

A Closer Look at the Revised Nursing Facility Regulations

Rehabilitation Services

Executive Summary

The substantive requirements for specialized rehabilitative services are largely unchanged from the prior version of the regulations, with the exception of “respiratory therapy,” which is added to the list of services that a facility must provide to its residents who need them. In responding to a question regarding whether respiratory therapy should include ventilator care, CMS emphasized that a nursing facility is obligated to meet residents’ needs.

Introduction

On September 28, 2016, the Centers for Medicare & Medicaid Services (CMS) released revised nursing facility regulations. These regulations govern most aspects of nursing facility operations, and apply nationwide to any nursing facility that accepts Medicare and/or Medicaid reimbursement.

Required Rehabilitation Services

Nursing facilities must provide “specialized rehabilitative services” to any resident who needs them. These services include “physical therapy,

speech-language pathology, occupational therapy, respiratory therapy, and rehabilitative services for a mental disorder and intellectual disability or services of a lesser intensity.”¹ The prior version of the regulations included the same list, except for the new addition of “respiratory therapy.”

The potential scope of respiratory therapy is broad. The nursing facility regulations do not list specific types of respiratory therapy, but the Medicare program recognizes many types of respiratory therapy for at-home care (for example); these services include Continuous Positive Airway Pressure (CPAP) devices, Intermittent Positive Pressure Breathing (IPPB) devices, nebulizers, oxygen supplies and accessories, and Respiratory Assist Devices.²

In comments issued when the regulations were released, CMS indicated that the scope of respiratory therapy should be broad, and may likely include ventilator care. CMS referenced concern by one commenter “regarding the difficulty smaller and more rural facilities may face when providing very complex respiratory therapy services such as mechanical ventilation,” and responded by emphasizing the facility’s broad obligations. While acknowledging the challenges faced by smaller and rural facilities, CMS reiterated the requirement

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1 42 C.F.R. § 483.65(a).

2 CMS, *DMEPOS Quality Standards*, MedLearn, at 11 (ICN 905709 September 2016), available at [cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/DMEPOS_Qual_Stand_Booklet_ICN905709.pdf](https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/DMEPOS_Qual_Stand_Booklet_ICN905709.pdf).

that facilities “be able to provide, directly or under arrangements, the necessary care that their residents require.”³

CMS urged facilities to use the facility assessment process, described at section 483.70(e), to assess the resources they need to provide care to their residents and to make decisions about direct care staffing needs. The regulations require facilities to conduct facility assessments “as necessary, and at least annually.”⁴ In the comments accompanying the regulations, CMS stated that once a facility completes an assessment, “changes in its resident population should not necessitate a change in the facility assessment unless the facility begins admitting residents that require substantially different care.”⁵

If a nursing facility does not employ therapy providers, it may use “outside” therapy providers. These providers are not required to be certified by Medicare or Medicaid, but it is a requirement that they not have been excluded from a federally funded health care program (including Medicare and Medicaid).⁶

In a change from current practice, the revised regulations authorize a resident’s attending physician to delegate the task of writing therapy orders to a qualified therapist, so long as the therapist is acting under the supervision of the physician and the delegation complies with state scope-of-practice law.⁷

Rehabilitation Services under Medicaid and Medicare

Residents sometimes have difficulty receiving required therapy services. Some nursing facilities improperly limit therapy to only Medicare-reimbursed care, and also limit Medicare coverage to an inappropriately small number of days or weeks.

Nursing facility residents should remember two important principles. The first principle is that facilities must not discriminate based on payment source in determining what care to provide and how to provide it. Thus, if a resident needs therapy, he or she should receive therapy, whether the resident’s care at that time is reimbursed through Medicare, Medicaid, or private payment.

The second principle is that Medicare coverage does not require that the resident’s functional capacity be improving. Residents often are told that Medicare coverage for physical or occupational therapy is ending because the resident supposedly has “plateaued.” That is wrong, as has been confirmed by a recent lawsuit against the Medicare program.

Jimmo v. Sebelius is a nationwide class action confirming Medicare coverage of professional nursing and professional therapy services that are needed to maintain a Medicare patient’s function or to prevent or slow the patient’s deterioration or decline.⁸ The Settlement applies both to traditional Medicare (Parts A and B) and to Medicare Advantage plans (managed care) and is applicable in three settings: nursing facilities, home health, and outpatient therapy (physical, occupational, and speech). The Settlement firmly rejects, as inconsistent with the Medicare law, nursing facilities’ frequent claims to residents and their families that Medicare will not pay for additional days of care when the resident has “plateaued” or “is not improving.”

3 81 Federal Register 68,688, 68,782 (2016).

4 42 C.F.R. § 483.70(e).

5 81 Federal Register at 68,786-68,787 (2016).

6 42 C.F.R. § 483.65(a)(2); 81 Federal Register at 68,782 (2016).

7 42 C.F.R. § 483.30(e)(3).

8 Case No. 5:11-cv-00017-cr (D. Vt., Feb. 16, 2017) (Corrective Statement), available at medicareadvocacy.org/medicare-info/improvement-standard/.

Jimmo is an important protection for nursing facility residents. As discussed, nursing facilities frequently tell residents that they are being “discharged” from Medicare because they are “not improving” or “have plateaued.” Residents and their families often interpret this statement to mean that they are also being “discharged” from the facility. This understanding is incorrect. Whether Medicare will continue to pay for a resident’s care under Part A or through a Medicare Advantage plan, is a different question from whether a resident must leave the facility.⁹

Residents are not automatically required to leave a nursing facility when Medicare coverage for their days of care ends. Residents whose stay is no longer covered by Medicare can remain in the facility with another source of payment, such as out-of-pocket (private) payment or Medicaid.

In addition, a denial or termination of Medicare coverage can be appealed through a Medicare appeal process. This is separate from the appeal process for transfer or discharge from the nursing facility (which is discussed in the second issue brief of this series).¹⁰ Residents who use Medicare to pay for their stay can, and should, use both appeal systems when Medicare coverage is denied or terminated, and the facility is seeking to force the resident to move out of the facility.

Effective Dates

Most provisions relating to rehabilitation became effective on November 28, 2016. The assessment requirement, however, is not effective until November 28, 2017.

Finding the Regulations

Rehabilitation services are discussed in section 483.65 of Title 42 of the Code of Federal Regulations.

Tips for Residents and Advocates

Advocate for rehabilitation services for all residents who need them. If the rehabilitation services are medically necessary and appropriate, they should be provided to any resident who needs them. Often, facilities provide therapy only to residents whose stay in the facility is covered by Medicare (traditional Medicare Part A or a Medicare Advantage plan) or who are paying out-of-pocket (private-pay). Residents using Medicaid may be experiencing limited access to rehabilitation services, but this type of payment-source discrimination is prohibited by the federal regulations.¹¹

Also, advocacy is necessary to ensure that Medicare coverage is not restricted inappropriately. The Medicare program covers rehabilitation services to maintain a resident’s functional level or to prevent or slow a resident’s decline or deterioration — in other words, a resident’s improvement is not necessarily required.

Also, Medicare coverage should not be limited to those residents eligible under Part A. Part A coverage requires a recent hospitalization of at least three nights, and is limited to no more than 20 days paid in full, and an additional 80 days per benefit period with a substantial daily co-payment. If

⁹ Center for Medicare Advocacy, “‘Discharge’ from a Skilled Nursing Facility: What Does It Mean and What Rights Does a Resident Have?” (CMA Alert, Jan. 13, 2016), available at medicareadvocacy.org/discharge-from-a-skilled-nursing-facility-what-does-it-mean-and-what-rights-does-a-resident-have/.

¹⁰ 42 C.F.R. § 483.15(c).

¹¹ 42 C.F.R. § 483.15(b).

these Part A requirements are not met, and the resident is paying privately or (in some states) is using Medicaid to pay for the stay, the resident may be able to pay for therapy services separately through Medicare Part B.

Recall that the revised regulations authorize attending physicians to delegate the “task of writing therapy orders” to the therapist, if the therapist operates under the supervision of the physician and the delegation is legal under the state’s scope-of-practice law.¹² Advocacy should be directed to the therapist (if authority has been delegated) or the physician (if authority has not been delegated).

The important point is that medically necessary rehabilitation services should be provided to all residents who need them, when the services are included in the resident’s care plan. Make sure that residents who need rehabilitation services receive them. Use the Medicare appeals process if the facility claims Medicare will not cover the services.¹³

Advocate for comprehensive respiratory care for residents who need it. Few facilities provide ventilator care to residents, resulting in many people moving to facilities that are far from their homes and families. Advocates, in particular, should be encouraging facilities in their communities to utilize their annual facility assessment process to determine what it would take to provide such care.

12 42 C.F.R. § 483.20(e)(3).

13 The Center for Medicare Advocacy has self-help materials for appealing denials of Medicare coverage by a nursing facility, [medicareadvocacy.org/self-help-packet-for-expedited-skilled-nursing-facility-appeals-including-improvement-standard-denials/](https://www.medicareadvocacy.org/self-help-packet-for-expedited-skilled-nursing-facility-appeals-including-improvement-standard-denials/).