

TRANSMITTAL 262

“What they haven’t told you about Medicare Coverage.”

Introduction:

FOX vs. BOWEN & TRANSMITTAL 262

Fox vs. Bowen

In 1986, a Connecticut Federal Judge in a lawsuit (Fox vs. Bowen) determined that HCFA (now CMS) had violated Medicare beneficiaries' entitled constitutional rights to skilled nursing services and ordered HCFA to revise the Skilled Nursing Manual to clarify the requirements for coverage under Medicare Part A. The court ordered them to reopen 14,000 cases and pay for the skilled care. The court also ordered them to look for a "reason to pay" instead of a "reason not to pay." The court's purpose was to ensure that claims are approved when the requirements are met.

Transmittal 262

As a result of Fox vs. Bowen HCFA took action in 1987 by issuing Transmittal 262, but never sent this information to the providers. It was only sent to the Fiscal Intermediaries who offered no education or training on the transmittal or the court-ordered process.

TRANSMITTAL 262
Taken directly from the CMS Website
Skilled Nursing Facility Manual
Chapter 2 - Section 214.1 – 214.7
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3. Medical Appropriateness.--An elapsed period of more than 14 days was permitted for skilled nursing facility admissions where the patient's condition makes it medically inappropriate to begin an active course of treatment in an SNF within 14 days after hospital discharge, and it was medically predictable at the time of the hospital discharge that he would require covered care within a predeterminable time period. The fact that a patient entered an SNF immediately upon discharge from a hospital, for either covered or noncovered care, does not necessarily negate coverage at a later date, assuming the subsequent covered care was medically predictable.

4. Readmission to an SNF.--If an individual who was receiving covered posthospital extended care left an SNF and was readmitted to the same or any other participating SNF for further covered care within 14 days, the 14-day transfer requirement was considered to be met. Thus, the period of extended care services could be interrupted briefly and then resumed, if necessary, without hospitalization preceding the readmission to an SNF. (See 3 above for situations where a period of more than 14 days between SNF discharge and readmission, or more than 14 days of noncovered care in an SNF, was followed by later covered care.)

214. COVERED LEVEL OF CARE - GENERAL

Care in a SNF is covered if all of the following three 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 §§214.1 - 214.3);*
- *The patient requires these skilled services on a daily basis (see §214.5); and*
- *As a practical matter, considering economy and efficiency, the daily skilled services can be provided only on an inpatient basis in an SNF. (See §214.6.)*

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

In determining whether the level of care requirements are met, the first consideration should be whether a patient needs skilled care. If a need for a skilled service does not exist, then the "daily" and "practical matter" requirements do not have to be addressed.

In addition, the services must be furnished pursuant to a physician's orders and be reasonable and necessary for the treatment of a patient's illness or injury, i.e., be consistent with the nature and severity of the individual's illness or injury, his particular medical needs, and accepted standards of medical practice. The services must also be reasonable in terms of duration and quantity.

EXAMPLE: Even though the irrigation of a catheter may be a skilled nursing service, daily irrigations may not be "reasonable and necessary" for the treatment of a patient's illness or injury.

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214.1 Skilled Nursing and Skilled Rehabilitation Services

- A. Skilled Services--Defined.--Skilled nursing and/or skilled rehabilitation services are those services, furnished pursuant to physician orders, that:*
- o Require the skills of qualified technical or professional health personnel such as registered nurses, licensed practical (vocational) nurses, physical therapists, occupational therapists, and speech pathologists or audiologists; and*
 - o 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.

Assume that skilled services provided by a participating SNF are furnished by or under the general supervision of the appropriate skilled nursing or skilled rehabilitation personnel.

B. Principles for Determining Whether a Service is Skilled

- o 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 catheters; and ultrasound, shortwave, and microwave therapy treatments.
- o The nature of the service and the skills required for safe and effective delivery of that service are considered 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: Even where a patient's full or partial recovery is not possible, a skilled service still could be needed to prevent deterioration or to maintain current capabilities. A cancer patient, for instance, whose prognosis is terminal may require skilled services at various stages of his illness in connection with periodic "tapping" to relieve fluid accumulation and nursing assessment and intervention to alleviate pain or prevent deterioration. The fact that there is no potential for such a patient's recovery does not alter the character of the services and skills required for their performance.

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 carried out by nonskilled personnel. (See §214.3.A.)

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- o *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 nursing or therapy notes.*

EXAMPLE: The existence of a plaster cast on an extremity generally does not indicate a need for skilled care. However, a patient with a preexisting acute skin problem, preexisting peripheral vascular disease, or a need for special traction of the injured extremity might need skilled nursing or skilled rehabilitation personnel to observe for complications or to adjust traction.

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.

- In determining whether services rendered in an 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 and has a Grade 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.

- 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.

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- C. *Specific Examples of Some Skilled Nursing or Skilled Rehabilitation Services*
 1. *Management and Evaluation of a Patient Care Plan.--The development, management, and evaluation of a patient care plan, based on the*

physician's orders, 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. Skilled management would be required where the sum total of unskilled services which are a necessary part of the medical regimen, when considered in light of the patient's overall condition, makes the involvement of skilled nursing personnel necessary to promote the patient's recovery and medical safety.

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 the patient's treatment regimen is essentially stabilized, even though the individual services involved are supportive in nature and do not require skilled nursing personnel.

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.

2. Observation and Assessment of Patient's Condition.--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 treatment regimen is essentially stabilized.

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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.

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.

EXAMPLE 3: A patient has undergone hip surgery and has been transferred to an SNF. Skilled observation and monitoring of the patient for possible adverse reaction to the operative procedure, development of phlebitis, skin breakdown, or need for the administration of subcutaneous Heparin, is both reasonable and necessary.

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.

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 an 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.

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.

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.

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3. *Teaching and Training Activities.* --Teaching and training activities which require skilled nursing or skilled rehabilitation personnel to teach a patient how to manage his treatment regimen would constitute skilled services. Some examples are:
 - o *Teaching self-administration of injectable medications or a complex range of medications;*
 - o *Teaching a newly diagnosed diabetic to administer insulin injections, to prepare and follow a diabetic diet, and to observe foot-care precautions;*
 - o *Teaching self-administration of medical gases to a patient;*
 - o *Gait training and teaching of prosthesis care for a patient who has had a recent leg amputation;*
 - o *Teaching patients how to care for a recent colostomy or ileostomy;*
 - o *Teaching patients how to perform self-catheterization and self-administration of gastrostomy feedings;*
 - o *Teaching patients how to care for and maintain central venous lines, such as Hickman catheters;*
 - o *Teaching patients the use and care of braces, splints and orthotics, and any associated skin care; and*
 - o *Teaching patients the proper care of any specialized dressings or skin treatments.*
- E. *Questionable Situations.* --There must be specific evidence that daily skilled nursing or skilled rehabilitation services are required and received if:
 - o *The primary service needed is oral medication; or*
 - o *The patient is capable of independent ambulation, dressing, feeding, and hygiene.*

214.2 Direct Skilled Nursing Services to Patients.--Some examples of direct skilled nursing services are:

- o Intravenous, intramuscular or subcutaneous injections and hypodermoclysis or intravenous feeding (although giving an insulin injection is considered a skilled service, it is customary to teach patients to self-administer such an injection; if self-injection cannot be learned, however, insulin injection is a skilled service);*
- o Nasogastric tube, gastrostomy, and jejunostomy feedings;*
- o Naso-pharyngeal and tracheotomy aspiration;*

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- o Insertion, sterile irrigation, and replacement of catheters; care of a suprapubic catheter and, in selected patients, urethral catheter (the mere presence of a urethral catheter, particularly one placed for convenience or the control of incontinence, does not justify a need for skilled nursing care. On the other hand, the insertion and maintenance of a urethral catheter as an adjunct to the active treatment of disease of the urinary tract may justify a need for skilled nursing care. In such instances, the need for a urethral catheter must be justified and documented in the patient's medical record; i.e., it must be established that it is reasonable and necessary for the treatment of the patient's condition.);*
- o Application of dressings involving prescription medications and aseptic techniques (see §214.4 for exception);*
- o Treatment of decubitus ulcers, of a severity rated at Grade 3 or worse, or a widespread skin disorder (see §214.4 for exception);*
- o Heat treatments which have been specifically ordered by a physician as part of active treatment and which require observation by skilled nursing personnel to adequately evaluate the patient's progress (see §214.4 for exception);*
- o 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;*
- o Initial phases of a regimen involving administration of medical gases such as bronchodilator therapy; and*
- o Care of a colostomy during the early postoperative 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.*

214.3 Direct Skilled Rehabilitation Services to Patients

A. Skilled Physical Therapy

1. *General.* --Skilled physical therapy services must meet all of the following conditions:
 - o *The services must be directly and specifically related to an active written treatment plan designed by the physician after any needed consultation with a qualified physical therapist;*
 - o *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;*

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- o *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;*
- o *The services must be considered under accepted standards of medical practice to be specific and effective treatment for the patient's condition; and*
- o *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 bedbound for one week and, as a result, has 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 services to restore lost functions, those services are reasonable and necessary.

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.

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, the physical therapy would not be reasonable and necessary, and thus would not be covered skilled physical therapy services.

Many SNF inpatients do not require skilled physical therapy services but do require services which are routine in nature. Those services can be performed by supportive personnel; e.g., aides or nursing personnel, without the supervision of a physical therapist. Such services, as well as services involving activities for the general good and welfare of patients (e.g., general exercises to promote overall fitness and flexibility and activities to provide diversion or general motivation) do not constitute skilled physical therapy.

2. *Application of Guidelines.--Some of the more common 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.*

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- 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, constitute skilled physical therapy.*
- c. *Gait Training.--Gait evaluation and training furnished a patient whose ability to walk has been impaired by neurological, muscular, or skeletal abnormality require the skills of a qualified physical therapist and constitute skilled physical therapy if they reasonably can be expected to improve significantly the patient's ability to walk.*

Repetitious exercises to improve gait, or to maintain strength and endurance, and assistive walking are appropriately provided by supportive personnel, e.g., aides or nursing personnel, and do not require the skills of a physical therapist. Thus, such services are not skilled physical therapy.

- 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 and the degree to be restored).*

Range of motion exercises which are not related to the restoration of a specific loss of function often may be provided safely by supportive personnel, such as aides or nursing personnel, and may not 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.

- e. *Maintenance Therapy.* --The repetitive services required to maintain function sometimes involve the use of complex and sophisticated therapy procedures and, consequently, the judgment and skill of a physical therapist might be required for the safe and effective rendition of such services. (See §214.1.B.) The specialized knowledge and judgment of a qualified physical therapist may be required to establish a maintenance program intended to prevent or minimize deterioration caused by a medical condition, if the program is to be safely carried out and the treatment aims of the physician achieved. Establishing such a program is a skilled service.

EXAMPLE: *A Parkinson's patient who has not been under a restorative physical therapy program may require the services of a physical therapist to determine what type of exercises are required for the maintenance of 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, and such infrequent reevaluations as may be required, would constitute skilled physical therapy.*

While a patient is under a restorative physical therapy program, the physical therapist should regularly reevaluate his condition and adjust any exercise program the patient is expected to carry out himself or with the aid of supportive personnel to maintain the

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function being restored. Consequently, by the time it is determined that no further restoration is possible, i.e., by the end of the last restorative session, the physical therapist will have already designed the 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 and are skilled physical therapy.
- 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.

- C. Speech Pathology. --See §230.3.B.*
- D. Occupational Therapy. --See §230.3.C.*

214.4 Nonskilled Supportive or Personal Care Services.--The following services are not skilled services unless rendered under circumstances detailed in §214.1.B:

- o Administration of routine oral medications, eye drops, and ointments (the fact that a patient cannot be relied upon to take such medications himself or that State law requires all medications to be dispensed by a nurse to institutional patients would not change this service to a skilled service);*
- o General maintenance care of colostomy and ileostomy;*
- o Routine services to maintain satisfactory functioning of indwelling bladder catheters (this would include emptying containers and cleaning them, and clamping tubing);*
- o Changes of dressings for noninfected postoperative or chronic conditions;*
- o Prophylactic and palliative skin care, including bathing and application of creams, or treatment of minor skin problems;*
- o Routine care of the incontinent patient, including use of diapers and protective sheets;*
- o General maintenance care in connection with a plaster cast (skilled supervision or observation may be required where the patient has a preexisting skin or circulatory condition or needs to have traction adjusted);*
- o Routine care in connection with braces and similar devices;*

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- o Use of heat as a palliative and comfort measure, such as whirlpool or steam pack;*
- o Routine administration of medical gases after a regimen of therapy has been established (i.e., administration of medical gases after the patient has been taught how to institute therapy);*
- o Assistance in dressing, eating, and going to the toilet;*
- o Periodic turning and positioning in bed; and*
- o General supervision of exercises which have been taught to the patient and the performance of repetitious exercises that do not require skilled rehabilitation personnel for their performance. (This includes the actual carrying out of maintenance programs where the performance of repetitive exercises that may be required to maintain function do not necessitate a need for the involvement and services of skilled rehabilitation personnel. It also includes the carrying out of repetitive exercises to improve gait, maintain strength or endurance; passive exercises to maintain range of*

motion in paralyzed extremities which are not related to a specific loss of function; and assistive walking.) (See §230.3.A.2(d).)

214.5 Daily Skilled Services--Defined.--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-day-a-week basis. However, if skilled rehabilitation services are not available on a 7-day-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 he needs and receives those services on at least 5 days a week. Accordingly, if a facility provides physical therapy on only 5 days a week and a patient in the facility requires and receives physical therapy on each of those days, the requirement that skilled rehabilitation services be provided on a daily basis is met. (If the services are available less than 5 days a week, though, 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.

214.6 Services Provided on an Inpatient Basis as a "Practical Matter".--In determining whether the daily skilled care needed by an individual can, as a "practical matter," only be provided in an SNF on an inpatient basis, the individual's physical condition and the availability and feasibility of using more economical alternative facilities or services are considered.

As a "practical matter," daily skilled services can be provided only in an 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:

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

The availability at home of capable and willing family or the feasibility of obtaining other assistance for the patient 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 restorative 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 of further injury from falling, of dehydration or of malnutrition because insufficient supervision or assistance could 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.

- A. The Availability of Alternative Facilities or Services.--Alternative facilities or services may be available to a patient if health care providers such as home health agencies were utilized. These alternatives are not always available in all communities and even where they exist they may not be available when needed.

EXAMPLE: Where the residents of a rural community generally utilize the outpatient facilities of a hospital located some distance from the area, the hospital outpatient department constitutes an alternative source of care that is available to the community. Roads in winter, however, may be impassable for some periods of time and in special situations institutionalization might be needed.

In determining the availability of more economical care alternatives, the coverage or noncoverage of that alternative care is not a factor to be considered. Home health care for a patient who is not homebound, for example, may be an appropriate alternative in some cases. The fact that such care cannot be covered by Medicare is irrelevant.

The issue is feasibility and not whether coverage is provided in one setting and not provided in another. For instance, an individual in need of daily skilled physical therapy might be able to receive the services needed on a more economical basis from an independently practicing physical therapist. However, the fact that Medicare reimbursement could not be made for the services because the \$500 expense limitation applicable to the services of an independent physical therapist had been exceeded or because the patient was not enrolled in Part B, would not be a basis for determining that, as a practical matter, the needed care could only be provided in a SNF.

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In determining the availability of alternate facilities or services, whether the patient or another resource can pay for the alternate services is not a factor to be considered. < >

- B. Whether Available Alternatives are More Economical in the Individual Case.-- If a generally more economical care alternative is available to provide the needed care, whether the use of the alternative actually would be more economical in the individual case is considered.*

EXAMPLE 1: If a patient's condition requires daily transportation to the alternative source of care (e.g., a hospital outpatient department) by ambulance, it might be more economical from a health care delivery viewpoint to provide the needed care in the SNF setting.

EXAMPLE 2: If needed care could be provided in the home, but the patient's residence is so isolated that daily visits would entail inordinate travel costs, care in an SNF might be a more economical alternative.

- C. Whether the Patient's Physical Condition Would Permit Him to Utilize an Available, More Economical Care Alternative.--In determining the practicality of using more economical care alternatives, the patient's medical condition should be considered. If the use of those alternatives would adversely affect the patient's medical condition, then as a practical matter the daily skilled services can only be provided by an SNF on an inpatient basis.

If the use of a care alternative involves transportation of the individual on a daily basis, whether daily transportation would cause excessive physical hardship is considered. Determinations on whether a patient's condition would be adversely affected if an available, more economical care alternative were utilized should not be based solely on the fact that the patient is nonambulatory. There are individuals confined to wheelchairs who, though nonambulatory, could be transported daily by automobile from their homes to alternative care sources without any adverse impact. Conversely, there are instances where an individual's condition would be adversely affected by daily transportation to a care facility, even though he is able to ambulate to some extent.

EXAMPLE: A 75-year-old woman has suffered a cerebrovascular accident and cannot climb stairs with safety. The patient lives alone in a second-floor apartment accessible only by climbing a flight of stairs. She requires physical therapy and occupational therapy on alternate days, and they are only available in a CORF one mile away from her apartment. However, because of her inability to negotiate the stairs, the daily skilled services she requires cannot, as a practical matter, be provided to the patient outside the SNF.

Do not interpret the "practical matter" criterion 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. While most beneficiaries requiring an SNF level of care find that they are unable to leave the facility for even the briefest of time, the fact that a patient is granted an outside pass, or short leave of absence, for the purpose of attending a special religious service, holiday meal or family occasion, for going on a ride or for a trial visit home, is not by itself evidence that the individual no longer needs to be in a SNF to receive required skilled care. Very often special arrangements, not feasible on a daily basis, have had to be made to allow for absence from the facility. Where frequent or prolonged periods away from the SNF become possible, however, then questions as to whether the patient's care can, as a practical matter, only be furnished on an inpatient basis in an SNF may be raised. Base decisions in these cases on information reflecting the care needed and received by the patient while in the SNF and on the arrangements needed for the provision, if any, of this care during any absences. (See §242.3 for counting inpatient days during a leave of absence.)

A conservative approach to retain the presumption for waiver of liability may lead a facility to notify patients that leaving the facility will result in denial of coverage. Such a notice is not appropriate. If an SNF determines that covered care is no longer needed, the situation does not change whether the patient actually leaves the facility or not. (See §356.2.)

214.7 Prohibition Against Use of "Rules of Thumb" in Medicare Review Determinations.--Do not notify patients that services are not covered by Medicare because of "rules of thumb" such as lack of restoration potential, ability to walk a certain number of feet, degree of stability, or because of general inferences about patients with similar diagnosis or general data related to utilization. A decision as to whether care is covered by Medicare must be made based on thorough analysis of the patient's total condition and individual need for care.

By understanding Transmittal 262 and seeking help to manage the complexities of Medicare, a provider can increase business, control cost and quality, and generate hundreds of thousands of dollars in additional revenue.

To find out what kind of Systems and Services Caregiver Management Systems can provide to help utilize Transmittal 262 in your Medicare program contact us at:



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