DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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MEDICARE DRUG & HEALTH PLAN CONTRACT ADMINISTRATION GROUP

DATE: December 11, 2013

TO: All Medicare Advantage Organizations, Section 1876 Cost Organizations, and PACE Organizations

FROM: Danielle R. Moon, J.D., M.P.A.
Director

SUBJECT: *Jimmo v. Sebelius* Settlement Agreement Program Manual Updates, MLN Matters® Article and Educational Conference Call Information

Below you will find information for an educational conference call the Centers for Medicare & Medicaid Services (CMS) will be hosting to communicate the policy clarifications reflected by the manual revisions agreed to as part of the Jimmo v. Sebelius Settlement Agreement. We recommend all Medicare Advantage Organizations (MAOs), cost plans and PACE Organizations participate in this educational conference call. We strongly suggest that your organization's Medical Director and Compliance Officer, in addition to any other staff responsible for ensuring adherence to organization determinations and appeals attend this call.

Educational Conference Call
Program Manual Updates to Clarify SNF, IRF, HH, and OPT Coverage Pursuant to Jimmo v. Sebelius — MLN Connects™ Call
Monday, December 16; 2-3pm ET

This confidential, internal call is for Part A and Part B Medicare Administrative Contractors (MACs), Medicare Advantage (MA) Organizations (Part C contractors), Part A/B Qualified Independent Contractors (QICs), Part C QIC/Independent Review Entity (IRE), Quality Improvement Organizations (QIOs), Recovery Audit Contractors (RACs), Administrative Law Judges (ALJs), Medicare Appeals Council, and CMS staff.

On January 24, 2013, the U. S. District Court for the District of Vermont approved a settlement agreement in the case of *Jimmo v. Sebelius*, involving skilled care for the inpatient rehabilitation facility (IRF), skilled nursing facility (SNF), home health (HH), and outpatient therapy (OPT) benefits. "Nothing in this Settlement Agreement modifies, contracts, or expands the existing eligibility requirements for receiving Medicare coverage."

The goal of this settlement agreement is to ensure that claims are correctly adjudicated in accordance with existing Medicare policy, so that Medicare beneficiaries receive the full coverage to which they are entitled. The settlement agreement sets forth a series of specific steps for CMS to undertake, including issuing clarifications to existing program guidance and new educational material on this subject.

As part of the educational campaign, this MLN Connects™ Call will provide an overview of the clarifications to the Medicare program manuals. These clarifications reflect Medicare's longstanding policy that when skilled services are required in order to provide reasonable and necessary care to prevent or slow further deterioration, coverage cannot be denied based on the absence of potential for improvement or restoration. In this context, coverage of skilled nursing and skilled therapy services "…does not turn on the presence or absence of a beneficiary's potential for improvement, but rather on the beneficiary's need for skilled care." Portions of the revised manual provisions also include additional material on the role of appropriate documentation in facilitating accurate coverage determinations for claims involving skilled care.

Agenda:

- Clarification of Medicare's longstanding policy on coverage for skilled services
- No "Improvement Standard" is to be applied in determining Medicare coverage for maintenance claims in which skilled care is required
- Enhanced guidance on appropriate documentation

Dial-in Number:
(877) 256 -8277 (no ID or passcode is needed)

Presentation:
The presentation will be posted at http://www.cms.gov/Outreach-and-Education/Outreach/NPC/Downloads/Dec16presentation.pdf prior to the call.

Important:
Do not distribute information about this December 16 call outside your organization. A separate call for providers will be held on December 19.

Medicare Benefit Policy Manual Update:
In accordance with the *Jimmo v. Sebelius* Settlement Agreement, the Centers for Medicare & Medicaid Services (CMS) has agreed to issue revised portions of the relevant program manuals used by Medicare contractors, in order to clarify that coverage of skilled nursing and skilled therapy services "…does not turn on the presence or absence of a beneficiary's potential for improvement, but rather on the beneficiary's need for skilled care." Skilled care may be necessary to improve a patient's current condition, to maintain the patient's current condition, or to prevent or slow further deterioration of the patient's condition.

The following are some significant aspects of the manual clarifications now being issued:

- **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). For example, the longstanding SNF level of care regulations, specify that 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 . . . skilled services . . . ." [42 CFR 409.32(c)] (This regulation is available at http://www.gpo.gov/fdsys/pkg/CFR-2011-title42-vol2/pdf/CFR-2011-title42-vol2-sec409-32.pdf on the Internet.)

While the example included in this provision pertains specifically to skilled nursing services, we also wish to clarify that, the concept of skilled therapy services can similarly involve not only services that are restorative in nature (or "rehabilitative" therapy in the OPT setting) but, if certain standards are met, maintenance therapy as well:

- 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. We note 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.

Accordingly, these revisions to the Medicare Benefit Policy Manual (MBPM) clarify that a beneficiary's lack of restoration potential cannot serve as the basis for denying coverage in this context. Rather, such coverage depends upon an individualized assessment of the beneficiary's medical condition and the reasonableness and necessity of the treatment, care, or services in question. Moreover, when the individualized assessment demonstrates that skilled care is, in fact, needed in order to safely and effectively maintain the beneficiary at his or her maximum practicable level of function, such 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.

Medicare has never supported the imposition of an "Improvement Standard" rule-of-thumb in determining whether skilled care is required to prevent or slow deterioration in a patient's condition. Thus, such coverage depends not on the beneficiary's restoration potential, but on whether skilled care is required, along with the underlying reasonableness and necessity of the services themselves. The manual revisions now being issued will serve to reflect and articulate this basic principle more clearly. Therefore, denial notices should contain an accurate summary of the reason for denial, which should be based on the beneficiary's need for skilled care and not be based on lack of improvement for a beneficiary who requires skilled maintenance nursing

services or therapy services as part of a maintenance program in the SNF, HH, or OPT settings.

In the MBPM (the Manual within which all revisions were made by CR8458), the revised Chapter 15, Section 220 specifically discusses Part B coverage under the OPT benefit. In that chapter, both rehabilitative and maintenance therapy are addressed. Rehabilitative therapy includes services designed to address recovery or improvement in function and, when possible, restoration to a previous level of health and well-being. A "MAINTENANCE PROGRAM (MP) means a program established by a therapist that consists of activities and/or mechanisms that will assist a beneficiary in maximizing or maintaining the progress he or she has made during therapy or to prevent or slow further deterioration due to a disease or illness." No mention of improving the patient's condition is noted within the MP definition.

- **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. Thus, even though the terms of the *Jimmo* settlement do not include an explicit reference to documentation requirements as such, CMS has nevertheless decided to use this opportunity to introduce additional guidance in this area, both generally and as it relates to particular clinical scenarios. An example of this material appears in a new Section 30.2.2.1 of the MBPM's revised Chapter 8, in the guidelines for SNF coverage under Part A.

We note that this material on documentation does not serve to require the presence of any particular phraseology or verbal formulation as a prerequisite for coverage (although it does identify certain vague phrases like "patient tolerated treatment well," "continue with POC," and "patient remains stable" as being *insufficiently explanatory* to establish coverage). Rather, as indicated previously, coverage determinations must consider the *entirety* of the clinical evidence in the file, and our enhanced guidance on documentation is intended simply to assist providers in their efforts to identify and include the kind of clinical information that can most effectively serve to support a finding that skilled care is needed and received—which, in turn, will help to ensure more accurate and appropriate claims adjudication.

Further, as noted in the discussion of OPT coverage under Part B in Section 220.3.D of the MBPM, Chapter 15, care must be taken to assure that documentation justifies the necessity of the skilled services provided. Justification for treatment would include, for example, objective evidence or a clinically supportable statement of expectation that:

- In the case of rehabilitative therapy, the patient's condition has the potential to improve or is improving in response to therapy; maximum improvement is yet to be attained; and, there is an expectation that the anticipated improvement is attainable in a reasonable and generally predictable period of time.
- In the case of maintenance therapy, the skills of a therapist are necessary to maintain, prevent, or slow further deterioration of the patient's functional status, and the services

cannot be safely and effectively carried out by the beneficiary personally or with the assistance of non-therapists, including unskilled caregivers.

The Settlement Agreement. The *Jimmo v. Sebelius* settlement agreement itself includes language specifying that **"Nothing in this Settlement Agreement modifies, contracts, or expands the existing eligibility requirements for receiving Medicare coverage."** Rather, the intent is to clarify Medicare's longstanding policy that when skilled services are required in order to provide care that is reasonable and necessary to prevent or slow further deterioration, coverage cannot be denied based on the absence of potential for improvement or restoration. As such, the revised manual material now being issued does not represent an expansion of coverage, but rather, provides clarifications that are intended to help ensure that claims are adjudicated accurately and appropriately in accordance with the existing policy.

The sections of the Medicare Benefit Policy manual that have been updated can be found in Attachment A. Access the Medicare Benefit Policy manual at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS012673.html?DLPage=1&DLSort=0&DLSortDir=ascending.

Medicare Learning Network® MLN Matters Article
MLN Matters® Article #MM8458, "Manual Updates to Clarify Skilled Nursing Facility (SNF), Inpatient Rehabilitation Facility (IRF), Home Health (HH), and Outpatient (OPT) Coverage Pursuant to *Jimmo vs. Sebelius*" has been released and is now available in downloadable format. The article was prepared and is being distributed as a result of the settlement agreement in the case of *Jimmo v. Sebelius.* This article is designed to provide education on the updated portions of the MBPM. It includes clarification on the coverage requirements of skilled nursing and skilled therapy services to Medicare beneficiaries.