Center for Medicare Advocacy
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The John A. Hartford Foundation

Checklist Toolkit

Medicare Skilled Nursing Facility Coverage and Appeals In Light of *Jimmo v. Sebelius*

You do not have to improve to qualify for Medicare coverage!

On January 24, 2013, the U.S. District Court for the District of Vermont approved the settlement agreement in *Jimmo v. Sebelius*, No. 5:11-CV-17 (D. VT). As a result of the *Jimmo* Settlement, the Centers for Medicare & Medicaid Services (CMS) was required to confirm that Medicare coverage is determined by a beneficiary's need for skilled care and not on a beneficiary's potential for improvement. 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).

The *Jimmo* Settlement means that Medicare beneficiaries should not be denied coverage for maintenance nursing or therapy provided in a skilled nursing facility when skilled personnel must provide or supervise the care for it to be safe and effective. Medicare-covered skilled services include care that improves, maintains, or slows the decline of a patient's condition. Medicare coverage should not be denied solely because an individual has an underlying condition that won't get better, such as MS, ALS, or Parkinson's disease.

Unfortunately, the Center for Medicare Advocacy still regularly hears from beneficiaries and their families about coverage denials for skilled care services based on some variation of an "Improvement Standard." The Center has created this Checklist Toolkit to assist individuals in responding to unfair terminations of care and denials. Each of the Checklists below provide valuable information on the rights of beneficiaries in regards to skilled nursing facility (SNF) coverage, expedited appeals in traditional Medicare, and fast-track appeals in Medicare Advantage. Although challenging a Medicare termination or denial may seem daunting, beneficiaries and their representatives can win appeals when equipped with the right information.

SNF Coverage Criteria in Light of *Jimmo*

Expedited Appeals in Traditional Medicare

Fast-Track Appeals in Medicare Advantage

For additional information, see the Center for Medicare Advocacy's Improvement Standard Homepage.

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Medicare Skilled Nursing Facility Coverage In Light of *Jimmo v. Sebelius*

Coverage Criteria → You do not have to improve to qualify!

3-Day Inpatient Hospital Stay

- ✓ You must have a qualifying three-day inpatient (as opposed to outpatient) hospital stay. Medicare Advantage plans might not have this requirement.
- ✓ Generally, the admission to the skilled nursing facility must occur within 30 days of leaving the hospital.

Physician's Order

- ✓ Your care at the skilled nursing facility must have been ordered by a physician and must relate to a condition for which you received inpatient hospital services or that arose at the skilled nursing facility while being treated for a condition for which you received inpatient hospital services.
- ✓ As a practical matter, the care must only be available on an inpatient basis.

Daily Skilled Care

- ✓ You must require and receive skilled nursing seven days a week, skilled therapy five days a week, or a combination of both skilled nursing and therapy services seven days a week.
- ✓ Skilled care means that services must be provided by, or under the supervision of, a skilled professional in order to be safe and effective.

No Improvement Standard

- ✓ Medicare 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; Medicare Benefit Policy Manual, Chapter 8, Sections 30.2, 30.3.

100-Day Benefit Period

- ✓ Your maximum benefit period is 100 days. It is possible to have more than one benefit period during the calendar year.
- ✓ You are entitled to notice and to file an appeal when your Medicare-covered skilled nursing facility care is terminated before the end of your benefit period.

For additional information, see the Center for Medicare Advocacy's Improvement Standard Homepage.

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Expedited Appeals in Traditional Medicare For Skilled Nursing Facility Care In Light of *Jimmo v. Sebelius*

You do not have to improve to qualify for Medicare coverage!

No Improvement Standard

Restoration potential is not necessary. Medicare 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; Medicare Benefit Policy Manual, Chapter 8, Sections 30.2, 30.3. See also, 42 CFR § 409.32(c).

Notice of Medicare Non-Coverage

- ✓ Your skilled nursing facility must give you the Notice of Medicare Non-Coverage two days before your covered services end.
- ✓ This notice must show the date your skilled nursing and/or therapy is scheduled to end and provide information about how to file an expedited appeal with the Beneficiary and Family Centered Quality Improvement Organization (BFCC-QIO).

Redetermination by the QIO

- ✓ You must file the appeal by noon the day after you received the notice.
- ✓ After receiving notice about the appeal from the QIO, the skilled nursing facility must provide you with a Detailed Explanation of Non-Coverage.
- ✓ The QIO must make a determination within 72 hours of receiving your request.
- ✓ Take this time to request your medical records and ask the physician who ordered your care to submit a written statement explaining why you continue to need daily skilled care.

Reconsideration by the QIC

- ✓ If the QIO decides against you, you must request an expedited reconsideration from the Qualified Independent Contractor (QIC) by noon the following day.
- ✓ The QIC must make a decision within 72 hours of your request.
- ✓ You have the right to extend this period up to 14 days to gather support for your case and prepare your argument.

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Expedited Appeals in Traditional Medicare For Skilled Nursing Facility Care In Light of *Jimmo v. Sebelius*

Administrative Law Judge Hearing

- ✓ If the QIC decides against you, you must request a hearing before an administrative law judge (ALJ) within 60 days of receiving the QIC's decision.
- ✓ ALJ hearings are not expedited. For beneficiary-initiated appeals, the ALJ should make a decision within 90 days of receiving the request for a hearing.
- ✓ You must submit your evidence with the request for hearing, by the date specified in the request for hearing, or, if a hearing has been scheduled, within 10 days of receiving the notice of hearing.

Medicare Appeals Council

- ✓ If the ALJ decides against you, you must request a review by the Medicare Appeals Council within 60 days of receiving the ALJ's decision.
- ✓ For beneficiary-initiated appeals, the Appeals Council should make a decision within 90 days of receiving the request for a hearing.

Federal District Court

- ✓ If the Appeals Council decides against you, follow the directions in the denial to file for judicial review in federal district court.
- ✓ You must file within 60 days of receiving the Appeals Council's decision.
- ✓ You must meet the amount in controversy requirement. The amount in controversy is adjusted annually.

Remember

- A skilled nursing facility's decision to terminate your Medicare-covered care based on an erroneous "Improvement Standard" is a violation of your rights under Medicare.
- An expedited appeal only addresses the decision to terminate Medicare-covered services. If you wish to continue receiving uncovered care at the SNF, a SNFABN must be issued. A standard appeal should be pursued for any services you continue to receive
- If you do not win your appeal or decide not to take further action, you will be responsible for the cost of your care after the termination date on the Notice of Medicare Non-Coverage.
- If Medicare Part A is not/no longer paying for your care, Part B coverage may be available for skilled therapy.

For additional information, see the Center for Medicare Advocacy's Improvement Standard Homepage.

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Fast-Track Appeals in Medicare Advantage For Skilled Nursing Facility Care In Light of *Jimmo v. Sebelius*

You do not have to improve to qualify for Medicare coverage!

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Notice of Medicare Non-Coverage

- ✓ Your skilled nursing facility must give you the Notice of Medicare Non-Coverage two days before your covered services end.
- ✓ This notice must show the date your skilled nursing and/or therapy is scheduled to end and provide information about how to file a fast-track appeal with the Beneficiary and Family Centered Quality Improvement Organization (BFCC-QIO).

Appealing to the QIO

- ✓ You must file the appeal by noon the day after you received the notice.
- ✓ The QIO must make a decision "by close of business of the day after it receives the information necessary to make the decision."
- ✓ After receiving notice about the appeal from the QIO, the skilled nursing facility must provide you with a Detailed Explanation of Non-Coverage.
- ✓ Take this time to request your medical records and ask the physician who ordered your care to submit a written statement explaining why you continue to need daily skilled care.

Reconsideration by the QIO

- ✓ If the QIO decides against you, you must request a reconsideration within 60 days of receiving notice of the QIO's decision.
- ✓ The QIO must make its determination "as expeditiously as the enrollee's health condition requires but no later than within 14 days" of receiving the request.

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Fast-Track Appeals in Medicare Advantage For Skilled Nursing Facility Care In Light of *Jimmo v. Sebelius*

Administrative Law Judge Hearing

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- ✓ ALJ hearings are not expedited. For beneficiary-initiated appeals, the ALJ should make a decision within 90 days of receiving the request for a hearing.
- ✓ You must submit your evidence with the request for hearing, by the date specified in the request for hearing, or, if a hearing has been scheduled, within 10 days of receiving the notice of hearing.

Medicare Appeals Council

- ✓ If the ALJ decides against you, you must request a review by the Medicare Appeals Council within 60 days of receiving the ALJ's decision.
- ✓ For beneficiary-initiated appeals, the Appeals Council should make a decision within 90 days of receiving the request for a hearing.

Federal District Court

- ✓ If the Appeals Council decides against you, follow the directions in the denial to file for judicial review in federal district court.
- ✓ You must file within 60 days of receiving the Appeals Council's decision.
- ✓ You must meet the amount in controversy requirement. The amount in controversy is adjusted annually.

Remember

- A skilled nursing facility's decision to terminate your Medicare-covered care based on an erroneous "Improvement Standard" is a violation of your rights under Medicare.
- A fast-track appeal only addresses the decision to terminate Medicare-covered services.
- If you do not win your appeal or decide not to take further action, you will be responsible for the cost of your care after the termination date on the Notice of Medicare Non-Coverage and may need to request an organization determination to appeal any subsequent services you may receive.

For additional information, see the Center for Medicare Advocacy's Improvement Standard Homepage.