

# Nursing Facility Coverage Under Medicare

Edward Dale

Cheryldiane Feuerman

Follow this and additional works at: <http://scholarship.law.marquette.edu/elders>



Part of the [Elder Law Commons](#)

---

### Repository Citation

Dale, Edward and Feuerman, Cheryldiane (2000) "Nursing Facility Coverage Under Medicare," *Marquette Elder's Advisor*: Vol. 2: Iss. 1, Article 12.

Available at: <http://scholarship.law.marquette.edu/elders/vol2/iss1/12>

This Column is brought to you for free and open access by the Journals at Marquette Law Scholarly Commons. It has been accepted for inclusion in Marquette Elder's Advisor by an authorized administrator of Marquette Law Scholarly Commons. For more information, please contact [megan.obrien@marquette.edu](mailto:megan.obrien@marquette.edu).

## MEDICARE

# Nursing Facility Coverage Under Medicare

*Many beneficiaries believe that Medicare provides substantial coverage for nursing home care.<sup>1</sup> The coverage actually available is of short duration, incomplete, and riddled with limitations.*

**By Edward Dale and Cheryldiane Feuerman**

---

*Edward Dale*, director of the Elder Law and Legal Assistance to Medicare Patients Unit of Connecticut Legal Services, Inc., since 1986, frequently provides instruction on Medicare and the Medicare appeals process for medical and legal professionals. *Cheryldiane Feuerman* is a senior staff attorney with the Elder Law and Legal Assistance to Medicare Patients Unit of Connecticut Legal Services, Inc., and has specialized in Medicare law for over 10 years.

**P**osthospital extended care services furnished to inpatients of a skilled nursing facility (SNF)<sup>2</sup> are covered under Part A<sup>3</sup> of the Medicare program. In order to be eligible for the SNF benefit, all of the following criteria must be met: (1) the beneficiary must be hospitalized and receiving Medicare-covered services for at least three days prior to admission to the nursing facility;<sup>4</sup> (2) generally, admission to the nursing facility must occur within 30 days of discharge from the hospital;<sup>5</sup> (3) the beneficiary must require and receive daily skilled nursing or skilled rehabilitation, or a combination of both, for a condition for which the beneficiary was hospitalized or which was treated in that hospital stay and which, as a practical matter, could only be provided in an SNF;<sup>6</sup> (4) the services must be ordered by a physician who must certify to the beneficiary's need for skilled care;<sup>7</sup> and (5) the beneficiary must receive these benefits in a Medicare-certified skilled nursing facility.<sup>8</sup>

If all of these criteria are met, the beneficiary is entitled to up to 100 days of benefits per "spell of illness,"<sup>9</sup> with only the first 20 days paid in full by Medicare.<sup>10</sup> Covered services include nursing services, provided by or under the supervision of a registered professional nurse;<sup>11</sup> bed and board in connection with the furnishing of nursing care;<sup>12</sup> physical, occupational, or speech therapy;<sup>13</sup> medical social services;<sup>14</sup> drugs, biologicals, supplies, appliances, and equipment;<sup>15</sup> and such other services necessary to the health of residents that are generally provided by SNFs.<sup>16</sup>

### **Three-Day Prior Hospitalization and Thirty-Day Transfer Requirements**

The first criterion that a beneficiary must meet in order to qualify for the Medicare SNF benefit is a medically necessary inpatient hospital stay of at least three consecutive days,<sup>17</sup> not counting the day of discharge.<sup>18</sup> This criterion has become a significant barrier to obtaining SNF coverage due to changes in medical practice. Conditions or

surgery that would routinely result in a several-day hospitalization a decade ago are now dealt with on an outpatient basis. A stay in a hospital that is not for an acute condition, such as a stay following a “social admission” where the physician deemed it unsafe for the beneficiary to return home, will not satisfy the three-day qualifying stay requirement, no matter how long the stay. Similarly, a beneficiary who is admitted to an SNF from the community will not be eligible for Medicare coverage even if the daily skilled care requirement is met.

Generally, Medicare law requires that the beneficiary must be admitted to the SNF within 30 days of discharge from the hospital.<sup>19</sup> However, the law provides for an exception to the 30-day transfer requirement if it would be medically inappropriate for the beneficiary to begin a course of treatment within that time.<sup>20</sup> For example, it may be medically inappropriate for a beneficiary whose leg was amputated to begin a course of physical therapy in an SNF within the 30-day time frame for lack of sufficient time for the surgical wound to heal. In such a case, an admission to begin rehabilitation that occurred after 30 days of discharge from the hospital would not be precluded from coverage as long as all of the other SNF coverage criteria were met.

### Daily Basis Requirement

To meet the requirement that the beneficiary receive daily skilled care while an inpatient of the facility, the beneficiary must need and receive skilled nursing

seven days per week, skilled rehabilitation at least five days per week, or a combination of both totaling seven days per week.<sup>21</sup> The daily skilled care requirement is not to be interpreted so strictly as to preclude coverage of beneficiaries who are unable to continue a regime of physical therapy for a short period due to their physical condition.<sup>22</sup> Thus, therapy can be suspended for several days to allow a fatigued beneficiary to rest without jeopardizing the beneficiary’s coverage under the SNF benefit.

### Skilled Services Requirement

While the Medicare Act does not define “skilled services,” the regulations provide that skilled services are services that are (1) ordered by a physician; (2) require the skills of technical and professional personnel, such as registered nurses, licensed practical nurses, physical therapists, occupational therapists, and speech pathologists or audiologists; and (3) are so inherently complex that they can only be safely and effectively performed directly by or under the supervision of such personnel.<sup>23</sup> Restoration potential is not the deciding factor in determining whether skilled services are required, as skilled care may be necessary to prevent deterioration or preserve current capabilities even when medical improvement is not possible.<sup>24</sup> The regulations contain some useful examples of skilled nursing and rehabilitation services.<sup>25</sup> In some cases, Medicare will allow coverage for services that are generally considered non-

skilled if, because of special medical complications, they must be performed by skilled nursing or rehabilitation personnel.<sup>26</sup> For example, while a plaster cast on a leg does not usually indicate the need for skilled services, a person with peripheral vascular disease might require skilled nursing for observation of potential complications as a result of that cast.

Medicare draws a distinction between skilled care and “custodial” care. Custodial care alone is never covered under Medicare.<sup>27</sup> Custodial care is defined by the regulations as any care that does not meet the requirements for coverage as posthospital SNF care.<sup>28</sup> The courts have defined custodial care as care that could be administered by a layperson, without any possible harm to the health of the one in custody.<sup>29</sup> In *Friedman v. Secretary of Dep’t of Health and Human Services*,<sup>30</sup> the court determined that the standard for review to determine whether care is custodial versus skilled should be based on a commonsense, nontechnical consideration of the patient’s condition as a whole. This “total condition” standard of review allows an advocate wide latitude in arguing for coverage of SNF services provided to a frail elderly person with multiple ailments.

### Practical Matter Requirement

The SNF benefit is available to beneficiaries if, as a practical matter, the required skilled nursing or skilled therapy services can only be provided in an SNF on an inpatient basis.<sup>31</sup> Medicare regulations provide that in mak-

ing a “practical matter” determination, consideration must be given to the beneficiary’s condition and to the feasibility of using more economical alternative facilities and services.<sup>32</sup> To determine whether the practical matter test has been met, the courts look to see whether receipt of the same services in an alternative setting, such as on an outpatient basis or through home care services, is actually feasible and more economical than SNF placement.<sup>33</sup> For example, physical therapy provided in the home may be more economical than SNF placement; however, it may not be feasible if the home has stairs that the beneficiary cannot climb. Interpretation of the “practical matter” criterion should never be so strict that it results in the automatic denial of coverage for beneficiaries 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. For example, a short leave of absence for the purpose of attending a family holiday dinner or religious service is not in itself evidence that the beneficiary no longer needs to be in an SNF for the receipt of the skilled care required.<sup>34</sup>

### Spell of Illness

The “spell of illness” concept under Medicare can be quite confusing. Contrary to what most people would assume, a spell of illness (also called a benefit period) is *not* based on a beneficiary’s diagnosis. Rather, Medicare regulations provide that a spell of illness or benefit period begins when a beneficiary

receives inpatient hospital or SNF services, and ends 60 days after a beneficiary no longer requires either a hospital level of care or skilled care in a skilled nursing facility.<sup>35</sup>

In calculating when a spell of illness ends, it is important to understand that a person who is a resident of an SNF receiving only noncovered custodial care is not considered an “inpatient” of that SNF for purposes of the spell of illness criterion.<sup>36</sup> Consider, for example, a beneficiary who entered an SNF for rehabilitation following a qualifying hospital stay for hip replacement surgery, then had a heart attack on the 90th day of the benefit period and was again hospitalized. The beneficiary would not be entitled to another 100 days of benefits on readmission to the SNF because there would have been no break of 60 consecutive days where the beneficiary did not receive either hospital care or skilled care. Under this example, the beneficiary would only be entitled to the remaining 10 days of the original spell of illness. In contrast, consider a beneficiary whose condition improved to the point that by the 90th day of her stay she required only custodial care in the SNF, until she suffered a heart attack 61 days later. On readmission to the SNF, the beneficiary would be entitled to a new 100-day benefit period because, although residing in the nursing facility, 60 days had elapsed without the receipt of hospital care or skilled care.

### Duration of Coverage

While the Medicare SNF benefit provides for 100 days of coverage per spell of illness,<sup>37</sup> Medicare coverage of the entire 100 days is not guaranteed. Medicare coverage will cease should the medical condition of a beneficiary improve to the point that skilled care is no longer needed, regardless of whether the full 100 benefit days are utilized.

### Coinsurance

All Medicare beneficiaries enrolled in the Original Medicare Program<sup>38</sup> are responsible for payment of a coinsurance<sup>39</sup> amount from day 21 through day 100<sup>40</sup> of their SNF stay. This coinsurance amount is subject to change annually. Beneficiaries enrolled in Medicare+Choice<sup>41</sup> managed care plans<sup>42</sup> are not responsible for payment of a coinsurance for skilled nursing facility services.<sup>43</sup>

### Coverage Denials, Terminations, and Access Problems

On a beneficiary’s admission to a nursing facility, the facility is required to determine whether the three-day hospital stay requirement has been met and must perform a residential assessment to determine whether all other criteria for Medicare coverage are met. If the beneficiary did not have a qualifying hospital stay or does not meet the coverage criterion, the beneficiary will be denied Medicare coverage. Similarly, should the beneficiary’s condition improve where skilled services are no longer needed, Medicare coverage of a continued nursing facil-

ity stay will be denied. In many instances, inappropriately strict standards are applied when evaluating a beneficiary's level of care for coverage purposes.

SNF coverage denials will often be based on the assertion that the beneficiary did not require or receive skilled services on a daily basis or that the services required could have been provided in an alternative setting. Such denial can often be challenged using frequently ignored provisions of Medicare regulations that provide that the patient's overall condition must be considered,<sup>44</sup> that skilled personnel may be required to perform and coordinate a series of tasks that, viewed individually, would not require a skilled professional,<sup>45</sup> and that Medicare coverage is available when skilled care is needed to prevent or delay further deterioration or preserve current capabilities.<sup>46</sup>

As noted above, Medicare regulations detail numerous types of specific services that are deemed skilled.<sup>47</sup> The standards found in these regulations also often supply the basis of an appeal. In most cases, the appeal will be founded on the claim that the medical evidence, particularly the opinion of the beneficiary's treating physician, shows that the beneficiary met one or more of the standards established by the regulations.

Medicare's limitation on skilled nursing facility coverage to those who received at least three days of hospital care has grown to also be a major cause of denials as the duration of hospital stays has decreased. When a beneficiary who has received daily skilled care in a facility has

been denied coverage on the lack of a qualifying hospital stay, an appeal should be considered. The courts have determined that time spent in the emergency room prior to formal admission to the hospital can be counted toward the three-day stay requirement if the services were part of a "continuous course of care."<sup>48</sup>

Recently, significant changes in the way Medicare pays skilled nursing facilities have had an effect on SNF coverage determinations and beneficiary access to services. Effective July 1, 1998,<sup>49</sup> a reasonable cost-based payment system<sup>50</sup> was replaced by a federal prospective per diem payment rate.<sup>51</sup> This per diem rate encompasses all costs of furnishing covered SNF services to a Medicare beneficiary during a Part A stay<sup>52</sup> subject to a limited list of exclusions.<sup>53</sup> The SNF prospective payment system (SNF PPS) establishes a resident classification system, called Resource Utilization Groups III (RUG-III, or RUGs), to classify patients into one of 44 RUGs<sup>54</sup> according to the amount and type of services required. A beneficiary is considered to meet the level of care requirements for SNF coverage when assigned to one of the top 26 RUGs.<sup>55</sup> The amount of daily payment the SNF receives for a beneficiary will be determined by the RUGs category to which the beneficiary is assigned.

The SNF PPS has severely limited coverage for beneficiaries with certain diagnoses, such as those suffering from dementia, who fall into the lower 18 RUG categories. Appeals of these denials of coverage should

be taken if the overall condition of the beneficiary requires the provision of daily skilled services.

In addition, many advocates have found that the SNF PPS has adversely affected access to nursing facilities for Medicare beneficiaries whose cost of care exceeds the per diem rate of the RUG category to which they are assigned. Generally, a nursing facility's failure to admit a Medicare beneficiary who meets Medicare criteria for coverage is a violation of the Medicare conditions of participation. In addition, it may be possible to challenge such discriminatory treatment under the Americans with Disabilities Act, as well as any state law or regulation that addresses nursing facility admission procedures.<sup>56</sup>

### **Medicare Appeals in Skilled Nursing Facility Cases<sup>57</sup>**

The Medicare Act provides a multilevel appeals process for individuals denied coverage of services received in a skilled nursing facility.

Nursing facilities are required to give beneficiaries a written notice of noncoverage, either on admission or during a nursing facility stay, if the facility is of the opinion that the beneficiary does not meet the criteria for Medicare coverage.<sup>58</sup> This notice must advise the beneficiary of the right to have a bill (known as a demand bill) submitted to Medicare for all services received that are considered to be noncovered.<sup>59</sup> The beneficiary's request for submission of a demand bill results in the issuance of a Medicare Summary Notice<sup>60</sup> from the

Medicare intermediary<sup>61</sup> that will advise of Medicare's "initial determination."<sup>62</sup> This initial determination triggers the beneficiary's federal appeals rights under the Medicare program, providing an opportunity to challenge the noncoverage determination. A beneficiary dissatisfied with an initial determination has 60 days to request a reconsideration of that determination,<sup>63</sup> also performed by the Medicare intermediary. A beneficiary dissatisfied with a reconsideration may request a hearing before an administrative law judge (ALJ)<sup>64</sup> if the amount in dispute is greater than \$100<sup>65</sup> and the request is made within 60 days of issuance of the reconsideration determination.<sup>66</sup> Should the ALJ issue a denial, the beneficiary has 60 days to request a review by the Medicare Departmental Appeals Board (DAB).<sup>67</sup> Finally, should the DAB issue a denial and the amount in controversy is greater than \$1,000, the beneficiary may file an action in a federal district court within 60 days of the DAB decision.<sup>68</sup>

## Endnotes

1. Medicare is a federal health insurance program for the elderly and disabled created by Congress in 1965 as part of the Social Security Act. *See generally* 42 U.S.C. § 1395 *et seq.* Pursuant to the Balanced Budget Act of 1997, Medicare beneficiaries can receive their Medicare benefits through the Original Medicare Program (also known as traditional Medicare or fee-for-service Medicare) or through the Medicare+Choice Program. *See generally* 42 U.S.C. § 1395w-21 *et seq.*; 42 C.F.R. § 422.1 *et seq.*
2. *See* 42 U.S.C. §§ 1395d, 1395i-3(a), 1395x(j).
3. Part B coverage may be available for services furnished to a beneficiary that are not covered under Part A (generally because the beneficiary has not met all of the qualifying criteria or has exhausted the 100 benefit days) if they constitute "medical and other health services." 42 C.F.R. § 409.27(a).
4. *See* 42 U.S.C. § 1395x(i); 42 C.F.R. § 409.30.
5. *See* 42 U.S.C. § 1395x(i); 42 C.F.R. § 409.30.
6. *See* 42 U.S.C. §§ 1395f(a)(2)(B), 1395x(i); 42 C.F.R. § 409.30 *et seq.*
7. *See* 42 U.S.C. § 1395f(a)(2); 42 C.F.R. §§ 409.31 (a)(1), 424.20.
8. *See* 42 U.S.C. § 1395cc.
9. *See* 42 U.S.C. § 1395d(a)(2).
10. *See* 42 C.F.R. § 409.61(b).
11. *See* 42 U.S.C. § 1395x(h)(1); 42 C.F.R. §§ 409.20(a)(1), 409.21.
12. *See* 42 U.S.C. § 1395x(h)(2); 42 C.F.R. §§ 409.20(a)(2), 409.22.
13. *See* 42 U.S.C. § 1395x(h)(3); 42 C.F.R. §§ 409.20(a)(3), 409.23.
14. *See* 42 U.S.C. § 1395x(h)(4); 42 C.F.R. §§ 409.20(a)(4), 409.24.
15. *See* 42 U.S.C. § 1395x(h)(5); 42 C.F.R. §§ 409.20(a)(5), 409.25.
16. *See* 42 U.S.C. § 1395x(h)(7); 42 C.F.R. §§ 409.20(a)(7), 409.27.
17. *See* 42 U.S.C. § 1395x(i); 42 C.F.R. § 409.30(a)(1).
18. *See generally* MEDICARE INTERMEDIARY MANUAL § 3131.1.
19. *See* 42 U.S.C. § 1395x(i); 42 C.F.R. § 409.30(b)(1).
20. *See* 42 C.F.R. § 409.30(b).
21. *See* 42 C.F.R. § 409.34(a).
22. *See* 42 C.F.R. § 409.34(b).
23. *See* 42 C.F.R. §§ 409.31, 409.32(a).
24. *See* 42 C.F.R. § 409.32(c).
25. *See* 42 C.F.R. § 409.33.
26. *See* 42 C.F.R. § 409.32(b).
27. *See* 42 U.S.C. § 1395y(a)(9).
28. *See* 42 C.F.R. § 411.15(g).
29. *See, e.g.,* Hurley v. Bowen, 857 F.2d 907 (2d Cir. 1988); Samuels v. Weinberger, 379 F. Supp. 120 (S.D. Ohio 1973).
30. 819 F.2d 42 (2d Cir. 1987).
31. *See* 42 U.S.C. § 1395f(a)(2)(B); 42 C.F.R. §§ 409.31(3), 409.35.
32. *See* 42 C.F.R. § 409.35(a).
33. *See* Ridgely v. Secretary of Dep't of Health, Educ. and Welfare, 345 F. Supp. 983 (D. Md. 1972); *see also* Gartmann v. Secretary of U.S. Dep't of

- Health and Human Servs., 633 F. Supp. 671 (E.D.N.Y. 1986).
34. *See generally* MEDICARE SKILLED NURSING FACILITY MANUAL § 214.6C.
35. *See* 42 U.S.C. § 1395x(a); 42 C.F.R. § 409.60.
36. *See* 42 C.F.R. § 409.60(b)(2).
37. *See* 42 U.S.C. § 1395(d)(a)(2) and (b)(2).
38. Medicare's traditional fee-for-service arrangement established in 1965, which covers Part A and Part B services, is now called the Original Medicare Program.
39. The coinsurance amount is a portion of the cost of care received. *See* 42 U.S.C. § 1395e(a)(3); 42 C.F.R. § 409.85.
40. For the year 2000, the coinsurance amount is \$97 per day. Persons enrolled in the Original Medicare Program generally purchase a Medicare Supplemental Insurance (Medigap) policy to cover the SNF coinsurance amount and other deductible and coinsurance amounts that the Medicare program imposes. Low-income and -asset Medicare beneficiaries can have these expenses covered by enrolling in the Qualified Medicare Beneficiary Program. *See* 42 U.S.C. § 1396d(p)(1).
41. The Medicare+Choice Program was created in 1997 to provide Medicare beneficiaries with more choices of Medicare health plans from which they can receive their Medicare benefits.
42. Medicare+Choice managed care plans include health maintenance organizations, provider sponsored organizations, and preferred provider organizations. *See* 42 U.S.C. § 1395w-21(a)(2)(A).
43. However, in order to receive plan coverage, admission may be restricted to specific nursing facilities listed by the plan.
44. *See* 42 C.F.R. § 409.33(a)(1).
45. *See* 42 C.F.R. § 409.32(b).
46. *See* 42 C.F.R. § 409.32(c).
47. *See* 42 C.F.R. § 409.33.
48. *See* Jenkel v. Shalala, 845 F. Supp. 69 (D. Conn. 1994).
49. A transitional rate applies to some facilities, with all utilizing the federal per diem rate by 2002. *See* 42 C.F.R. § 413.340.
50. Under the reasonable cost-based system, SNFs received payment for three major categories of costs: routine costs (those services included by the provider in a daily service charge such as regular room, nursing services, and some medical supplies); ancillary costs directly identifiable to individual patients (costs for specialized services such as therapy, drugs, and laboratory services); and capital-related costs (costs of land, building, equipment, and the like).
51. The federal per diem rate was developed using 1995 allowable costs, a wage index adjustment, projections of increases in costs from the SNF market basket index, resident assessment data, and an estimate of the amount payable under Part B. *See* 42 C.F.R. § 413.330 *et seq.*
52. *See* 42 C.F.R. § 413.335.
53. Some services are excluded from the consolidated billing requirement and may be billed separately. *See* 42 C.F.R. § 411.15(p)(2).
54. The RUG-III classification system classifies SNF residents into mutually exclusive groups based on clinical, functional, and resource-based criteria and consists of seven major categories. They are, in hierarchical order: Rehabilitation, Extensive Services, Special Care, Clinically Complex, Impaired Cognition, Behavior Only, and Physical Function Reduced. These major categories are further differentiated into 44 more specific groupings, each of which is assigned a revenue code. *See generally* MEDICARE PROVIDER MANUAL § 2832.
55. *See* 42 C.F.R. § 409.30.
56. There is ample case law involving skilled nursing facility coverage under Medicare. *See generally* Ryan v. Sullivan, No. 90-CV-1096E, 1992 WL 73159 (W.D.N.Y. April 3, 1992); Stefanko v. Secretary of Health and Human Servs., No. B-88-566, 1990 WL 130002 (D.Conn. March 27, 1990) (preceding cases found a relationship between SNF care and the prior hospitalization); *see generally* Goodrich v. Bowen, No. H-84-1054, 1988 WL 235577 (D.Conn. May 31, 1988); Mazzella v. Heckler, No. H-83-953, 1985 WL 77956 (D.Conn. Aug. 18, 1985) (preceding cases held that the need for care as a

practical matter could only be provided at an SNF); *see generally* Israel by Geyer v. Secretary of Health and Human Servs., 669 F. Supp. 61 (W.D.N.Y. 1987); Hirsch v. Bowen, 655 F. Supp. 342 (S.D.N.Y. 1987); Gartmann v. Secretary of Health and Human Servs., 633 F. Supp. 671 (E.D.N.Y. 1986); Roth v. Secretary of Health and Human Servs., 606 F. Supp. 636 (W.D.N.Y. 1985) (preceding cases held that consideration of the patient's total condition in determining whether skilled services were required); *see generally* Aurora v. Secretary of U.S. Dep't of Health and Human Servs., 715 F. Supp. 466 (E.D.N.Y. 1989); Fox v. Bowen, 656 F. Supp. 1236 (D.Conn. 1986); Walsh v. Secretary of U.S. Dep't of Health and Human Servs., 636 F. Supp. 358 (E.D.N.Y. 1986); Howard v. Heckler, 618 F. Supp. 1333 (E.D.N.Y. 1985);

- Kuebler v. Secretary of U.S. Dep't of Health and Human Servs., 579 F. Supp. 1436 (E.D.N.Y. 1984) (preceding cases held that covered skilled care is distinct from noncovered custodial care).
57. The appeal process explained pertains to beneficiaries enrolled in the Original Medicare Program. Appeals of denials of coverage issued by Medicare+Choice plans will be covered in a future column.
58. Generally, the facility cannot charge a beneficiary for services that are not covered by Medicare until the beneficiary receives a written notice of noncoverage.
59. *See* Sarrassat v. Sullivan, No. C88-20161, 1989 WL 208444 (N.D. Cal. May 17, 1989).
60. Formerly called a Notice of Medicare Claim Determination.
61. A private entity (usually an insurance company) that contracts with Medicare to handle claims processing, payment, and the first stages of the appeals process. *See* 42 C.F.R. § 400.202.
62. *See* 42 C.F.R. § 405.72.
63. *See* 42 C.F.R. §§ 405.702, 405.710, 405.711.
64. *See* 42 C.F.R. § 405.720.
65. *See* 42 U.S.C. § 1395ff(b)(2)(A); 42 C.F.R. § 405.720(d).
66. *See* 42 C.F.R. § 405.722.
67. *See* 20 C.F.R. § 404.967 *et seq.*; 42 C.F.R. § 405.724.
68. *See* 42 U.S.C. §§ 405(g), 1395ff(b)(2); 42 C.F.R. § 405.730.