endurance, and functional ability.

#### B. Therapeutic Exercises

Therapeutic exercises, which must be performed by or under the supervision of the qualified physical therapist, due either to the type of exercise employed or to the condition of the patient.

#### C. Gait Training

Gait evaluation and training furnished to a patient whose ability to walk has been impaired by neurological, muscular, or skeletal abnormality often require the skills of a qualified physical therapist.

Repetitious exercises to improve gait, or to maintain strength and endurance, and assistive walking *can be* appropriately provided by supportive personnel, e.g., aides or nursing personnel, and *would not necessarily* require the skills of a physical therapist. Thus, such services are not *inherently* skilled. *However, see §30.2.2. for the specific circumstances in which an ordinarily nonskilled service can nevertheless be considered skilled. Documentation of the patient's condition in the medical record must describe the circumstances which delineate the need for skilled rather than unskilled services during gait training.*

#### **D. Range of Motion**

Only the qualified physical therapist may perform range of motion tests and, therefore, such **tests** are skilled physical therapy. Range of motion **exercises** constitute skilled physical therapy only if they are part of active treatment for a specific disease state which has resulted in a loss or restriction of mobility (as evidenced by physical therapy notes showing the degree of motion lost, the degree to be restored and the impact on mobility and/or function).

*Generally*, range of motion exercises which are not related to the restoration of a specific loss of function may be provided safely by supportive personnel, such as aides or nursing personnel, and *as such would not necessarily* require the skills of a physical therapist. Passive exercises to maintain range of motion in paralyzed extremities that can be carried out by aides or nursing personnel would not be considered skilled care. *However, see §30.2.2. for the specific circumstances in which an ordinarily nonskilled service can nevertheless be considered skilled. Documentation of the patient's condition in the medical record must describe the circumstances which delineate the need for skilled rather than unskilled services during range of motion training.*

#### **E. Maintenance Therapy**

*Therapy services in connection with a maintenance program are considered skilled when they are so inherently complex that they can be safely and effectively performed only by, or under the supervision of, a qualified therapist. (See 42CFR §409.32) If all other requirements for coverage under the SNF benefit are met, 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 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 do not constitute a covered level of care.*

*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 supervision of a therapist. If a service can be self-administered or safely and effectively furnished by an unskilled person, without the direct supervision of a therapist, the service cannot be regarded as a skilled therapy service even when a therapist actually furnishes the service. Similarly, the unavailability of a competent person to provide a non-skilled service, regardless of the importance of the service to the patient, does not make it a skilled service when a therapist furnishes the service.*

*However, even though it would not otherwise require the skills of a therapist, the performance of a maintenance program may nevertheless require such skills under certain circumstances. Specifically, skilled therapy services are 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.*

*If the specialized knowledge and judgment of a qualified therapist are required, 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 considered skilled therapy services, to the extent provided by regulation.*

**EXAMPLE:** A patient with Parkinson's disease may require the services of a physical therapist to determine the type of exercises that are required to maintain his present level of function. The initial evaluation of the patient's needs, the designing of a maintenance program which is appropriate to the capacity and tolerance of the patient and the treatment objectives of the physician, the instruction of the patient or supportive personnel (e.g., aides or nursing personnel) in the carrying out of the program, would constitute skilled physical therapy *and must be documented in the medical record (see §30.2.2.1).*

While a patient is receiving a skilled physical therapy program, the physical therapist should regularly reevaluate the patient's condition and adjust any exercise program the patient is expected to carry out independently or with the aid of supportive personnel to maintain the function being restored. Consequently, by the time it is determined that no further *skilled therapy services are needed*, i.e., by the end of the last skilled session, the physical therapist will have already designed *any* maintenance program required and instructed the patient or supportive personnel in the carrying out of the program.

## **F. Ultrasound, Shortwave, and Microwave Diathermy Treatments**

These modalities must always be performed by or under the supervision of a qualified physical therapist.

## **G. Hot Packs, Infra-Red Treatments, Paraffin Baths, and Whirlpool Baths**

Heat treatments and baths of this type ordinarily do not require the skills of a qualified physical therapist. However, the skills, knowledge, and judgment of a qualified physical therapist might be required in the giving of such treatments or baths in a particular case, e.g., where the patient's condition is complicated by circulatory deficiency, areas of desensitization, open wounds, fractures, or other complications. *There must be clear documentation in the medical record of the special medical complications that describe the need for the skilled therapy provided by the therapist.*

### **30.4.2 - Speech -Language Pathology**

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

See Pub. 100-02, Medicare Benefit Policy Manual, Chapter 1, "Inpatient Hospital Services."

*See §30.4.1.2.E. Maintenance Therapy for the specific circumstances in which speech-language pathology therapy is appropriate in connection with a maintenance program.*

### **30.4.3 - Occupational Therapy**

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

A3-3132.3.C, SNF-214.3.C

See Pub. 100-02, Medicare Benefit Policy Manual, Chapter 1, "Inpatient Hospital Services."

*See §30.4.1.2.E. Maintenance Therapy for the specific circumstances in which occupational therapy is appropriate in connection with a maintenance program.*

## **30.6 - Daily Skilled Services Defined**

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

Skilled nursing services or skilled rehabilitation services (or a combination of these services) must be needed and provided on a "daily basis," i.e., on essentially a 7-days-a-week basis. A patient whose inpatient stay is based solely on the need for skilled rehabilitation services would meet the "daily basis" requirement when they need and receive those services on at least 5 days a week. (If therapy services are provided less than 5 days a week, the "daily" requirement would not be met.)

This requirement should not be applied so strictly that it would not be met merely because there is an isolated break of a day or two during which no skilled rehabilitation services are furnished and discharge from the facility would not be practical.

#### **EXAMPLE:**

A patient who normally requires skilled rehabilitation services on a daily basis may exhibit extreme fatigue, which results in suspending therapy sessions for a day or two. Coverage may continue for these days since discharge in such a case would not be practical.

In instances when a patient requires a skilled restorative nursing program to positively affect his functional well-being, the expectation is that the program be rendered at least 6 days a week. (Note that when a patient's skilled status is based on a restorative program, medical evidence must *be documented* to justify the services. In most instances, it is expected that a skilled restorative program will be, at most, only a few weeks in duration.)

The daily basis requirement can be met by furnishing a single type of skilled service every day, or by furnishing various types of skilled services on different days of the week that collectively add up to "daily" skilled services. However, arbitrarily staggering the timing of various therapy modalities though the week, merely in order to have some type of therapy session occur each day, would not satisfy the SNF coverage requirement for skilled care to be needed on a "daily basis." To meet this requirement, the patient must actually **need** skilled rehabilitation services to be furnished on each of the days that the facility makes such services available.

It is not sufficient for the scheduling of therapy sessions to be arranged so that some therapy is **furnished** each day, unless the patient's medical needs indicate that daily therapy is required. For example, if physical therapy is furnished on 3 days each week and occupational therapy is furnished on 2 other days each week, the "daily basis" requirement would be satisfied only if there is a valid medical reason why both cannot be furnished on the same day. The basic issue here is not whether the services are needed, but **when** they are needed. Unless there is a legitimate medical need for scheduling a therapy session each day, the "daily basis" requirement for SNF coverage would not be met.

### **30.7 - Services Provided on an Inpatient Basis as a "Practical Matter"**

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

**A3-3132.6, SNF-214.6**

In determining whether the daily skilled care needed by an individual can, as a "practical matter," only be provided in a SNF on an inpatient basis, the intermediary *or MAC* considers the individual's physical condition and the availability and feasibility of using more economical alternative facilities or services.

As a “practical matter,” daily skilled services can be provided only in a SNF if they are not available on an outpatient basis in the area in which the individual resides or transportation to the closest facility would be:

- An excessive physical hardship;
- Less economical; or
- Less efficient or effective than an inpatient institutional setting.

The availability of capable and willing family or the feasibility of obtaining other assistance for the patient at home should be considered. Even though needed daily skilled services might be available on an outpatient or home care basis, as a practical matter, the care can be furnished only in the SNF if home care would be *ineffective* because the patient would have insufficient assistance at home to reside there safely.

**EXAMPLE:** A patient undergoing skilled physical therapy can walk only with supervision but has a reasonable potential to learn to walk independently with further training. Further daily skilled therapy is available on an outpatient or home care basis, but the patient would be at risk for further injury from falling, because insufficient supervision and assistance could not be arranged for the patient in his home. In these circumstances, the physical therapy services as a practical matter can be provided effectively only in the inpatient setting.

*Frequently Asked Questions*  
([www.CMS.gov](http://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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*Medicare Appeals Booklet*  
([www.Medicare.gov](http://www.Medicare.gov))



This **official** government booklet has important information about:

- How to file an appeal if you have Original Medicare
- How to file an appeal if you have a Medicare Advantage Plan or other Medicare health plan
- How to file an appeal if you have Medicare prescription drug coverage
- Where to get help with your questions



The information in this booklet describes the Medicare Program at the time this booklet was printed. Changes may occur after printing. Visit [Medicare.gov](https://www.medicare.gov), or call 1-800-MEDICARE (1-800-633-4227) to get the most current information. TTY users can call 1-877-486-2048.

“Medicare Appeals” isn’t a legal document. Official Medicare Program legal guidance is contained in the relevant statutes, regulations, and rulings.

Paid for by the Department of Health & Human Services.

## Notice of Availability of Auxiliary Aids & Services

We're committed to making our programs, benefits, services, facilities, information, and technology accessible in accordance with Sections 504 and 508 of the Rehabilitation Act of 1973. We've taken appropriate steps to make sure that people with disabilities, including people who are deaf, hard of hearing or blind, or who have low vision or other sensory limitations, have an equal opportunity to participate in our services, activities, programs, and other benefits. We provide various auxiliary aids and services to communicate with people with disabilities, including:

**Relay service** — TTY users can call 1-877-486-2048.

**Alternate formats** — This product is available in alternate formats, including large print, Braille, audio, CD, or as an eBook.

To request a Medicare product in an alternate format, call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048. To request the Medicare & You handbook in an alternate format, visit [Medicare.gov/medicare-and-you](https://www.Medicare.gov/medicare-and-you).

For all other CMS publications:

1. Call 1-844-ALT-FORM (1-844-258-3676). TTY users can call 1-844-716-3676.
2. Send a fax to 1-844-530-3676.
3. Send an email to [AltFormatRequest@cms.hhs.gov](mailto:AltFormatRequest@cms.hhs.gov).
4. Send a letter to:  
Centers for Medicare & Medicaid Services  
Offices of Hearings and Inquiries (OHI)  
7500 Security Boulevard, Room S1-13-25  
Baltimore, MD 21244-1850  
Attn: CMS Alternate Format Team

**Note:** Your request for a CMS publication should include your name, phone number, mailing address where we should send the publications, and the publication title and product number, if available. Also include the format you need, like Braille, large print, audio CD, or a qualified reader.



## Nondiscrimination Notice

The Centers for Medicare & Medicaid Services (CMS) doesn't exclude, deny benefits to, or otherwise discriminate against any person on the basis of race, color, national origin, disability, sex, or age. If you think you've been discriminated against or treated unfairly for any of these reasons, you can file a complaint with the Department of Health and Human Services, Office for Civil Rights by:

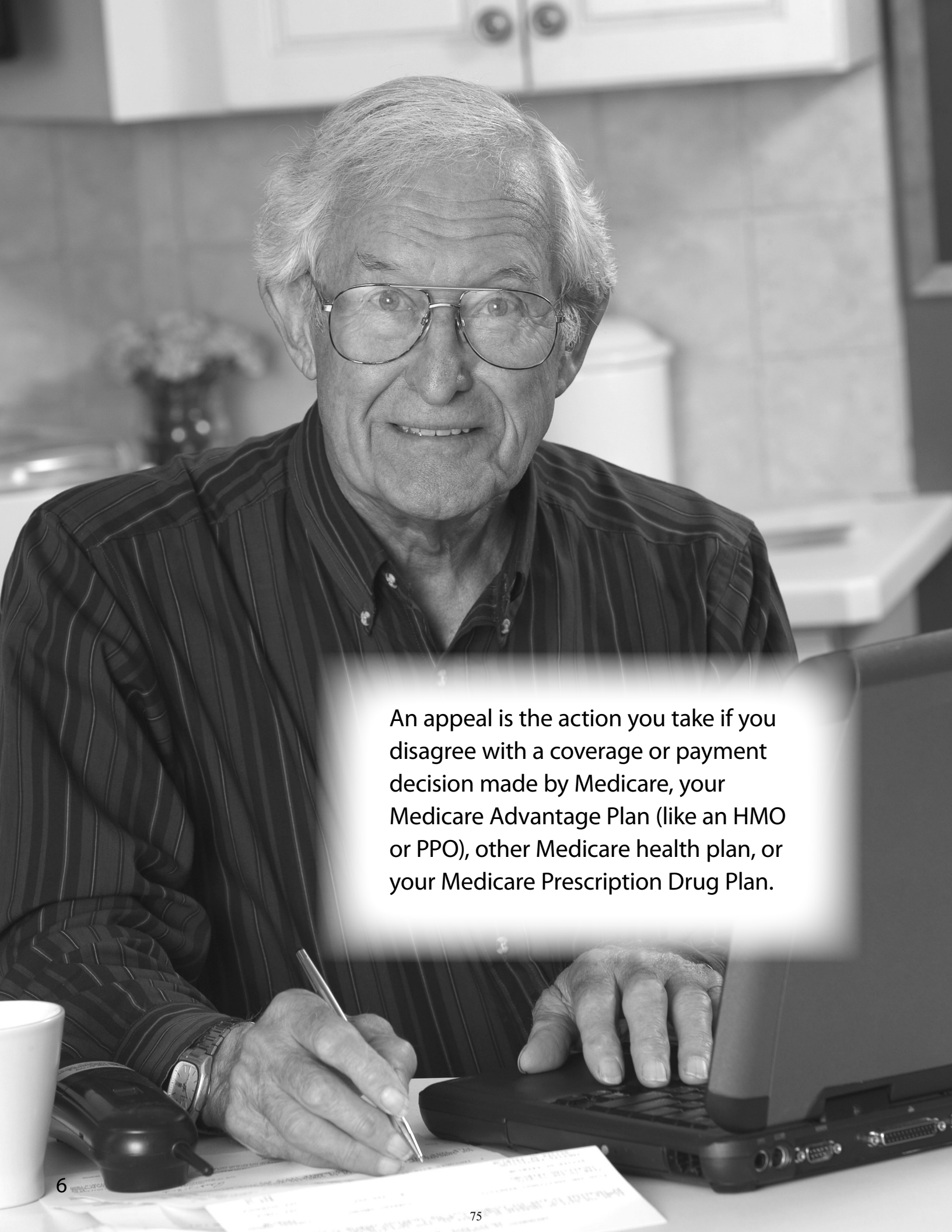
- Calling 1-800-368-1019. TTY users can call 1-800-537-7697.
- Visiting [hhs.gov/ocr/civilrights/complaints](https://hhs.gov/ocr/civilrights/complaints).

- 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](https://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](https://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](https://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.

## How do I appeal if I have Original Medicare?

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](https://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](https://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](https://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?**

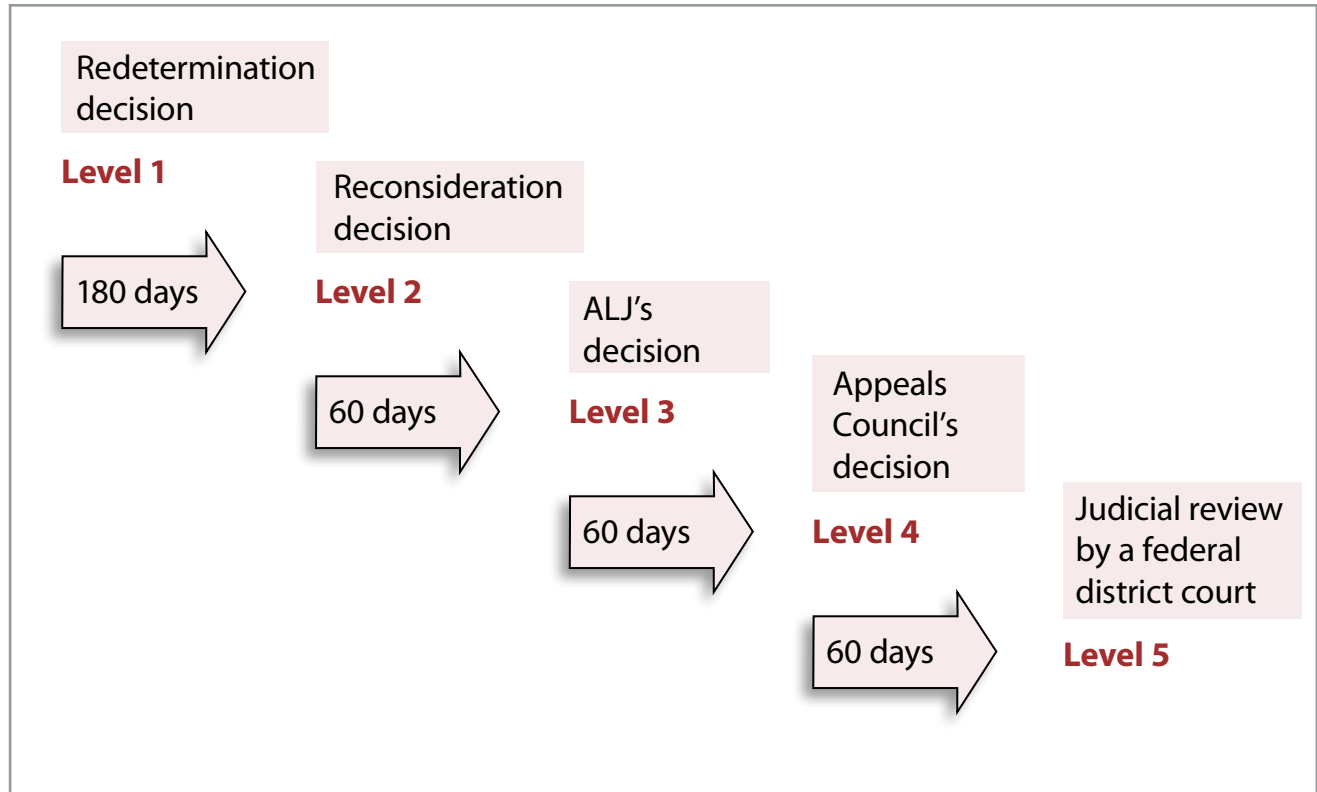
Follow the directions in the Appeals Council's decision letter you got in level 4 to file a complaint in federal district court.

### **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?

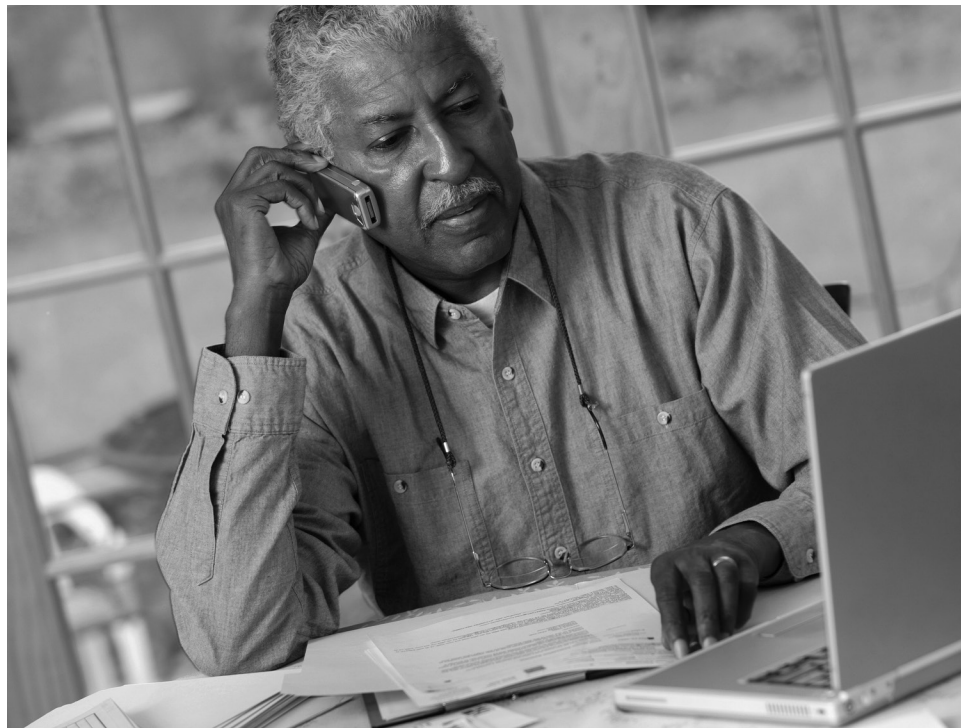
### 4. “Detailed Explanation of Non-Coverage” (DENC)

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.

# 2

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](https://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](https://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](https://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.

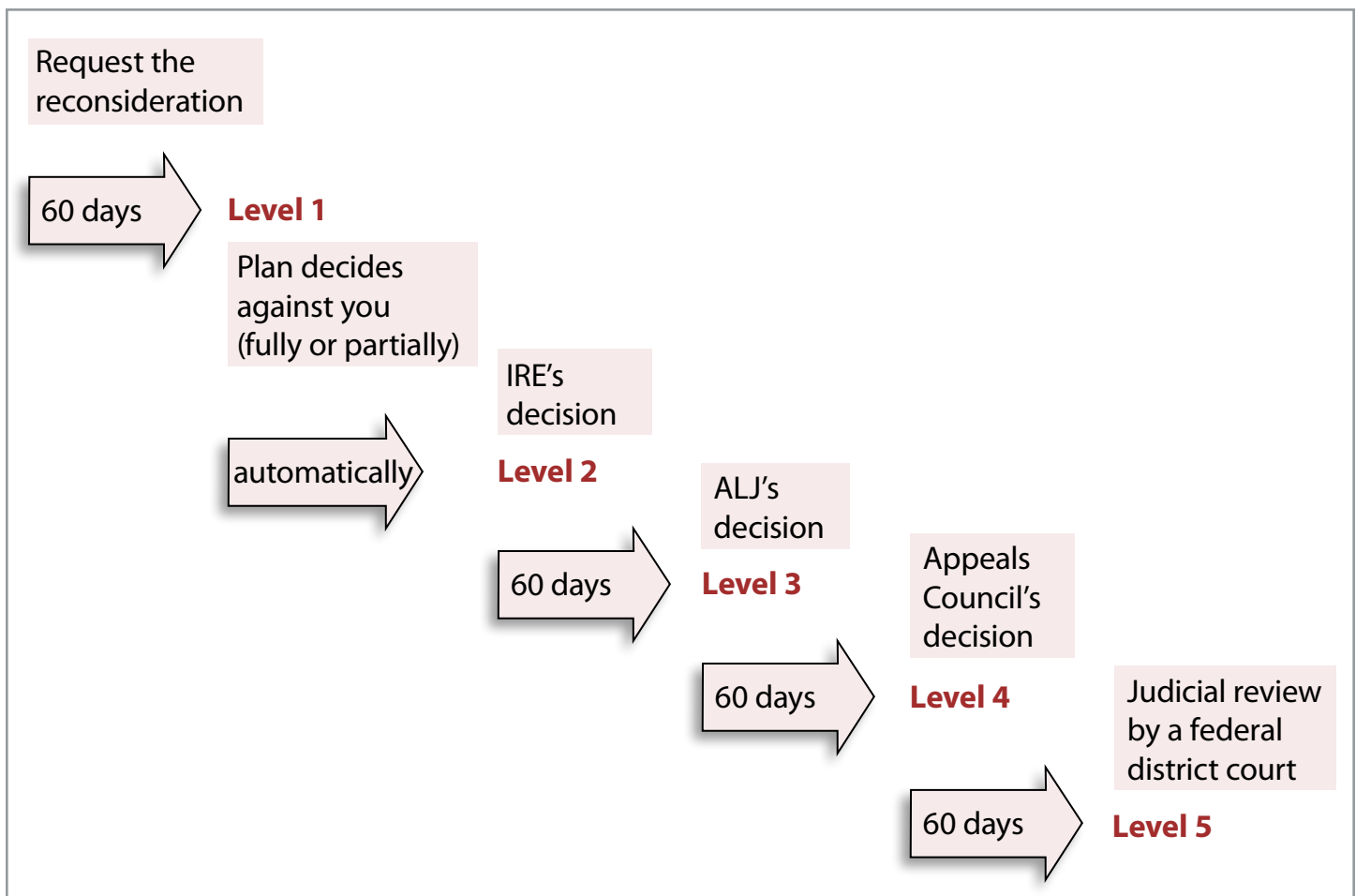
## How do I appeal if I have a Medicare Advantage Plan or other Medicare health plan?

### 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](https://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.

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

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](http://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.

## 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](https://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](https://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](https://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](https://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](https://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.

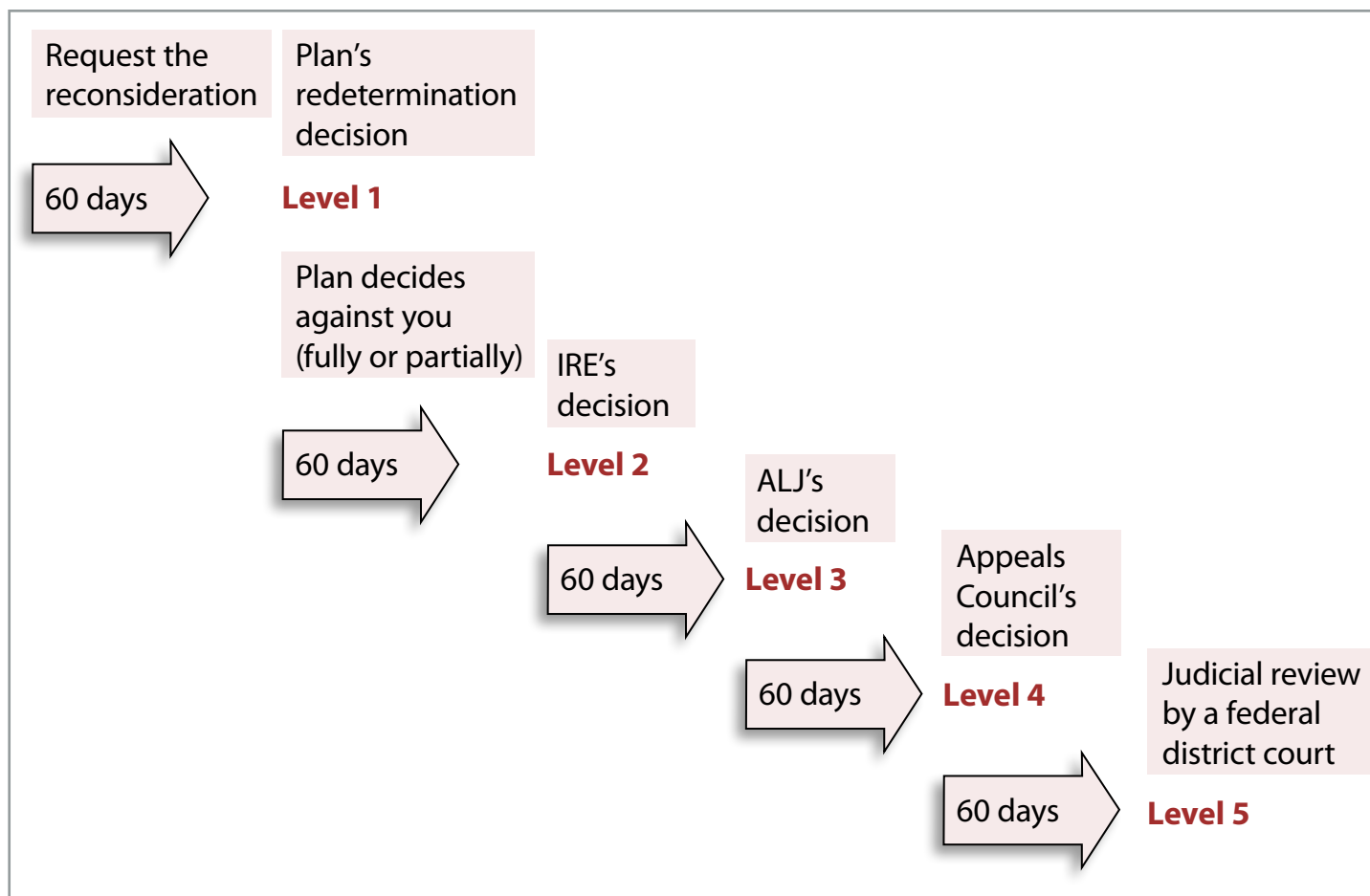
Once the Appeals Council gets the request for review, you'll get a decision. Expedited (fast) Appeals Council decision, you'll get a decision as quickly as your health condition requires, but generally no later than 10 days beginning on the day the Appeals Council receives the request for review, unless that time period is extended.

To learn more about the Appeals Council review process, visit [hhs.gov/dab](https://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](https://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.

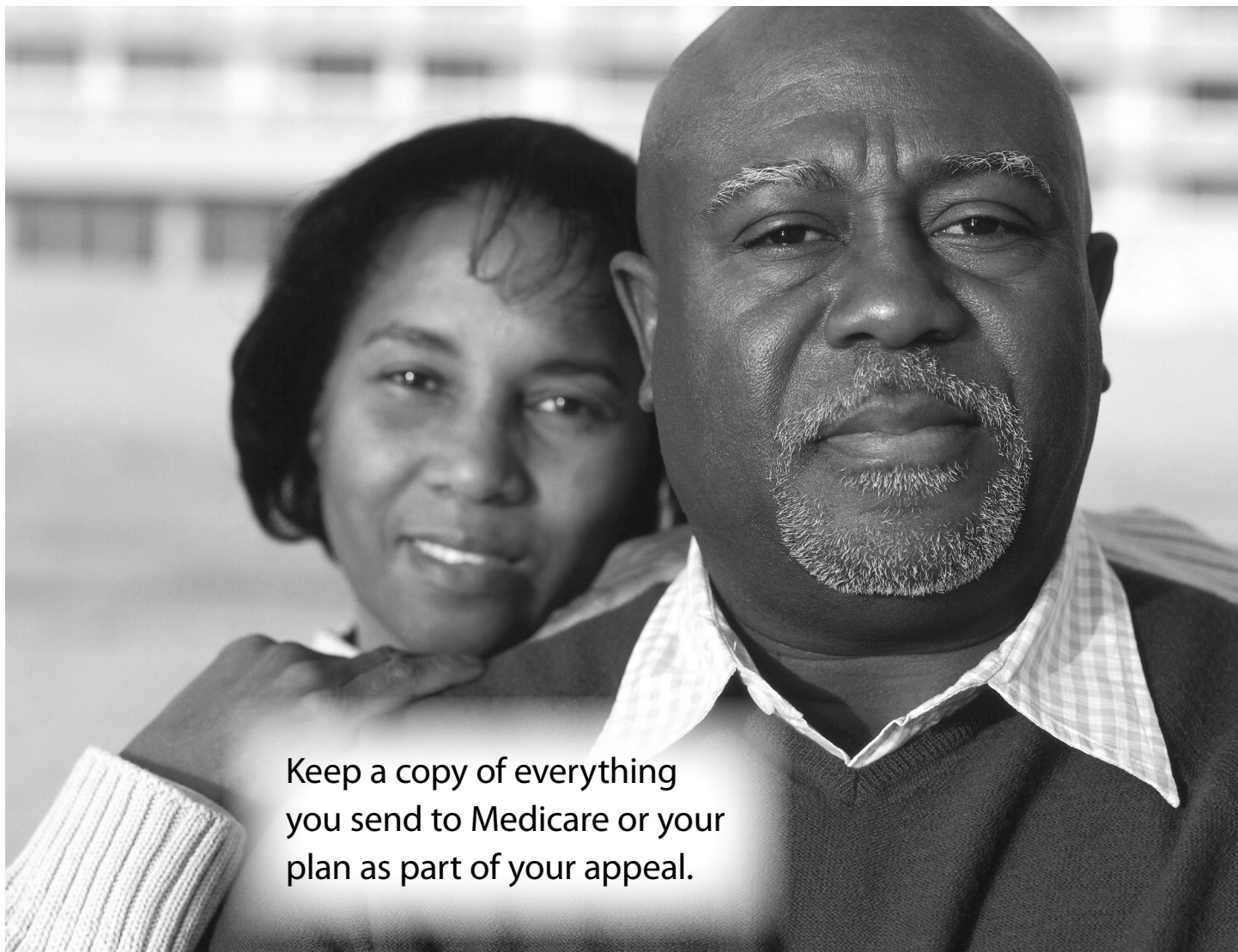
### More information on filing a complaint

- 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?



**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  
7500 Security Blvd.  
Baltimore, MD 21244-1850

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Para obtener su copia GRATIS, llame al  
1-800-MEDICARE (1-800-633-4227).

*Frequently Asked Questions*  
([www.MedicareAdvocacy.org](http://www.MedicareAdvocacy.org))

## Frequently Asked Questions (FAQs) Regarding the Jimmo v. Sebelius “Improvement Standard” Settlement

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[medicareadvocacy.org/jimmo-v-sebelius-the-improvement-standard-case-faqs/](http://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 Skilled Nursing Facility  
Appeals*

([www.MedicareAdvocacy.org](http://www.MedicareAdvocacy.org))



# Self-Help Packet for Skilled Nursing Facility Appeals Including “Improvement Standard” Denials

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<https://www.medicareadvocacy.org/self-help-packet-for-expedited-skilled-nursing-facility-appeals-including-improvement-standard-denials/>

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  - The “Improvement Standard” Myth and Skilled Nursing Facility Care
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  - Federal Regulations – Expedited Appeals
  - Centers for Medicare & Medicaid Services (CMS) Manual Provisions

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## 1. Introduction

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

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

For additional assistance, contact your State Health Insurance Assistance Program (SHIP). You can find your state program's information at <https://shipnpr.acl.gov/Default.aspx>.

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

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

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

☐ 1. [Review the “Quick Screen”](#) included in this packet to determine whether the care you need is covered by Medicare.

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

☐ 3. [Gather support for your case.](#)

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

☐ 4. [Receive the BFCC-QIO decision.](#)

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

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

- Unless you request an extension of time, the QIC must tell you its decision within 72 hours of receipt of your call, as well as if any medical or other records are needed for the Expedited Reconsideration.
- You have the right to extend this period to up to 14 days to gather medical records and prepare your argument.
- If you did not get your medical record during the first review, you can get it from the

BFCC-QIO now. The BFCC-QIO can charge you for the cost of copying. It must comply with your request for records by no later than close of business of the first day after your request for the documents.

- If you did not submit support from the physician who ordered your care at the BFCC-QIO level, use the 14 day extension to get and submit that support to the QIC now.
- During your appeal, you will be financially responsible for your continued stay at the nursing home.

☐ 6. Receive the QIC decision.

☐ 7. (3rd Appeal Level) If the QIC issues a denial, please review the detailed sections on Administrative Law Judge (ALJ) Hearings and Other Options for Coverage, described below.

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

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

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

#### Other Important Points:

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

his/her helper by the skilled nursing facility.

7. Don't be satisfied with a Medicare determination unreasonably limiting coverage; appeal for the benefits the patient deserves.
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## 4. Skilled Nursing Facility Appeal Details

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

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

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

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

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

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

- Read the Standardized (Generic) Notice. It will contain the telephone number for your region’s BFCC-QIO.
- To start the Expedited Appeal, you or your representative **must contact the BFCC-**

**QIO by no later than noon of the calendar day following receipt of the standardized notice.**

- You can do this in writing or by telephone. If you call, get the name of the person you speak to, and keep written notes of what you are told.
- Once the contact is made, the nursing home should give you a more specific notice which will include a detailed explanation as to why it believes the Medicare covered care should end a description of any applicable Medicare coverage rules and information about how to obtain them, and other facts specific to your case.

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

- Ask your community physician(s) to contact your facility's physician.
- Have them explain why your care continues to be medically reasonable and necessary
- Ask your community physician to submit a written statement to the QIO explaining why you continue to need daily skilled medical care.
- Ask that your physician speak to the BFCC-QIO by telephone to support the need for continued care and to answer any questions.

## **3. Watch for the BFCC-QIO Decision**

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

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

- At your request or the request of your representative, the facility must give you a copy of or access to any documentation it sends to the BFCC-QIO, including records of any information provided by telephone.
- In most states, the facility may charge you the cost of copying and sending documents. However, some states, including Connecticut and Massachusetts, prohibit providers from billing patients for copies of their medical records when they are appealing Medicare denials of coverage.
- The facility must honor your request by no later than close of business of the first day after the material is requested.

- This information can be very helpful in supporting the medical need for the continuation of your care and in assisting your community physician with understanding your current medical condition.
- If you get these records, be sure to give a copy to your community physician.

**If the BFCC-QIO agrees with you:**

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

**If the BFCC-QIO agrees with the nursing home:**

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

**5. You have the right to another appeal – an “Expedited Reconsideration.”**

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

**6. Watch for the QIC (Reconsideration) decision.**

- Ordinarily, the QIC must tell you its decision within 72 hours of receipt of your call and any medical or other records needed for an Expedited Reconsideration.
- You have the right to extend this period to up to 14 days so that you can gather medical records and prepare your argument.
- If you did not get your medical records during the QIO review, you can get them at this stage. You can request them from the QIO who must send you a copy of or give you access to any documentation it sent to the QIC. The QIO may charge for the cost of duplicating documents and for the cost of delivery. The QIO must comply with your request no later than close of business of the first day after your request for the documents.
- If you were not able to submit support from your community physician to the QIO, at this second stage of the appeal process, it is a good idea to use the 14 day extension to get and submit that support.
- If you get your medical records, be sure and share them with your doctor.

**If the QIC agrees with you:**

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

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

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

## 7. Request an ALJ Hearing

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

## Other Ways to Get Medicare Covered Care

### In the Nursing Home (Skilled Nursing Facility)

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

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

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

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

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

### **At Home**

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

### **Conclusion**

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

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## **Additional Information – The Medicare “Improvement” Myth: Skilled Care to Maintain an Individual’s Condition Can Be Covered**

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

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

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

### **Medicare Coverage for Nursing Home (Skilled Nursing Facility) Care**

Medicare provides limited coverage for nursing home care for a limited period of time. For Medicare coverage purposes, nursing homes are referred to as skilled nursing facilities (abbreviated as SNF). The SNF benefit is available for a short time at best – for up to 100 days during each Medicare benefit period, known as the “spell of illness.” 42 USC §1395d(a)(2)(A).

If Medicare coverage requirements are met, the patient is entitled to full coverage of the first 20 days of SNF care. From the 21st through the 100th day, Medicare pays for all covered services except for a daily coinsurance amount. Beneficiaries in traditional Medicare are not entitled to any Medicare SNF coverage unless they were hospitalized as an inpatient for at least three days prior to the SNF admission. This requirement has become increasingly difficult to meet since hospitals often categorize patients as “outpatients” on Observation Status. These outpatient Observation stays do not count toward the SNF prior inpatient hospital requirement. Usually patients must be admitted to the SNF within 30 days of the inpatient hospital discharge. 42 USC §1395x(i). Further, SNF patients must require daily skilled nursing or rehabilitation to qualify for Medicare coverage. 42 USC §1395f (a)(2)(B).

There are certain requirements that must be met for an individual to receive Medicare skilled nursing facility coverage. These requirements are:



1. A physician must certify that the patient needs skilled nursing facility care; and
2. The beneficiary must generally be admitted to the SNF within 30 days of a 3-day qualifying inpatient hospital stay; and
3. The beneficiary must require daily skilled nursing or rehabilitation; and
4. The care needed by the patient must, as a practical matter, only be available in a skilled nursing facility on an inpatient basis; and
5. The skilled nursing facility must be a Medicare-certified provider.

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

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

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

42 USC §1395x(h).

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

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

42 CFR §409.33

### **Important Advocacy Tips**

Unfortunately, Medicare coverage is often denied to individuals who qualify under the law.

**In particular, beneficiaries are often denied coverage because they have certain chronic conditions such as Alzheimer's disease, Parkinson's disease, and Multiple**

**Sclerosis, or because they need nursing or therapy “only” to maintain their condition. Again, these are not legitimate reasons for Medicare denials.**

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

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

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

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

42 CFR §409.32(c)

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

42 CFR §409.33(c)(5)

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

If a nursing home or Medicare Advantage plan says Medicare coverage is not available and the patient seems to satisfy the criteria above, ask the nursing home to submit a claim for a formal Medicare coverage determination. The nursing home must submit a claim if the patient or representative requests; the patient is not required to pay until he/she receives a formal initial determination from Medicare.

## **Conclusion**

Medicare coverage for nursing home care is limited – it is only available for 100 days per benefit period and only if the individual needs skilled care and has had a prior 3-day inpatient hospital stay. Further, under the law, *Medicare coverage is not limited to services that will improve the individual's condition.* Coverage *can* be available for items and services needed to maintain the person's condition or to arrest or retard further deterioration.

Medicare coverage is often erroneously denied for individuals with chronic conditions, for people who are not improving, or who are in need of services to maintain their condition. ***It is not necessary for the individual's underlying condition to improve to qualify for Medicare coverage!***

The Medicare program has an appeal system to contest such denials. Beneficiaries and their advocates should use this system to appeal Medicare determinations that unfairly deny or limit coverage.

For more information about *Jimmo* and the Improvement Standard, see <http://www.medicareadvocacy.org/medicare-info/improvement-standard/>.

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## **Glossary of Terms**

### **BENEFICIARY**

An individual enrolled in the Medicare program.

### **CLAIMANT**

An individual requesting reimbursement from Medicare for expenses incurred for medical care (or the individual requesting payment on behalf of a Medicare enrollee).

### **CO-INSURANCE**

The amount a beneficiary must pay as his or her share of the cost of a given service. For example, a beneficiary must pay part of the cost of days 21 through 100 in a skilled nursing facility. There is also a co-insurance (20% of the reasonable charge) which must be paid for Part A or B services.

### **CMS (Centers for Medicare and Medicaid Services)**

The federal agency which administers the Medicare program: part of the United States Department of Health and Human Services.

### **DEDUCTIBLE**

The amount which a beneficiary must pay before Medicare (or other insurance program) will begin to cover the bill. Each calendar year a deductible must be paid before Medicare will cover hospital care under Part A, or physician visits and other services under Medicare Part B.

### **HEALTH INSURANCE CLAIM NUMBER**

The Social Security number under which you receive benefits. This number is the number on your health insurance (Medicare) card.

### **INPATIENT**

An individual admitted to a hospital, skilled nursing facility, or other health care institution for treatment

### **MEDICARE ADVANTAGE**

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

### **MEDICARE CLAIM DETERMINATION**

The written notice of denial of Medicare coverage issued by the intermediary.

## **MEDICARE CONTRACTOR**

An agent of the federal government, often an insurance company, which makes Part A Medicare claim determinations for skilled nursing facility and home health coverage, and issues payments to providers.

## **MEDIGAP**

Private insurance which covers the “gaps” in Medicare (such as deductibles and co-insurance amounts). Significantly, these policies generally do not pay when Medicare refuses coverage.

## **OBSERVATION STATUS**

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

## **SHIP**

State Health Insurance Assistance Program. These programs are funded to help beneficiaries with insurance choices, enrollment and appeals. See [www.shiptalk.org](http://www.shiptalk.org).

## **SKILLED CARE**

Care which requires the skill of technical or professional personnel in order to ensure its safety and effectiveness, and is furnished directly by, or under the supervision of, such personnel. (Nurses and physical or occupational therapists are examples of professional personnel.)

## **SKILLED NURSING FACILITY (SNF)**

A skilled nursing facility, or “SNF,” is a nursing home which delivers a relatively substantial degree of skilled nursing and rehabilitative care, and personal care. In order to receive Medicare coverage for nursing home care, a patient must receive daily skilled care in a Medicare-certified skilled nursing facility.

## **SPELL OF ILLNESS (BENEFIT PERIOD)**

The name of the benefit period for Medicare Part A. The “spell of illness” begins on the first day a patient receives Medicare-covered inpatient hospital care and ends when the patient has spent 60 consecutive days outside the institution, or remains in the institution but does not receive Medicare-coverable care for 60 consecutive days.



## *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