Tennessee Legislation

**Tenn. Code Ann. § 71-5-1423 Involuntary Discharge Appeal.** If a resident appeals the facility's notice of involuntary discharge to that resident and a hearing is requested pursuant to 42 C.F.R. § 431.220(a)(3) before the bureau of TennCare:

1. The hearing shall be conducted and a final order rendered within ninety (90) days from the date of the resident's appeal of the facility's involuntary discharge notice;
2. The timeframe specified in subdivision (1) may be extended or continued with the consent of both the facility and the resident; and
3. The timeframe specified in subdivision (1) may be extended by the presiding administrative law judge without the consent of the facility, **but only after a showing by the resident, or the resident's representative, that the resident faces a substantial threat of irreparable damage or injury if a continuance is not granted.**

**Tenn. Code Ann. § 8-42-101, §33-6-901 and § 33-6-407** provides immunity to health providers determining that a person needs emergency mental health treatment or needs physical restraint or vehicle security during transportation to a hospital or treatment resource. **Effective July 1, 2013.**

**Tenn. Code Ann. §68-11-1628** - As enacted, permits relocation under certificate of need statute of up to 30 beds from an existing nursing home that is part of a continuing care retirement community under certain conditions.

**Optical Program for Alzheimer’s** - 683 HB2483 Health, Dept. of - As enacted, requires the department to develop an optical examination waiver form to permit any patient diagnosed with alzheimer's disease, alzheimer's related dementia, or vascular dementia, to obtain lenses, spectacles, eye glasses, or optical devices using an expired prescription when such patient's disease or dementia would preclude the patient from undergoing an optical examination. - Amends TCA Title 63; Title 68 and Title 71. **Effective July 1, 2014**

**Tenn. Code Ann. § 68-11-216** - As enacted, extends for one year the nursing home privilege tax and renames such tax the nursing home annual assessment fee.

**Tenn. Code Ann. § 68-11-216(c)(7)(B)** - As enacted, revises provisions governing nursing homes that are delinquent in paying an installment of annual nursing home assessment fee; allows for reduction of penalties and interest in certain situations.

**Tenn. Code Ann. § 71-5-2801 Hospitals and Health Care Facilities** - As enacted, imposes an assessment fee on persons engaged in the business of providing nursing home care, and creates the nursing home assessment trust fund. Initial monthly installments beginning on June 30, 2015 shall be 4.5% of net patient service revenue as defined by 71-5-2801. **Effective July 1, 2014**

**Tenn. Code Ann. § 68-11-1609(b) and 68-11-1622(a)** Extending moratorium on issuing certificates of need for additional nursing home and skilled nursing facility beds by one year. **Effective July 1, 2014.**

**Tenn. Code Ann. § 68-11-1609(b) and 68-11-1622(a)** As enacted, extends the current moratorium on the issuance of certificates of need (CONs) for new nursing home and skilled nursing facility beds until June 30, 2015. **Effective July 1, 2014.**

**Hospitals and Health Care Facilities** - As enacted, makes out-of-state medical laboratories subject to rebate prohibition in medical laboratory statute and other provisions of that statute deemed necessary by the medical laboratory board to protect the public. - Amends TCA Title 68, Chapter 29. **Effective July 1, 2014**

**Nurse Depositions (SB1754/HB1556)** -- APN’s are exempt from subpoena to trial but are still subject to subpoena to deposition. Effective March 28, 2014

**HB2171 - Medical Occupations** - As enacted, adds to the information each board regulating a provider must collect and provide to the department of health in order for the department to create individual profiles on licensees, the name of the supervising physician of a nurse practitioner who holds a certificate of fitness and of a physician assistant; revises related provisions. - Amends TCA Title 63 and Title 67. **Effective January 1, 2015**
Registered Nurse First Assistant - This bill allows registered nurses with the educational and practice credentials to apply to the board of nursing for a certificate to practice as a registered nurse first assistant. Effective January 1, 2015

SB1502 / HB1494 Certain physician assistants to perform duties of a physician. -- Under present law, in regards to the involuntary admission of an individual to an inpatient mental health facility, the commissioner may designate a person to take any action authorized or duty imposed on a physician if the person is a qualified mental health official, is licensed or certified to practice in the state if required for the profession, and completes a training program on emergency commitment criteria and procedures that is approved and provided by the department. This bill adds a "licensed physician's assistant with a master's degree and expertise in psychiatry as determined by training, education or experience" to the persons the commissioner may so designate, if the person meets the other described requirements. The board will determine if the physician assistant has an expertise in psychiatry, based on the training, education or experience of the individual. Enacted as Public Chapter 0688 effective April 15, 2014.

SB2427 / HB2303 Health Care Provider Stability Act. --
Provides that a third party may not effect material change to a contract under which a health care provider is paid for providing items or services during either the first year of the contract or the initial term of the contract, whichever is longer. States that after the initial term or first year of the contract in which a health care provider is paid, the third-party payer may only effect a material change on the renewal date of the contract or the anniversary if the effective date of the contract, whichever is longer.
House sponsor requested bill to summer study.

CMS Rules and Proposed Rules


Counting a period of receipt of outpatient observation services in a hospital toward the 3-day inpatient hospital requirement for coverage of skilled nursing facility services under Medicare.

In order to access the SNF benefit under Medicare Part A, patients currently must be admitted to a hospital for at least three days. The Improving Access to Medicare Coverage Act of 2013 would deem time an individual spends under observation status eligible to count towards satisfying the three-day stay requirement to count all time a Medicare beneficiary spends in the hospital toward the three-day stay requirement. Increasing numbers of Medicare beneficiaries are finding out that Medicare will not cover their post-acute skilled nursing facility stays because they were kept in the hospital for observation rather than being admitted as inpatients.
Proposed Amendment -- (a) Section 1861(i) of the Social Security Act (42 U.S.C. 1395x(i)) is amended by adding at the end the following: For purposes of this subsection, an individual receiving outpatient observation services shall be deemed to be an inpatient during such period, and the date such individual ceases receiving such services shall be deemed the hospital discharge date (unless such individual is admitted as a hospital inpatient at the end of such period).

**CMS: Medicare and Medicaid Programs; Requirements for Long-Term Care (LTC) Facilities; Hospice Services, 78 Fed. Reg. 38594 (June 27, 2013)**

This Final Rule, which became effective on Aug. 26, 2013, revises SNF/NF requirements for arranging provision of hospice care. It is intended to “improve quality and consistency of care between hospices and LTC facilities in the provision of hospice care to LTC residents,” and to “help eliminate duplication of and/or missing services.”

**CMS: Medicare and Medicaid Programs; Requirements for Long-Term Care (LTC) Facilities; Notice of Facility Closure, 78 Fed. Reg. 16795 (Mar. 19, 2013)**

This Rule, which became effective on April 18, 2013, finalizes, “with technical changes,” the Interim Final Rule with Comment (IFR), published by CMS on Feb. 18, 2011 and became effective on Mar. 23, 2011. The IFR implemented Section 6113 of the ACA to “ensure that, in the case of a facility closure, individuals serving as administrators provide written notification of the impending closure and a plan for the relocation of residents at least 60 days prior to the impending closure or, if the Secretary terminates the facility’s participation in Medicare or Medicaid, not later than the date the Secretary determines appropriate.” Any accompanying Survey & Certification Letter is detailed at Page 35, infra.


This memo reviews and reiterates current interpretive guidelines for 483.10(j), F-Tag 172, resident rights surrounding access and visitation.

**Key Provisions:**

- LTC facilities must ensure that all individuals seeking to visit a resident be given full and equal visitation privileges, consistent with resident preference and within reasonable restrictions that safeguard residents.
- Residents must be notified of their rights to have visitors on a 24-hour basis, including, but not limited to, spouses (including same-sex spouses), domestic partners (including same-sex domestic partners), other family members, or friends.
- Surveyors are instructed to inquire during resident and family interviews if all understand that visitors are allowed 24-hrs a day and whether the facility has restricted or limited any
visitors.

• If interviews indicate that residents do not understand visitation policies or that the facility has limited or restricted visitors against resident wishes and outside of any reasonable restrictions, the surveyor should review the circumstances around those restrictions/limitations, interview facility staff, and evaluate the facility’s visitation policies.


This letter announces the rollout of the CMS QAPI website, including “introductory materials to help nursing homes establish a foundation to implement and sustain QAPI.”

QAPI at a Glance - QAPI at a Glance is a detailed guide illustrating “QAPI in action;” it describes the five elements of QAPI; the action steps for implementing the QAPI principles; and provides tools and resources nursing homes may use as they further develop their systems.

QAPI Tools:

• **QAPI Self-Assessment:** evaluates the extent to which components of QAPI are in place within an organization and identifies areas requiring further development.

• **Guide for Developing Purpose, Guiding Principles, and Scope:** identifies principles to guide decision making and help set priorities.

• **Guide for Developing a QAPI Plan:** guides the organization’s quality efforts and serves as the main document to support implementation of QAPI.

• **Goal Setting Worksheet:** helps set goals that are specific, measurable, attainable, relevant, and time-bound.

• Questions may also be emailed to: Nhqapi@cms.hhs.gov.

Advance Copy - Changes for Sub-Task 5E, Medication Pass Observation Protocol for Long Term Care (LTC) Facilities, S&C: 13-36-NH (June 7, 2013)

This memo details changes made to the Traditional LTC Facility Survey, Sub-Task 5E-Medication Pass Observation.

**CMS: Medicare Program; Contract Year 2015 Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs, 79**

This proposed rule would implement new criteria for identifying protected classes of drugs, institute revisions to promote competition in Part D plans, enact changes to the regulatory definition of negotiated prices, and make changes to ensure that plan choices are meaningful for beneficiaries. While the proposed rule would have an indirect impact on nursing facility providers, its overall impact on long-term care is significant.


This proposed rule would establish national emergency preparedness requirements for Medicare- and Medicaid-participating providers and suppliers to ensure they adequately plan for both natural and man-made disasters, and coordinate with federal, state, tribal, regional, and local emergency preparedness systems. It is also intended “to ensure that these providers and suppliers are adequately prepared to meet the needs of patients, residents, clients, and participants during disasters and emergency situations.”

Key Definitions: “Emergency” or “disaster” can be defined as an event affecting the overall target population or the community at large that precipitates the declaration of a state of emergency at a local, state, regional, or national level by an authorized public official such as a governor, the Secretary of the Department of Health and Human Services (HHS), or the President of the United States.”

System Elements: CMS has identified four (4) core elements that are central to a comprehensive and effective emergency preparedness system:

- Emergency plan: Based on a risk assessment, develop an emergency plan using an all-hazards approach focusing on capacities and capabilities.
  - Risk assessment and planning: This proposed rule would require that prior to establishing an emergency plan, a risk assessment would be performed based on utilizing an “all-hazards” approach. An all-hazards approach is an integrated approach to emergency preparedness planning that focuses on capacities and capabilities that are critical to preparedness for a full spectrum of emergencies or disasters. This approach is specific to the location of the provider and supplier considering the particular types of hazards which may most likely occur in their area.
- **Policies and procedures**: Develop and implement policies and procedures based on the plan and risk assessment.

- **Communication**: Develop and maintain a communication plan that complies with both Federal and State law. Resident/Patient care must be well-coordinated within the facility, across health care providers, and with State and local public health departments and emergency systems.
  - Patient care must be well-coordinated within the facility, across health care providers, and with state and local public health departments and emergency systems to protect patient health and safety in the event of a disaster.

- **Training and testing**: Develop and maintain training and testing programs, including initial and annual trainings, conducting drills and exercises or participate in an actual incident that tests the plan.
  - A well-organized, effective training program must include providing initial training in emergency preparedness policies and procedures. The facility must ensure that staff can demonstrate knowledge of emergency procedures and provide this training at least annually. Facilities would be required to conduct drills and exercises to test the emergency plan.

**AOA/ACL: State Long-Term Care Ombudsman Program, 78 Fed. Reg. 36449 (June 18, 2013), Comments Due Aug. 19, 2013**

The Ombudsman Program and related functions have been delineated in Title VII of the Older Americans Act (OAA) since 1992; however, to date, no regulations have been promulgated for any Title VII program. The absence of regulatory guidance has resulted in variation across states in interpretation of the State LTC Ombudsman program provisions. This Rule would provide regulatory guidance and greater clarity / consistency in implementation.

**Topics addressed in the NPRM:**

- Definitions of:
  - Immediate family
  - Office of the State Long-Term Care Ombudsman
  - Representative of the Office of the State Long-Term Care Ombudsman
  - Establishment of the Office of the State Long-Term Care Ombudsman
  - Functions and Responsibilities of the State Long-Term Care Ombudsman
  - State Agency (SA) Responsibilities Related to the Long-Term Care Ombudsman Program
  - Functions and Duties of the Office of the State Long-Term Care Ombudsman
  - Conflicts of Interest
• States would have 1 year from publication of the final rule to comply; the AoA does not anticipate any substantial financial impact on states or long-term care providers.

CMS: Medicare Program; Requirements for the Medicare Incentive Reward Program and Provider Enrollment, 78 Fed. Reg. 25013 (Apr. 29, 2013), Comments Due: June 28, 2013

Incentive Reward Program (IRP) - This rule would increase rewards paid to Medicare beneficiaries and others whose tips about suspected fraud lead to the recovery of funds.

Survey & Certification Letters


Original S&C Letter: This letter addresses the status of the Notice of Proposed Rulemaking (NPRM) allowing requests for a time‐limited extension with respect to the Aug. 13, 2013 nursing home sprinkler mandate.

Citations at F Tag 454 – 42 CFR §483.70 Physical Environment, §483.70(a) Life Safety from Fire, S&C: 14-03-NH/LSC (Oct. 25, 2013)

CMS has determined that that F-Tag 454 (§483.70 Physical Environment, §483.70(a) Life Safety from Fire) is cited primarily as a cross reference to Life Safety Code (LSC) K-Tags and that deficiencies and other findings cited at F-Tag 454 “would have been more appropriately cited under other F-Tags or K-Tags.” In order to avoid unnecessary duplication and for accurate deficiency citations, CMS has determined that the regulations at §483.70(a) are more appropriately cited under LSC requirements.

Cardiopulmonary Resuscitation (CPR) in Nursing Homes, S&C: 14-01-NH (Oct. 18, 2013)

Background:
• §483.10 provides that residents of a SNF/NF have the “right to a dignified existence” and “self-determination” including the right “to formulate an advance directive.”
• §489.102 requires providers, including SNFs and NFs, to provide written information to residents at the time of admission about their rights to make decisions about medical care, including the right to formulate advance directives.

• The American Heart Association (AHA) publishes guidelines every 5 years for CPR and Emergency Cardiovascular Care (ECC).

• According to the AHA, reversal of clinical death is among the goals of ECC since brain death begins four to six minutes following cardiac arrest if CPR is not administered during that time. AHA guidelines urge “all potential rescuers to initiate CPR unless: (1) a valid DNR order is in place; (2) obvious signs of clinical death (e.g., rigor mortis, dependent lividity, decapitation, transection, or decomposition) are present; or (3) initiating CPR could cause injury or peril to the rescuer.”

Facility CPR Policy
• “Nursing facilities must not implement policies that prevent full implementation of advance directives and do not promote person-centered care.”

• Facilities must not establish and implement facility-wide no CPR policies as this does not comply with the resident’s right to formulate an advance directive under F155.

• While acknowledging research showing that CPR is ineffective in the elderly nursing home population, CMS notes that “the population in nursing homes is increasingly comprised of younger residents, residents needing short-term rehabilitation, and residents from different cultural backgrounds.” Accordingly, any limits on how a facility may implement advance directives should be applied on a case by case basis, taking into consideration a resident’s preferences, medical conditions, and cultural beliefs.

• CPR-certified staff must be available at all times to provide CPR when needed.


Key Provisions:
• In accordance with 42 CFR 489.18(b), an owner contemplating or negotiating a sale of a Medicare-participating provider or supplier must notify CMS. Under 42 CFR 424.516(e)(a), CMS must be notified within 30 days of a change of ownership or control of a participating provider or supplier. Both the seller and buyer provide the required notifications via submission of the Medicare enrollment form, CMS 855A or CMS 855B to their Medicare Administrative Contractor (MAC).
• CMS encourages new owners of a provider/supplier to accept automatic assignment of the seller’s Medicare agreement.
  o When an acquisition has occurred, CMS automatically assigns the existing Medicare provider agreement/supplier approval to the new owner (42 CFR 489.18(c)). Automatic assignment means uninterrupted participation of the acquired provider/supplier in the Medicare program. There is no required survey of the provider/supplier as a result of the acquisition and assignment, although the Regional Office (RO) may direct the SA to conduct a survey when it has cause for concern about quality of care. In cases of deemed status providers/suppliers, automatic assignment means the new owner must notify the Area Office of the acquisition, and that accreditation continues until the AO decides whether a resurvey is necessary.
  o Acceptance of automatic assignment also means the buyer is subject to all applicable statutes and regulations and to the terms and conditions under which the assigned agreement was originally issued. These include, but are not limited to, Medicare requirements to adjust payments to account for prior overpayments and underpayments, even if they relate to a pre-acquisition period (successor liability), and to adjust payments to collect CMPs.


Generally:
• Under current regulations “CMS may waive specific provisions of the 2000 edition of the LSC in hospitals, critical access hospitals, long-term care facilities, ambulatory surgical centers, and inpatient hospice, which, if rigidly applied, would result in unreasonable hardship upon a provider or supplier, but only if the waiver does not adversely affect the health and safety of patients or residents.”
• CMS has determined that the 2000 edition of the LSC and 1999 NFPA 99 contain several provisions that may result in unreasonable hardship for providers/suppliers, for which an adequate alternative level of protection may be achieved. CMS is making available several categorical waivers to new and existing providers and suppliers subject to the LSC.
  o The 1999 NFPA 99, Health Care Facilities Code is cross-referenced in the 2000 LSC and, as a result, it contains requirements applicable to providers and suppliers who must meet the 2000 edition of the LSC.
• Providers/suppliers wanting to take advantage of one or more of the categorical waivers identified must formally elect to use one or more of the waivers and must document their decision.
Process for Nursing Homes – Applicable to All Civil Money Penalties (CMPs), S&C: 13-57-NH (Aug. 30, 2013)

Section 6111 of the ACA added new sections to 1819 (Medicare) and 1919 (Medicaid) of the Social Security Act (SSA) providing for “timely collection and escrow of CMPs,” and allowing facilities to request an Independent IDR (IIDR) if CMS imposes a CMP and the CMP amounts are subject to collection and placement in an escrow account.

Minimum Data Set (MDS) 3.0 Discharge Assessments that Have Not Been Completed and/or Submitted, S&C: 13-56-NH (Aug. 23, 2013)

This memo clarifies the steps facilities must take to address MDS 3.0 discharge assessments that have not been completed and/or submitted as required under 42 CFR § 483.20(g) and 42 CFR § 483.20(f)(1). 42 CFR § 483.20(g)-Accuracy of Assessment, requires that assessments “accurately reflect the resident’s status.” 42 CFR § 483.20 (f)-Automated Data Processing, requires facilities to encode the following information for each resident in the facility within 7 days from completion of a resident’s assessment: (i) Admission assessment; (ii) Annual assessment updates; (iii) Significant change in status assessments; (iv) Quarterly review assessments; and (v) A subset of items upon a resident’s transfer, reentry, discharge, and death. A “subset of items upon discharge” means discharge assessment.


CMS is providing advanced guidance regarding the federal requirements for Notification of Facility Closure. Any individual serving as the administrator of a skilled nursing facility (SNF), nursing facility (NF) or dually participating facility (SNF/NF) must provide written notification of an impending closure of a facility including the plan for relocation of residents at least 60 days prior to the impending closure.

Background:

• In accordance with the final rule effective on Apr. 18, 2013 (see supra), and under Sections 1128I(h) and 1819(h)(4) of the Social Security Act (the Act) and regulations at 42 CFR §§ 483.75(r) and (s), individuals serving as the administrator of a SNF, SNF/NF or NF must provide written notification of an impending closure of a facility, including the plan for relocation of residents, at least 60 days prior to the impending closure; or, if the Secretary terminates the facility’s participation in Medicare or Medicaid, not later than the date the Secretary determines appropriate.

• Notice must be provided to CMS, the state long term care ombudsman, all the residents / representatives / responsible parties.

• An advanced copy of the revisions to Appendix PP of the SOM is attached to the Letter,
revising tags F203 [§ 483.12(a)(5) Timing of the notice]; and F204 [§ 483.12(a)(7) Orientation for Transfer or Discharge] and adding new tags F523 [§ 483.75(r) Facility closure – Administrator] and F524 [§ 483.75(s) Facility closure]. CMS notes that the “final version, when published in the online SOM may differ slightly from this interim advanced copy.”


CMS has posted the results of an analysis by Abt Associates that examined trends in the first three years of the Five-Star Quality Rating System. The report addresses the distribution of star ratings in each of the three individual domains (survey, staffing, quality measures) and the overall domain during 2009-2011, overall and stratified by facility characteristics. Also included are the variations in ratings across time. The report is attached to the Letter.

Summary of Report:
• Generally: Since the implementation of the Five-Star Quality Rating System, all three independent domains, inspection, QM, and staffing, have shown improvement. Due to the transition from the MDS 2.0 to the MDS 3.0 and the ‘freezing’ of the QM domain 3/11 to 7/12, fewer analyses of the QM component are included. CMS plans to release a new QM rating based on QMs derived from MDS 3.0 assessments conducted in 2012.
• Inspections: Due to the design of the Five-Star Rating System, the distribution of inspection ratings over the 3 years has remained essentially unchanged. However, with the exception of one-star facilities, there has been general improvement in the average number of deficiencies and survey scores for more recent surveys.
  o The prevalence of three indicators of poor survey performance was examined: actual harm; immediate jeopardy (IJ); substandard quality of care (SQC).

Advanced Copy: Dementia Care in Nursing Homes: Clarification to Appendix P State Operations Manual (SOM) and Appendix PP in the SOM for F309 – Quality of Care and F329 – Unnecessary Drugs, S&C: 13-35-NH (May 24, 2013)

This memo clarifies Appendices P and PP related to nursing home residents with dementia and unnecessary drug use. The revised CMS guidance and surveyor training highlight and re-emphasize many of the dementia care elements/key principles already required under the Social Security Act and/or current regulations: Person–Centered Care; Quality and Quantity of Staff; Thorough Evaluation of New or Worsening Behaviors; Individualized Approaches to Care; Critical Thinking Related to Antipsychotic Drug Use; Interviews with Prescribers; Engagement of Resident and/or Representative in Decision-Making.

Access to Statements of Deficiencies (CMS-2567) on the Web for Skilled Nursing

In July 2012, CMS began posting Statements of Deficiencies (CMS-2567s) for skilled nursing facilities and nursing facilities on Nursing Home Compare. In March 2013, CMS initiated posting of CMS-2567s for short-term acute care hospitals and critical access hospitals (CAHs) for surveys based on complaint investigations. This memo describes the contents and location of these files.

Nursing Homes:

- Since July, 2012, users of Nursing Home Compare have been able to view final CMS-2567s for the most recent standard health survey and the most recent 15 months of complaint surveys. In July, 2012, CMS also began posting in an electronic database the same CMS-2567 deficiency data on the Five-Star Nursing Home Quality Rating System. Both websites are updated monthly.
- In April 2013, CMS will expand access to CMS-2567s from the current single survey cycle to the preceding three standard health surveys and three years of complaint surveys.
- To “improve the public’s ability to interpret CMS-2567 findings,” CMS also plans to add indicators for the scope and severity of each deficiency cited.
- CMS-2567 reports are publicly releasable upon request and do not require release through a Freedom of Information Act (FOIA) request.
- Current posted CMS data do not contain any Plan of Correction (POC) information. Facility POCs may be requested from either the facility or the State Survey Agency (SA). Section 1902(a)(9)(D) of the Social Security Act (SSA) requires each State to maintain a consumer-oriented website that includes the nursing home CMS-2567 and the facility POC. Links to the State websites may be found on Nursing Home Compare.

Physician Delegation of Tasks in Skilled Nursing Facilities (SNFs) and Nursing Facilities (NFs), S&C: 13-15-NH (Mar. 8, 2013)

This Letter replaces the Survey and Certification memo from Nov. 13, 2003, addressing physician delegation of tasks in SNFs and NFs. It clarifies Federal guidance for physician delegation of certain tasks in SNFs and NFs to non-physician practitioners (NPPs; formerly “physician extenders”) such as nurse practitioners, physician assistants, or clinical nurse specialists. It also implements Section 3108 of the ACA, which adds physician assistants to the list of practitioners that can perform SNF certifications and re-certifications; and clarifies policy on co-signing orders in SNFs and NFs.

Generally - Section 483.40(e)(2) provides that, “A physician may not delegate a task when the regulations specify that the physician must perform it personally, or when the delegation is prohibited under State law or by the facility’s own policies.”
SNF

- Section 483.40(c)(3), mandates that all required physician visits be made by the physician personally and not be delegated.
  - A required physician visit includes the initial comprehensive visit and every alternate required visit thereafter.
- The initial comprehensive visit in a SNF is the initial visit, no later than 30 days from admission, “during which the physician completes a thorough assessment, develops a plan of care and writes or verifies admitting orders for the resident.”
  - The physician may not delegate the initial comprehensive visit. Non-physician practitioners may perform other medically necessary visits prior to and after initial comprehensive visit.
- Alternate visits may be delegated to a Physician Assistant (PA), Nurse Practitioner (NP), or Clinical Nurse Specialist (CNS) licensed by the State and performing within the scope of practice.
- Alternate visits, as well as medically necessary visits, may be performed and signed by the NPP—physician co-signature is not required.
- Section 424.20(e)(2) states that NPs and CNSs who are not employed by the facility and are working in collaboration with a physician may sign the required initial certification and re-certifications when permitted under the State scope of practice.
- Effective with services furnished on or after January 1, 2011, in accordance with section 3108 of the ACA, PAs who are not employed by the facility may perform the required initial certification and periodic re-certifications of a SNF beneficiary.

NF

- Similar to SNFs, the initial comprehensive visit in a NF is the initial visit, no later than 30 days from admission, “during which the physician completes a thorough assessment, develops a plan of care and writes or verifies admitting orders for the resident.”
- Section 483.40(f) provides that “At the option of the State, any required physician task in a NF (including tasks which the regulations specify must be performed personally by the physician) may also be satisfied when performed by a nurse practitioner, clinical nurse specialist, or physician assistant who is not an employee of the facility but who is working in collaboration with a physician.”
- At the option of the State, NPs, PAs, and CNSs who are employees of the facility, while not permitted to perform visits required under § 483.40(c)(1), are permitted to perform other medically necessary visits and write orders based on these visits.
- The physician is not required, other than under State law, to verify and sign orders written by NPPs employed by the facility for other medically necessary visits.
  - Medically necessary visits may not take the place of physician required visits, and may not count towards meeting the required physician visit schedule.
- In contrast to the initial SNF visit, NPPs may provide initial NF visits and other required visits under §§ 483.40(c)(3) and (f) if the State permits.
- Required physician tasks, such as verifying and signing orders in a NF, may be delegated.
to a PA, NP, or CNS who is not an employee of the facility but is working in collaboration with a physician.

- Orders written by an NPP employed by the NF during visits that are not required visits, and are “other medically necessary visits,” do not require physician co-signature except as mandated by State law.
- The Federal requirements restricting NPPs employed by the NF from performing a required visit, do not apply to other medically necessary visits.

**SNF/NF**

- In dually-certified facilities, the facility must determine the payment source. For a Part A Medicare stay, the NPP must follow the guidelines for services in a SNF. For residents in a Medicaid stay, the NPP must follow the provisions outlined for care in NFs.

**Other Developments**

**CMS Manual Updates to Clarify Skilled Nursing (SNF), Inpatient Rehabilitation Facility (IRF), Home Health (HH), and Outpatient (OPT) Coverage Pursuant to Jimmo vs. Sebelius, MLN Matters Article #MM8458 (Jan. 14, 2014, rev. Jan. 15, 2014)**

This document reflects changes to the Medicare Benefit Policy Manual (MBPM) in response to the settlement agreement in the case of *Jimmo v. Sebelius* regarding the so-called “Improvement Standard” for therapy services. It applies to Skilled Nursing Facilities (SNFs); Inpatient Rehabilitation Facilities (IRFs); Home Health Agencies (HHAs); providers and suppliers of therapy services under the Outpatient Therapy (OPT) Benefit—including Critical Access Hospitals (CAHs), hospitals, rehabilitation agencies, SNFs, HHAs, physicians, certain non-physician practitioners, and therapists in private practice.

**Key Provisions:**

- No “Improvement Standard” is 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).
  - Restorative/Rehabilitative therapy - In evaluating a claim for skilled therapy that is restorative/rehabilitative (i.e., whose goal and/or purpose is to reverse, in whole or in part, a previous loss of function), it would be entirely appropriate to consider the beneficiary’s potential for improvement from the services. CMS notes that such a consideration must always be made in the IRF setting, where skilled therapy must be reasonably expected to improve the patient’s functional capacity or adaptation to impairments in order to be covered.
  - Maintenance therapy - Even if no improvement is expected, under the SNF, HH, and OPT coverage standards, skilled therapy services are covered when an individualized assessment of the patient’s condition demonstrates that skilled
care is necessary for the performance of a safe and effective maintenance program to maintain the patient’s current condition or prevent or slow further deterioration. Skilled maintenance therapy may be covered when the particular patient’s special medical complications or the complexity of the therapy procedures require skilled care.

- **Coverage depends upon an individualized assessment of the beneficiary’s medical condition and the reasonableness and necessity of the skilled treatment, care, or services in question.** When such assessment demonstrates that skilled care is needed in order to safely and effectively maintain the beneficiary at his or her maximum practicable level of function, the care is covered (assuming all other applicable requirements are met). Conversely, coverage in this context would not be available in a situation where the beneficiary’s maintenance care needs can be addressed safely and effectively through the use of *nonskilled* personnel.

- **Enhanced guidance on appropriate documentation** - Portions of the revised manual provisions now include additional material on the role of appropriate documentation in facilitating accurate coverage determinations for claims involving skilled care. While the presence of appropriate documentation is not, in and of itself, an element of the definition of a “skilled” service, such documentation serves as the *means* by which a provider would be able to establish and a Medicare contractor would be able to confirm that skilled care is, in fact, needed and received in a given case.