TRACKS OF THE FUTURE OF ELDER LAW

MEDICARE

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Nothing in this paper is to be construed as the rendering of legal advice.

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I. INTRODUCTION

This paper is written to provide the elder law attorney with a basic plan to handle Medicare Appeals. There are many possible areas that offer an opportunity for advocacy in the Medicare Program. This paper will specifically address an appeal for a denial of skilled nursing benefits. Most of the information, law and techniques used for an appeal of a denial of skilled nursing benefits will be applicable to appeals of denials of care or benefits for other services under the Medicare program. This paper presents a simplistic view of handling such an appeal but as with most areas of the law no one paper can begin to prepare an attorney for handling such a matter. In order to successfully handle such an appeal, the attorney should have a comprehensive understanding of the Medicare statutes, regulations, and policies. Additionally, the advocate must have a working knowledge of the qualifying criteria and covered services, the decision-making process, important case law, and total familiarity with the medical records and status of the Medicare beneficiary.[1] The specific factors to identify such a case will be covered as well as some of the substantive legal issues involved and finally the issue of fees will be examined. It is not the intention of the author to suggest that this is the only set of facts or circumstances that give rise to a case for an appeal of a denial of skilled nursing care. The facts set forth are real world examples of such a case that an elder law attorney will most likely encounter during their practice.

II. THE ALMOST PERFECT CASE DENIAL OF SKILLED NURSING CARE

The almost perfect case will show up in the elder law attorney's office on a regular basis if the attorney does any work in the Medicaid nursing home field. The client will walk into your office with the almost perfect case without even knowing that they have a case. By asking some simple background questions you can identify the almost perfect case. Once you are satisfied that the basic requirements are met, then more intensive investigation will be required but what follows is a description of the basic facts and circumstances that must exist in the almost perfect case.

A. Must meet the criteria for skilled nursing care

This type of case was selected because it is not only the most likely case that the elder law attorney will encounter in their practice, but it is also the type that will provide a great benefit for the client. The almost perfect case will come to your office not as an appeal of denial of skilled nursing care benefits but as a Medicaid nursing home case. The client will be seeking advice on how to qualify for Medicaid to help them pay for nursing home care. The specific facts that must exist to qualify for the skilled nursing benefit under Medicare are set forth below, but you will not have to worry about these facts in the almost perfect case. In the almost perfect case the client will tell you they have already met the requirements for the skilled nursing benefit because they received some amount of the benefit already in a skilled nursing facility (SNF) in the hospital. They will tell you that for some reason the hospital has informed them that they are no longer qualified for skilled nursing care under Medicare rules and that they must move to a nursing home. Many times these clients almost magically are better on the day that their 20 days of full pay for skilled care under Medicare have been exhausted. The client is either being

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[1] Stein and Chiplin ed, Medicare Handbook,Panel Publishers (2000) p.3-17.

transferred to a nursing home or is already at the nursing home and is seeking your advice as to qualification for Medicaid. So the most important part of the case is already established. The person has met the criteria for coverage of for skilled nursing care. This is the first requirement of the almost perfect case.

B. Must have Medigap coverage

The second most important fact in the almost perfect case is that the client must have Medigap insurance that will cover the copayment of $99.00 a day for Medicare skilled nursing benefits for the 21st thru 100th day of care. The Medigap will only cover the copayment if the person qualifies for skilled care under the Medicare rules. In most cases the cost of the care for the person will be less than $100.00 a day so even if the person qualifies, Medicare will not pay anything towards the bill but the Medigap policy will cover the entire cost.

C. **Facility must be Medicare certified**

The third fact that must exist is that the nursing home must be approved or certified to provide Medicare covered services. If the facility is not Medicare certified, then you cannot obtain Medicare payment for the services provide by the facility.

D. **Not eligible for Medicaid**

The fourth circumstance that must exist for the almost perfect case is that the client must not be able to qualify for Medicaid coverage for at least three to four months. If the client is unable to obtain coverage from Medicaid for this period of time, either they or their family will have to privately pay for the care. This is the part that makes this sort of case so rewarding to both the advocate and the client. Your client has already paid the bill for the care and basically lost the money around $8,000.00 or more. Now you have a chance to recover that "lost money" by filing and winning an appeal of the denial of Medicare skilled nursing care benefits. If you are successful in the appeal, the client will be eligible for the Medicare benefit and in turn the Medigap coverage. In effect, the bill that the client or his or her family paid will now be paid by the Medigap policy and entitle the client to a refund of the monies they paid to the nursing home. Your client has already paid the premiums on the Medigap policy, and now it is time to collect the benefits. If the person qualifies for Medicaid, then the stay will be covered by the Medicaid program and the client will not be entitled to return of any money.

III. SKILLED NURSING CARE CRITERIA [42CFR § 409.30]

A. **Basic requirements. The beneficiary must–**

1. Have been hospitalized in a participating or qualified hospital for medically necessary inpatient hospital or inpatient care for at least 3 consecutive calendar days, not counting the date of discharge; and
2. Have been discharged from the hospital after the month he or she attained age 65, or in a month for which he or she was entitled to hospital or insurance benefits on the basis of disability or end-stage renal disease, in accordance with part 406 of this chapter.
   and
3. The beneficiary must be in need of posthospital SNF care, be admitted to the facility, and receive the needed care within 30 calendar days after the date of

discharge from a hospital. Except for a beneficiary for whom posthospital SNF care would not be medically appropriate within 30 days after discharge from the hospital may be admitted at the time, it would be medically appropriate to begin an active course of treatment.

B. **Additional requirements. The services must - [42 C.F.R. § 409.31]**

1. Be ordered by a physician;
2. Require the skills of technical or professional personnel such as registered nurses, licensed practical (vocational) nurses, physical therapists, occupational therapists, and speech pathologists or audiologists; and
3. Be furnished directly by, or under the supervision of, such personnel.
4. Meet specific conditions for level of care requirements.
   a. The beneficiary must require skilled nursing or skilled rehabilitation services, or both, on a daily basis.
   b. Those services must be furnished for a condition–
      (1) For which the beneficiary received inpatient hospital services; or
      (2) Which arose while the beneficiary was receiving care in a SNF or swing-bed hospital for a condition for which he or she received inpatient hospital services.
   c. The daily skilled services must be ones that, as a practical matter, can only be provided in a SNF on an inpatient basis.

IV. RECOGNIZING WRONGFUL DENIALS OF COVERAGE

As stated above, no paper can provide the knowledge or expertise to handle an appeal of a denial of Medicare benefits. To obtain the knowledge and skills necessary, the advocate must be familiar with the federal law and regulations. Additionally, knowledge of the procedure of such appeals is also important. The best source of knowledge and expertise in this area (other than the federal law) can be obtained from the publications of the Center for Medicare Advocacy, Inc. The Center for Medicare Advocacy, Inc. has many different publications available to assist advocates in handling appeals. The foremost of these is the Medicare Handbook. It was originally published by Legal Counsel for the Elderly, Inc. of the AARP in 1990 as the Medicare Practice Manual. A new updated version edited by Judith A. Stien and Alfred J. Chiplin Jr. has been published by Panel Publishers (2000). This handbook and the other publications of the Center are an invaluable resource for the advocate. The materials contained in the Medicare Handbook include checklists that can help in screening cases to determine which cases have merit and present the greatest possibility for success. The Seminar materials available from the National Academy of Elder Law Attorneys include many excellent articles on Medicare law and appeals. It is critical that any attorney attempting to handle one of these appeals obtain resource materials such as these in order to learn the specific techniques for opposing denials of benefits. Having prefaced the discussion with this caveat it is possible to point out some of the more common reasons for denial of benefits and how to deal with them.

A. The denial is because the patient has stopped responding to the therapy or they are not improving

One of the services that will qualify a beneficiary for skilled nursing care benefits is rehabilitation services delivered on a daily basis at least 5 days per week. [2 C.F.R. § 409.31]

If you are looking at a potential case and the services that had qualified the beneficiary for skilled nursing care were physical therapy services and suddenly the beneficiary has been told that they are no longer eligible for the skilled nursing benefit to pay for the physical therapy, then the question is, on what basis has the provider made this determination? Many times the reason given for the determination that Medicare will no longer pay for therapy as skilled nursing care is that the beneficiary is no longer improving. The reason for the denial is that the care is not restorative, the beneficiary will not get any better. Since many beneficiaries suffer from chronic conditions such as Parkinson's disease, the skilled services of a therapist may be necessary to determine what type of exercises will contribute the most to maintenance of the beneficiary's present level of functioning. If the denial of benefits is because the care is not restorative, then the denial is not valid. The regulations specifically address this issue at 42 C.F.R. § 409.32 (c) :

> The restoration potential of a patient is not the deciding factor in determining whether skilled services are needed. Even if full recovery or medical improvement is not possible, a patient may need skilled services to prevent further deterioration or preserve current capabilities. For example, a terminal cancer patient may need some of the skilled services described in Sec. 409.33. [48 FR 12541, Mar. 25, 1983, as amended at 59 FR 65493, Dec. 20, 1994]

Any time that the reason given for the denial of care is lack of restorative potential, then this is one of those almost perfect cases. If the care meets all of the other criteria of the regulations, and the care is needed to maintain or prevent deterioration of the beneficiary, then it should qualify the person for skilled nursing care.

B. **None of the services the patient requires are skilled services**

The regulations set forth examples of services that are by definition considered skilled services. 42 C.F.R. § 409.33 If your client is receiving one of these enumerated services, then they most likely but not always would not have been denied the benefit. But what about a case where your client is not receiving any of the services defined in the regulations as skilled care? Although such a case can be difficult, it is still one that can be won based on the overall management of the plan for the patient. In many of the cases that an elder law attorney will encounter, the client is suffering from several different chronic and debilitating medical conditions. Additionally, many of these patients will have some type of cognitive impairment as well, that will prevent them from responding to or assisting their care givers in their care. The regulations again specifically address this type of case at 42 C.F.R. § 409.32 (b):

> A condition that does not ordinarily require skilled services may require them because of special medical complications. Under those circumstances, a service that is usually nonskilled (such as those listed in Sec. 409.33(d)) may be considered skilled because it must be performed or supervised by skilled nursing or rehabilitation personnel. For example, a plaster cast on a leg does not usually require skilled care. However, if the patient has a preexisting acute skin condition or needs traction, skilled personnel may be needed to adjust traction or watch for complications. In situations of this type, the complications and the skilled services they require must be documented by physicians' orders and nursing or therapy notes.

The thing to keep in mind is that most of the clients in the almost perfect case will have already

met the requirements for skilled care coverage because they were already receiving the benefit in the hospital and suddenly something has changed or so the providers that are making the determination of whether the care is covered by Medicare have decided. It is important to determine what has changed in the patient's situation. Has the patient actually gotten better? Is the disease or condition they were suffering from while in the hospital suddenly better or cured? Most of the conditions or illnesses of this group of patients will be chronic conditions that will not ever be cured. While investigating the facts surrounding the condition of the patient, remember the aforementioned bad reason for denial, that we are not improving.

V. NEW RULES ON ATTORNEY FEES

The most dramatic change in many years that has a direct impact on Elder Law attorneys and their clients was not an amendment to the Medicare law by Congress but a change in interpretation of existing law by the Health Care Financing Administration (HCFA), now known as the Medicare and Medicaid Service Center (MMSC). As anyone who has attempted to represent Medicare beneficiaries in the past knows, the rules and regulations concerning attorney fees made it very difficult to handle these cases. A recent change in how HCFA views the restrictions on attorney fees makes it much easier for an attorney to handle and receive a fee for these cases.

A. Title II of the Social Security Act

The regulations that control the fees that an attorney can charge in a Medicare Appeal or for representation in any Medicare area have always been linked to the provisions of Title II of the Social Security Act that limit how attorney fees can be handled in Social Security cases.

The statute telling us that all of the procedural laws dealing with SSD appeals apply to Medicare appeals (at the ALJ level and beyond) is located at 42 U.S.C.A. § 1395ii entitled Application of Certain Provisions of Subchapter II. The formal name for subchapter II is TITLE 42 THE PUBLIC HEALTH AND WELFARE CHAPTER 7 SOCIAL SECURITY SUBCHAPTER II - FEDERAL OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE BENEFITS. This statute essentially says that the provisions of §405 and §406 of the Social Security law apply to Medicare as well. References in this article and the statutes to the "Secretary" refers to Secretary of the Department of Health and Human Services. Additionally, the provisions of the Title II are linked to Medicare appeals through agency-created cross-reference in the Code of Federal Regulations at 42 C. F. R. § 405.7-1(c).

Under the provisions of the Title II of the Social Security Act an attorney is limited to a fee not to exceed 25% of the total amount of any past due benefits or $4,000.00, which ever is less. 42 U.S.C.A. § 406(a)(2)(A). There is another method to obtain payment of fees referred to as the fee petition process that is very complicated and lengthy such that it is not used by most attorneys in Social Security Disability (SSD) cases. The fee must be approved by the Commissioner of Security Social Security and is only awarded if the case is won and results in the payment of back benefits. The fee is paid out of these back benefits prior to the claimant receiving their monies. There is a provision that allows for the approval of a fee in the event a case is lost but to the best of the author's knowledge, no one has actually ever used it. Regardless of the method used, the fee must be approved by the Commissioner prior to the attorney getting paid.

B. **The problem - NO BACK BENEFITS**

Under the Medicare Program Title XVIII of the Social Security Act, payments for medical care are generally made directly to providers of healthcare services. There is generally not a cash payment made directly to the Beneficiary. In most cases, a Beneficiary may have to pay a deductible to the hospital or to the doctor if they are on Medicare Part A or Part B. If the beneficiary is under Medicare Part C, then they may not even have a deductible. Hence the problem, there is no lump-sum payment for retroactive or past due benefits that will be paid to the beneficiary. Since there is no check going to the beneficiary, there is no pool of money from which to withhold the attorney's fees or to base the 25% limitation upon. These facts make the Social Security fee structure and limitations set forth in the law and regulations unworkable in the Medicare area. In the almost perfect case there will be a check coming from the medigap insurer reimbursing the beneficiary for the monies they paid on the copayment due for days 21 thru 100 on the skilled nursing benefit. In most instances, this check will amount to close to $8,000.00 if the beneficiary did not receive any additional rehabilitation services or therapy. If the beneficiary received these additional services, then the reimbursement check would be larger.

C. **The solution**

The problem of applying the Social Security fee rules to Medicare cases was widely discussed among Elder Law advocates and a group of these attorneys was formed to pursue a solution. The Public Policy Committee of the National Academy of Elder Law Attorneys, the Center for Medicare Advocacy, Inc., The National Senior Citizens Law Center, the Medicare Rights Center, and the Consumer Coalition for Quality Healthcare formed a committee to address the problem with HCFA. [2] After more than a year of negotiations with various representatives of HCFA with what seemed like little progress, suddenly the entire area dealing with attorney fees was stood on its ear. On August 17, 2000, a letter from HCFA was received explaining HCFA's position on the application of the Social Security rules to Medicare cases. The letter stated:

> This letter serves as a formal clarification that the Health Care Financing Administration (HCFA) lacks the requisite statutory authority to reimburse attorneys who represent beneficiaries in the Medicare appeals process. At this time, HCFA does not plan to amend the regulations at 42 C.F.R. §422.560 et. seq. to address the issue of whether Medicare pays attorneys fees.
>
> If you require additional assistance, please do not hesitate to contact me or Michele Edmondson of my staff.
>
> Sincerely,
> Margaret P. Sparr
> Director Beneficiary Membership Administration Group

[2] Chiplin, Barrett, French and Mayo, New Area of Practice: Attorneys Fees in Medicare Appeals. presented to NAELA Institute, Colorado Springs, Co., Nov. 16, 2000, p. 7.

The reference to § 422.560 relates to the M+C appeals process. Subsequent to the receipt of the letter, the committee had discussions about the exact meaning of the letter and questions about what were the implications for the practicing attorney in handling a Medicare appeal. As a result of those questions the chairman of the committee Alfred J. Chiplin, Jr. contacted Ms. Sparr's office at HCFA. The phone conference verified that it was HCFA's position that the structure and fee limitations do not apply to Medicare. [3]

D. **How to get paid**

In the almost perfect case, you have a client that is forced to pay the monthly fee to the nursing home for the remaining 80 days that the skilled nursing benefit for Medicare and their supplement or Medigap policy should have paid. In such a case, the client has already spent the money and your case consists of trying to get the nursing home stay covered by Medicare and the Medigap which will in turn result in a reimbursement to the beneficiary of all of the monies they have paid to the nursing home for the 80 days covered by Medicare. It is important to note that there are some old Medigap policies that cover the skilled nursing care for a full 365 days if the beneficiary is a skilled nursing care designate. In such cases, the reimbursement check would be more like $34,500.00.

The client in such a case will most likely be very happy to allow the attorney to try to obtain the reimbursement provided they do not have to pay any additional fees for the opportunity. This is the part where the change in policy by HCFA or MMSC comes into the case. Since, the Commissioner no longer has to approve the fee, the attorney is free to contract with the client as in any other legal matter. The obvious choice for such a case is a contingent fee contract. It must be noted that at one time the Model Rules required that a client must be offered a choice of fee arrangements before a contingent fee can be used so be sure to check your specific state's rules before entering into a contingent fee agreement. However, in this situation the client would most likely prefer such an agreement. They have already paid the bill and if they enter into a contingent fee agreement, they will not have to pay any more money but if the effort is successful they will obtain a refund of the monies they have paid minus the attorney's fee. It is a nobrainer for the client. They have nothing to lose if they pursue the matter as long as they are not charged for any expenses.

VI. **CONCLUSION**

The facts set forth in this paper have been referred to as the almost perfect case. What makes it the almost perfect case? The Elder Law attorney has a chance to obtain Medicare or Medigap benefits for a client that has already paid for the benefits. The client has also had to pay out of their pocket the cost of their stay in the nursing facility. Now the client is afforded an opportunity to obtain a refund of the money they have paid out with no additional cost to them. The facts of the case already prove they were entitled to skilled care benefits while in the hospital. All that remains is for the advocate to determine if the denial of further benefits was wrongful and to prove it at the appeal. This is the perfect case for the Elder Law attorney to do well by doing good.

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[3] Id. at 9 footnote 24.

[Code of Federal Regulations]
[Title 42, Volume 2, Parts 400 to 429]
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CHAPTER IV--HEALTH CARE FINANCING ADMINISTRATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES

PART 409--HOSPITAL INSURANCE BENEFITS--Table of Contents

Subpart C--Posthospital SNF Care

Sec. 409.21 Nursing care.

(a) Basic rule. Medicare pays for nursing care as posthospital SNF care when provided by or under the supervision of a registered professional nurse.

(b) Exception. Medicare does not pay for the services of a private duty nurse or attendant. An individual is not considered to be a private duty nurse or attendant if he or she is an SNF employee at the time the services are furnished.

[63 FR 26306, May 12, 1998]

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Subpart C--Posthospital SNF Care

Sec. 409.**27** Other services generally provided by (or under arrangements made by) SNFs.

In addition to those services specified in Secs. 409.21 through 409.26, **Medicare pays as posthospital SNF care for such other diagnostic and therapeutic services as are generally provided by (or under arrangements made by) SNFs, including**--

(a) Medical and other health services as described in subpart B of part 410 of this chapter, subject to any applicable limitations or exclusions contained in that subpart or in Sec. 409.20(b); and

(b) Respiratory therapy services prescribed by a physician for the assessment, diagnostic evaluation, treatment, management, and monitoring of patients with deficiencies and abnormalities of cardiopulmonary function.

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PART 409--HOSPITAL INSURANCE BENEFITS--Table of Contents

Subpart D--**Requirements for Coverage of Posthospital SNF Care**

Sec. 409.31 Level of care requirement.

(a) Definition. As used in this section, skilled nursing and skilled rehabilitation services means services that:

(1) Are ordered by a physician;

(2) Require the skills of technical or professional personnel such as registered nurses, licensed practical (vocational) nurses, physical therapists, occupational therapists, and speech pathologists or audiologists; and

(3) Are furnished directly by, or under the supervision of, such personnel.

(b) Specific conditions for meeting level of care requirements. (1) The beneficiary must require skilled nursing or skilled rehabilitation services, or both, on a daily basis.

(2) Those services must be furnished for a condition--

(i) For which the beneficiary received inpatient hospital or inpatient CAH services; or

(ii) Which arose while the beneficiary was receiving care in a SNF or swing-bed hospital for a condition for which he or she received inpatient hospital or inpatient CAH services.

(3) The daily skilled services must be ones that, as a practical matter, can

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only be provided in a SNF, on an inpatient basis.

[48 FR 12541, Mar. 25, 1983, as amended at 58 FR 30666, May 26, 1993]

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Subpart D--Requirements for Coverage of Posthospital SNF Care

Sec. 409.32 Criteria for skilled services and the need for skilled services.

(a) To be considered a skilled service, the service must be so inherently complex that it can be safely and effectively performed only by, or under the supervision of, professional or technical personnel.

(b) A condition that does not ordinarily require skilled services may require them because of special medical complications. Under those circumstances, a service that is usually nonskilled (such as those listed in Sec. 409.33(d)) may be considered skilled because it must be performed or supervised by skilled nursing or rehabilitation personnel. For example, a plaster cast on a leg does not usually require skilled care. However, if the patient has a preexisting acute skin condition or needs traction, skilled personnel may be needed to adjust traction or watch for complications. In situations of this type, the complications, and the skilled services they require, must be documented by physicians' orders and nursing or therapy notes.

(c) The restoration potential of a patient is not the deciding factor in determining whether skilled services are needed. Even if full recovery or medical improvement is not possible, a patient may need skilled services to prevent further deterioration or preserve current capabilities. For example, a terminal cancer patient may need some of the skilled services described in Sec. 409.33.

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Subpart D--**Requirements for Coverage of Posthospital SNF Care**

Sec. 409.**33** Examples of skilled nursing and rehabilitation services.

(a) Services that qualify as skilled nursing services. (1) Intravenous or intramuscular injections and intravenous feeding.

(2) Enteral feeding that comprises at least 26 per cent of daily calorie requirements and provides at least 501 milliliters of fluid per day.

(3) Nasopharyngeal and tracheostomy aspiration;

(4) Insertion and sterile irrigation and replacement of catheters;

(5) Application of dressings involving prescription medications and aseptic techniques;

(6) Treatment of extensive decubitus ulcers or other widespread skin disorder;

(7) Heat treatments which have been specifically ordered by a physician as part of active treatment and which require observation by nurses to adequately evaluate the patient's progress;

(8) Initial phases of a regimen involving administration of medical gases;

(9) Rehabilitation nursing procedures, including the related teaching and adaptive aspects of nursing, that are part of active treatment, e.g., the institution and supervision of bowel and bladder training programs.

(b) Services which would qualify as skilled rehabilitation services.

(1) Ongoing assessment of rehabilitation needs and potential: Services concurrent with the management of a patient care plan, including tests and measurements of range of motion, strength, balance, coordination, endurance, functional ability, activities of daily living, perceptual deficits, speech and language or hearing disorders;

(2) Therapeutic exercises or activities: Therapeutic exercises or activities which, because of the type of exercises employed or the condition of the patient, must be performed by or under the supervision of a qualified physical therapist or occupational therapist to ensure the safety of the patient and the effectiveness of the treatment;

(3) Gait evaluation and training: Gait evaluation and training furnished to restore function in a patient whose ability to walk has been impaired by neurological, muscular, or skeletal abnormality;

(4) Range of motion exercises: Range of motion exercises which are part of the active treatment of a specific disease state which has

resulted in a loss of, or restriction of, mobility (as evidenced by a therapist's notes showing the degree of motion lost and the degree to be restored);

(5) Maintenance therapy; Maintenance therapy, when the specialized knowledge and judgment of a qualified therapist is required to design and establish a maintenance program based on an initial evaluation and periodic reassessment of the patient's needs, and consistent with the patient's capacity and tolerance. For example, a patient with Parkinson's disease who has not been under a rehabilitation regimen may require the services of a qualified therapist to determine what type of exercises will contribute the most to the maintenance of his present level of functioning.

(6) Ultrasound, short-wave, and microwave therapy treatment by a qualified physical therapist;

(7) Hot pack, hydrocollator, infrared treatments, paraffin baths, and whirlpool; Hot pack hydrocollator, infrared treatments, paraffin baths, and whirlpool in particular cases where the patient's condition is complicated by circulatory deficiency, areas of desensitization, open wounds, fractures, or other complications, and the skills, knowledge, and judgment of a qualified physical therapist are required; and

(8) Services of a speech pathologist or audiologist when necessary for the restoration of function in speech or hearing.

(c) Personal care services. Personal care services which do not require the skills of qualified technical or professional personnel are not skilled services except under the circumstances specified in Sec. 409.32(b). Personal care services include, but are not limited to, the following:

(1) Administration of routine oral medications, eye drops, and ointments;

(2) General maintenance care of colostomy and ileostomy;

(3) Routine services to maintain satisfactory functioning of indwelling bladder catheters;

(4) Changes of dressings for noninfected postoperative or chronic conditions;

(5) Prophylactic and palliative skin care, including bathing and application of creams, or treatment of minor skin problems;

(6) Routine care of the incontinent patient, including use of diapers and protective sheets;

(7) General maintenance care in connection with a plaster cast;

(8) Routine care in connection with braces and similar devices;

(9) Use of heat as a palliative and comfort measure, such as whirlpool and hydrocollator;

(10) Routine administration of medical gases after a regimen of therapy has been established;

(11) Assistance in dressing, eating, and going to the toilet;

(12) Periodic turning and positioning in bed; and

(13) General supervision of exercises which have been taught to the patient; including the actual carrying out of maintenance programs, i.e., the performance of the repetitive exercises required to maintain function do not require the skills of a therapist and would not constitute skilled rehabilitation services (see paragraph (c) of this section). Similarly, repetitious 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 do not constitute skilled rehabilitation services.

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Subpart D--Requirements for Coverage of Posthospital SNF Care

Sec. 409.34 Criteria for ``daily basis''.

(a) To meet the daily basis requirement specified in Sec. 409.31(b)(1), the following frequency is required:

(1) Skilled nursing services or skilled rehabilitation services must be needed and provided 7 days a week; or

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(2) As an exception, if skilled rehabilitation services are not available 7 days a week those services must be needed and provided at least 5 days a week.

(b) A break of one or two days in the furnishing of rehabilitation services will not preclude coverage if discharge would not be practical for the one or two days during which, for instance, the physician has suspended the therapy sessions because the patient exhibited extreme fatigue.