Medicare
Entitlement, Eligibility and Coverage Criteria
Part I

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Medicare Entitlement, Eligibility and Coverage Criteria Part I

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"HHI **C.A.R.E.S.** about Care"

Compliance

Audit
Analysis

Reimbursement
Regulatory
Rehabilitation

Education
Efficiency

Survey

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About Kris

Kris Mastrangelo OTR/L, LNHA, MBA

President and CEO

Owns and operates
Harmony Healthcare International (HHI) a Nationally recognized, premier Healthcare Consulting firm specializing in C.A.R.E.S.
There are no nonfinancial disclosures to share.

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Educational Activity Completion

Requirements for Successful Completion

1 contact hour will be awarded for this continuing nursing education activity. **Criteria for successful completion includes:**

Attendance for 100% of the entire course (2 and 3 day trainings requires at last 80% attendance). Contact hours will be awarded for time

Must complete post course exam within 2 weeks of the course and course/teacher evaluation.

Clearly demonstrate the learning outcome of the program.

Participants will receive a certificate of completion immediately following completing the above requirements.

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CEU Disclosure

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Speaker and Planning Committee Disclosure

- **Disclosures**: The planners and presenters of this educational activity have no relationship with commercial entities or conflicts of interest to disclose. Please visit https://www.harmony-healthcare.com/hhi-team for all speaker's financial and nonfinancial disclosures
- **Planners:**
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  - Pamela Duchene, PhD, APRN-BC, NEA, FACHE
- **Presenters:**
  - Kris Mastrangelo, OTR/L, LNHA, MBA

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Learning Outcomes

1. Identify 2 factors that impact Medicare Eligibility.
2. Identify how a beneficiary Breaks a Spell of Illness.
3. Identify 3 Skilled Qualifiers for Medicare Part A Coverage.

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Medicare Entitlement, Eligibility and Coverage Criteria

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Medicare Entitlement

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Medicare Entitlement

- 65 Years or Older
- Paid into Medicare Taxes for 10 years or 40 quarters
- Under 65 and disabled
- Open Enrollment
- Part A Inpatient
- Part B Outpatient

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Medicare Eligibility

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Medicare Eligibility in a SNF

1. 3 Night Qualifying Stay
2. Certified Bed
3. Benefit Period (Days Available)
4. 30 Day Transfer Rule
5. Practical Matter
6. Medicare Coverage/Skilled Care Qualifiers

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1. Qualifying Stay

The beneficiary must have 3 day

(3 overnights)

in an acute care hospital

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2. Medicare Eligibility

Treated for a condition which was **treated** during a qualified stay…or… which **arose** while in a SNF for a treatment of condition for which the beneficiary **previously was treated in a hospital**.

For Example

Fractured hip **develops pneumonia** secondary to **immobility**

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3. Certified Bed

Beneficiary must reside in Medicare Certified Bed in order to receive payments for services rendered

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4. Benefit Period

- Up to 100 days of SNF coverage if patient meets level of care criteria
- Ends after 60 consecutive days of non-skilled level of care
- If level of care remains skilled, resident does not break spell of illness
- No limit to number of benefit periods

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4. Benefit Period

- Under the Final Rule criteria, an **insulin dependent diabetic**
- **G-tube feeder** can potentially receive a new spell of illness without going home or cessation of disease

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4. Benefit Period

- A benefit period ends with the conclusion of 60 consecutive days in which the resident does not receive skilled services

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4. Benefit Period

USED	NON-CERT	HOSP	DAY ON
55	65 no skill	4	
44	50 no skill	4	
48	25 no skill	0	
100	G-tube 62 no skill	25	
100	G-tube 62 skill	25	

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4. Benefit Period

USED	NON-CERT	HOSP	DAY ON
55	65 no skill	4	1
44	50 no skill	4	45
48	25 no skill	0	49
100	G-tube 62 no skill	25	1
100	G-Tube 62 skill	25	0

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5. 30 Day Transfer Rule

- Applies to some patients admitted from home
- Applies to some patients admitted from a non-acute care setting
- Applies to patients discharged from Part-A benefits prior to utilizing all available 100 benefit days
- Do not count day of discharge from hospital

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6. “Practical Matter” Criteria

“As a practical matter, considering economy and efficiency, the daily skilled services can only be provided in a skilled nursing facility”

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6. “Practical Matter” Criteria

1. **Outpatient services are not available** in the area where the individual lives

2. Outpatient services are available in the area where the individual lives, but **transportation** to the closest facility could cause an **excessive physical hardship**, be less economical, or less effective than placement in the skilled nursing facility

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6. “Practical Matter” Criteria

3. The availability at home of a capable and willing **caregiver** should be considered, but the care can be furnished only in the skilled nursing facility if home care would be ineffective because there would be **insufficient assistance** at home for the patient/resident to reside there safely

4. If the use of **alternative services would adversely affect** the patient/resident’s **medical condition**, then as a practical matter the daily skilled service(s) can only be provided on an inpatient basis

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6. “Practical Matter” Criteria
Leave of Absence

- Medicare Benefit Policy Manual, Chapter 8, Section 30.7.3
  - The regulations “should never be interpreted so **strictly** that it results in the automatic denial of coverage for patients who have been meeting all of the SNF level of care requirements, but who have **occasion to be away from the SNF** for a brief period of time”

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6. “Practical Matter” Criteria
Leave of Absence

- **Frequent or prolonged periods away from the SNF** may leave the MAC to question whether the patient’s care can, as a practical matter, only be furnished on an inpatient basis in a SNF

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7. Medicare Coverage/Skilled Care

- Skilled Nursing or Skilled Rehabilitation Services
- On a Daily Basis
- Services rendered are Reasonable and Necessary
- Physician Ordered

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7. What is Skilled Care?

- Nature of service requires the skills of RN, LPN
- Care rendered by a licensed person. Federal regulations define licensed person as physician, nurse and/or therapist.
- Provided directly by or under general supervision of a licensed nurse to assure the safety of the patient and to achieve the medically desired result
- "General" = initial direction and periodic inspection of the activity

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Medicare
Coverage and Skilled Care

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Medicare Coverage

- Additionally, the requirements for participation at section 1819 (b)(4)(A) of the act require an SNF to furnish the full range of nursing and specialized rehabilitation services needed to attain or maintain each resident's highest practical state of well-being, in accordance with Care Plan

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Medicare Coverage and Skilled Care

1. Presumptive Coverage
2. Skilled Nursing Services
3. Management and Evaluation of a Care Plan
4. Observation and Assessment
5. Teaching and Training
6. Skilled Rehabilitation

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Medicare Coverage
1. Presumptive Coverage

- When the initial Medicare 5 day Assessment results in a beneficiary being correctly coded to one of the top Nursing CMG's, creates a "presumptive coverage" from admission up to and including ARD (Assessment Reference Date)
- Lower 8 at risk for denial and audit

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Medicare Coverage
1. Presumptive Coverage

The coverage that arises from this presumption requires documentation to support skilled care

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Medicare Coverage
1. Presumptive Coverage

Nursing CMG Intimacy

- Do you know the **Nursing CMG?**
- Do the **nursing notes** support the CMG level?

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Medicare Coverage
2. Skilled Nursing
"Inherent Complexity"

- **Enteral Feeding** - 26% daily calorie requirements and at least 501 milliliters fluid per day
- **Suprapubic Catheters** - This procedure is a major vector for infection that can be fatal if improperly performed (insertion, sterile irrigation and replacement)
- **Hypodermoclysis** and subcutaneous injections **no longer skilled**
- **Daily insulin injections** with 2 order changes over last 14 days

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Medicare Coverage
2. Skilled Nursing
"Inherent Complexity"

- IV (parental) medications
- N/G, gastrostomy tubes, jejunostomy tubes
- Application of dressing with prescription medications and aseptic technique
- Treatment of pressure ulcer grade 3 or worse
- Initial phases of a regimen involving medical gases such as bronchodilators and oxygen therapy
- Colostomy Care
- Bowel and Bladder Training

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Medicare Coverage
3. Management of Care Plan

"Constitute skilled services when, because of the patient's physical or mental condition, those activities require the involvement of technical or professional personnel in order to meet the patient's needs, promote recovery and ensure medical safety." (Final Rule 7/31/99)

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Medicare Coverage
3. Management of Care Plan

Example #1

"An aged patient with a history of diabetes mellitus and angina pectoris who is recovering from an open reduction of a fracture of the neck of the femur requires, among other services, careful skin care, appropriate oral medications, a diabetic diet, an exercise program to preserve muscle tone and body condition, and observation to detect signs of deterioration in his or her condition or complications resulting from restricted, but increasing mobility." (Final Rule 7/31/99)

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Medicare Coverage
3. Management of Care Plan

Example #1 (Cont.)

"Although any of the required services could be performed by a properly instructed person, such a person would not have the ability to understand the relationship between the services and evaluate the ultimate effect of one service on the other. Since the nature of the patient's condition, age, and immobility create a high potential for serious complications, such an understanding is essential to ensure the patient's recovery and safety." (Final Rule 7/31/99)

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Medicare Coverage
3. Management of Care Plan

Example #1 (Cont.)

"Under these circumstances, the management of the plan of care would require the skills of a nurse even though the individual services are not skilled. Skilled planning and management activities are not always specifically identified in the patient's clinical record. Therefore, if the patient's overall condition supports a finding that recovery and safety can be ensured only if the total care is planned, managed, and evaluated by technical or professional personnel, it is appropriate to infer that skilled services are being provided." (Final Rule 7/31/99)

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Medicare Coverage
4. Observation and Assessment

- Reasonable probability for **complications** or potential for further acute episodes of the patient's changing condition
- Needed to **identify and evaluate** the patient's need for modification of treatment or
- Additional **medical procedures** until his or her condition is stabilized

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Medicare Coverage
4. Observation and Assessment

Example #1

"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." (Final Rule 7/31/99)

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Medicare Coverage
4. Observation and Assessment

Example #2

"Similarly, surgical patients transferred from a hospital to an SNF while in the complicated, un-stabilized postoperative period, for example, after hip prosthesis or cataract surgery, may need continued close skilled monitoring for postoperative complications and adverse reaction." (Final Rule 7/31/99)

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Medicare Coverage
4. Observation and Assessment

Example #3

"Patients who, in addition to their physical problems, exhibit acute psychological symptoms such as depression, anxiety, or agitation, may also require skilled observation and assessment by technical or professional personnel to ensure their safety or the safety of others, that is, to observe for indications of suicidal or hostile behavior. The need for services of this type must be documented by physicians' orders or nursing or therapy notes." (Final Rule 7/31/99)

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Medicare Coverage
5. Patient Education Services

- Skilled if the use of technical or professional personnel is necessary to teach a patient self-maintenance

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Medicare Coverage
5. Patient Education Services

Example #1

"A patient who has had a recent leg amputation needs skilled rehabilitation services provided by technical or professional personnel to provide gait training and to teach prosthesis care. Similarly, a patient newly diagnosed with diabetes requires instruction from technical or professional personnel to learn the self-administration of insulin or foot-care precautions." (Final Rule 7/31/99)

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Medicare Coverage
5. Patient Education Services

Colostomy Care

Stump Wrapping

Medication Management

Self Administration Insulin

Bowel and Bladder Training

"Teaching and Training"

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Medicare Coverage
6. Skilled Rehabilitation

- Transmittal 262
  - On a **daily** basis
  - Services rendered are **reasonable and necessary**
  - **Physician** ordered
  - **Practical matter**
  - An appropriately licensed or certified individual must provide or **directly supervise** the therapeutic service and coordinate the intervention with nursing services

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Medicare Coverage
6. Skilled Rehabilitation
MD Involvement

- The service must be **ordered by a physician**
- The therapy intervention must **relate directly and specifically to an active written treatment** regimen established by the physician after any needed consultation with the qualified rehabilitation therapy professional and must be **reasonable and necessary** to the treatment of the beneficiary's illness or injury necessary to the treatment of the beneficiary's illness or injury

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Medicare Coverage
6. Skilled Rehabilitation
MD Involvement

- MD involvement to **prevent injuries**
- Medicare allows the professional therapist to develop a **suggested plan** of treatment and to begin providing services based on the plan prior to MD signature
- **MD signature** required before facility bills Medicare
- MD **faxed signatures** acceptable

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Jimmo v. Sebelius

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Skilled Care Historical Perspective

- Expectation of improvement
- Actual improvement over a reasonable amount of time
- Prior level of function

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Improvement Standard

- "Improvement Standard" is not to be applied in determining Medicare coverage for maintenance claims in which skilled care is required
- Medicare has long recognized that even in situations where no improvement is expected, skilled care may nevertheless be needed for maintenance purposes (i.e., to prevent or slow a decline in condition)

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Jimmo v. Sebelius

- The Jimmo v. Sebelius case challenged Medicare's use of an "Improvement Standard" to make coverage determinations
- The lawsuit was brought on behalf of:
  - Six individuals representing a Nationwide class of Medicare beneficiaries
  - National organizations representing people with chronic conditions

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Jimmo v. Sebelius
Individual Plaintiffs

- Lead plaintiff, **Glenda Jimmo**, is a 76-year-old Medicare beneficiary from Bristol, Vermont
- **Blind** since birth and has had her right **leg amputated** due to complications from **diabetes**
- Requires a wheelchair, and receives **multiple home health care visits** per week for various treatments for her complex condition
- Medicare denied coverage for these services, saying that she was **unlikely to improve**

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Jimmo v. Sebelius
Individual Plaintiffs
Glenda Jimmo

Paul O. Boisvert for New York Times

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Jimmo v. Sebelius
Individual Plaintiffs
Rosalie J. Berkowitz

New York Times October 22, 2012

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The Jimmo Settlement

- In 2013, a U.S. District Court approved the settlement agreement in **Jimmo v. Sebelius,**
- [1] requiring the Centers for Medicare & Medicaid Services (CMS) to confirm that Medicare coverage of **home health, skilled nursing facility (SNF), and outpatient therapy** services is determined by a beneficiary's need for skilled nursing and/or therapy, not on a beneficiary's potential for improvement.
- [2] The Jimmo Settlement clearly directs that **Medicare covers skilled services** not only to **improve a resident's condition**, but equally to **maintain or slow the decline** of a patient's condition.
- Sadly, **seven years later**, beneficiaries and their families are still being denied skilled care on the basis of an erroneous "Improvement Standard."

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The Jimmo Case Study
Center for Medicare Advocacy (CMA)

- In early 2020, the son of a Medicare beneficiary in traditional Medicare wrote the Center for Medicare Advocacy (the Center) to describe his experience with the poor implementation of the Jimmo Settlement.

- He stated that his father's Medicare coverage in a SNF was terminated because he had "plateaued" and was purportedly no longer making progress in skilled therapy.

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The Jimmo Case Study
Center for Medicare Advocacy (CMA)

- During the expedited appeals process, Medicare contractors "stressed . . in advance over the phone that they would **only consider medical records as evidence and they would absolutely refuse to consider any violations of Jimmo law when they ruled on our appeal.**"
- A 1-800-MEDICARE representative told him that "[t]he Jimmo regulations were from **2014, and they are outdated now and don't apply anymore**." After pointing to CMS's Jimmo-dedicated webpage,[3] the Medicare representative escalated the case to the Advanced Resolution Center (ARC). Unfortunately, the ARC also refused to discuss the SNF's violation of the Jimmo Settlement.

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The Jimmo Case Study
Center for Medicare Advocacy (CMA)

- Because the SNF terminated Medicare coverage, the beneficiary was responsible for the cost of any skilled care he received after the termination date (which amounted to over $10,000).
- The beneficiary's father asked the SNF twice to submit a "demand bill" to Medicare for the cost of those services, thereby setting up his father's right to file a standard appeal. Two months later, the SNF had yet to fulfill his request. During his conversation with the ARC, he was told there was no "such a thing as a Standard Medicare Appeal or a Demand Bill."

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The Jimmo Case Study
Center for Medicare Advocacy (CMA)

- Contrary to what the Medicare representative told the beneficiary's son, the Jimmo Settlement absolutely still represents official Medicare policy. There is no end to the Settlement's conclusions.
- As noted on CMS's Jimmo webpage, "[t]he 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 . . . and nursing and therapy in inpatient rehabilitation hospitals for beneficiaries who need the level of care that such hospitals provide."

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The Jimmo Case Study
Center for Medicare Advocacy (CMA)

- The Settlement applies to all Medicare beneficiaries nationwide, regardless of whether the individual is in real/traditional Medicare or a private Medicare Advantage plan.
- Thus, any SNF that has been certified to participate in the Medicare program may not end Medicare-covered skilled services solely on the basis that a beneficiary lacks the potential to improve.

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The Jimmo Case Study
Center for Medicare Advocacy (CMA)

- Medicare contractors **cannot simply refuse** to follow the law or accept relevant evidence.
- Federal regulations state that **beneficiaries can submit evidence** to be considered by the Medicare contractors overseeing **expedited appeals** in making their decision.
- Additionally, the Medicare provider has the burden of proof to demonstrate that **"termination of coverage is the correct decision, either on the basis of medical necessity, or based on other Medicare coverage policies."**

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The Jimmo Case Study
Center for Medicare Advocacy (CMA)

- Contrary to what the Advance Resolution Center (ARC) told the beneficiary's son, demand bills and standards appeals are real, important components of Medicare beneficiary appeal rights. The Medicare Claims Processing Manual (MCPM) states that "demand bills are both a principle and a mechanism of Medicare."
- The principle goes back to the founding of the Program, reflected in the protection of the rights of the Program's beneficiaries being among the first sections of Title XVIII. The principle assures that beneficiaries have the right to demand that Medicare be billed for the services provided to them, whether or not that billing provides Medicare payment. By assuring claims are sent to and processed by Medicare, permitting official payment decisions to be made, beneficiaries retain the right to appeal payment decisions made on those claims, when they believe need to use that right exists

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The Jimmo Case Study
Center for Medicare Advocacy (CMA)

- SNFs cannot refuse to submit demand bills to Medicare.
- Medicare beneficiaries have the right to demand that SNFs submit claims to Medicare for services they have received.
- The refusal to bill Medicare for those services impedes a beneficiary's ability to exercise his or her right to a standard appeal.

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The Jimmo Case Study
Center for Medicare Advocacy (CMA)

- CMS has opportunity to ensure that the Jimmo Settlement Agreement is being properly implemented in the applicable health care settings.
- Moreover, the poor education of Medicare representatives and contractors about the Settlement is continuing to harm Medicare beneficiaries in need of maintenance nursing and/or therapy services, and is shifting the cost of Medicare-covered care onto beneficiaries and families.
- CMS must conduct a meaningful education campaign to ensure that Medicare providers, contractors, and adjudicators are correctly implementing the Jimmo Settlement (as well as other Medicare laws, regulations, and policies).

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Medicare Coverage Criteria Documentation Part II

Coming Soon!

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We **C.A.R.E.** About Care

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R eimbursement
egulatory
ehabilitation

E ducation
fficiency

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Our Process

- Prescribed medical record review process that encompasses HHI's core business
- HHI Regional HealthCARE Specialists provide expertise through teaching and training and an extensive chart audit process in order to ensure:
  - MDS Accuracy
  - MDS Supporting Documentation
  - Billing Accuracy
  - Nursing Documentation
  - Therapy Documentation
  - Clinically Appropriate Care

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HHI
Services and Plans

Gold C.A.R.E.
2 Year Service Plan

Platinum C.A.R.E.
3 Year Service Plan

List of HHI Services

PDPM Training and Audits | Medicare | Compliance | Rehab Program Development | Seminars | MMQ Audits | Mock RAC Audits | Rehab Certification | Mock Health Inspection Survey | MDS Competency | Talent Management | Denials Management | Compliance Certification | Clinically Appropriate Stay | QAPI | QIS | Medicare Part B Program | MDSC Mentor Program | Case Mix Consulting | Professional Development | Leadership Trainings | Regulatory and Survey Assistance | Five Star | PBJ | Quality Measures | Analysis | Staff Training | Infection Control and More!

Silver C.A.R.E.
1 Year Service Plan

A La C.A.R.E.
Customized Service Plan

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Our Senior HHI Specialists

- Founded in 2001
- Privately owned and operated
- Ranked among Inc. Magazine's top 5,000 fastest growing private companies in America three years in a row
- Active monthly contracts in 24 states
- Over 1,000 Skilled Nursing Facilities serviced
- Over 3,000 Clinicians Certified on the MDS

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https://www.harmony-healthcare.com/harmonyhelp

Live Support Available
8:00 a.m. – 5:00 p.m. EST

HarmonyHelp

With **HarmonyHelp**, Harmony Healthcare International (HHI) provides an invaluable resource for the entire interdisciplinary team. Imagine having questions answered by a Harmony HealthCARE Specialist within minutes of the inquiry. Fill out the form on the right to learn more about HarmonyHelp and our various Service Plans.

The **Knowledge Center** is loaded with **information** that will assist with your daily responsibilities at your facility. This self-help site is broken up into **5 Sections:**

Manuals I Tools I C.A.R.E. Community I Hot Topics I FAQ (Frequently Asked Questions)

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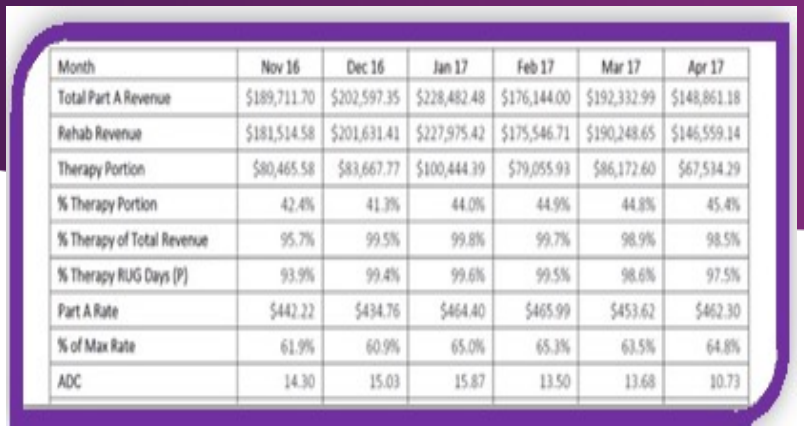
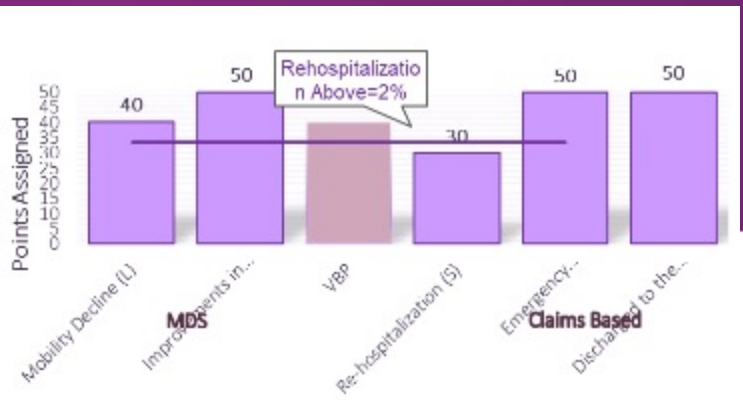
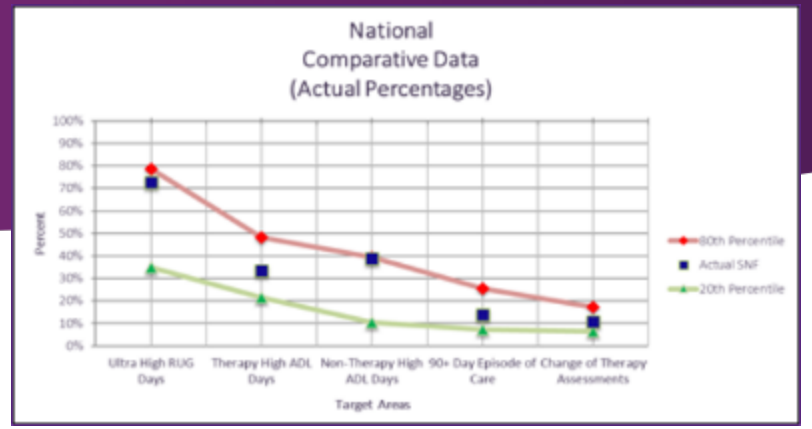


Month	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Apr 17
Total Part A Revenue	$189,711.70	$202,597.35	$228,482.48	$176,144.00	$192,332.99	$148,861.18
Rehab Revenue	$181,514.58	$201,631.41	$227,975.42	$175,546.71	$190,248.65	$146,559.14
Therapy Portion	$80,465.58	$83,667.77	$100,444.39	$79,055.93	$86,172.60	$67,534.29
% Therapy Portion	42.4%	41.3%	44.0%	44.9%	44.8%	45.4%
% Therapy of Total Revenue	95.7%	99.5%	99.8%	99.7%	98.9%	98.5%
% Therapy RUG Days (P)	93.9%	99.4%	99.6%	99.5%	98.6%	97.5%
Part A Rate	$442.22	$434.76	$464.40	$465.99	$453.62	$462.30
% of Max Rate	61.9%	60.9%	65.0%	65.3%	63.5%	64.8%
ADC	14.30	15.03	15.87	13.50	13.68	10.73





Complimentary HHI Offerings

- PDPM Revenue and Risk Analysis
- Medicare Part A Revenue and Risk Analysis
- Five-Star Quality Measure Points Analysis
- PEPPER Analysis

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