

**Summary of the questions posed and responses provided during the
December 16, 2013, *Jimmo v. Sebelius* National Call for contractors and adjudicators**

**This document clarifies certain original CMS responses and
supersedes the original summary document in whole**

Effect of *Jimmo v. Sebelius* Settlement on Coverage Requirements Other than the Requirement for Skilled Care

CMS received multiple inquiries concerning what type of impact the *Jimmo v. Sebelius* settlement might have on other aspects of Medicare coverage requirements beyond the need for skilled care—for example, whether *Jimmo v. Sebelius* impacts the requirements concerning the frequency of provider visits needed to demonstrate reasonableness and necessity; the SNF benefit’s “daily basis” requirement that therapy patients must need and receive skilled therapy on at least 5 out of 7 days of the week; coverage of room and board; the 100-day limit for Part A SNF benefits during each benefit period; and the appeal procedure for claims specific to these clarifications.

CMS Response: The settlement concerns only the “skilled care” requirement; all other coverage requirements are unchanged.

How to Determine When Services Would No Longer Be Covered — Response Revised May 2017

CMS was asked how contractors could determine when maintenance services were no longer covered. For instance, if a patient on maintenance therapy continues to deteriorate, at what point would the maintenance services no longer be covered? How do contractors make that determination? CMS was also asked to provide guidance on specific clinical examples.

CMS Response: Skilled services would be covered where such skilled services are necessary to maintain the patient’s current condition or prevent or slow further deterioration so long as the beneficiary requires skilled care for the services to be safely and effectively provided. The health care provider must continually evaluate the individual’s need for skilled care (as well as whether such care meets Medicare’s overall requirement for being reasonable and necessary to diagnose or treat the individual’s condition, in accordance with §1862(a)(1)(A) of the Social Security Act) and make such determinations on an ongoing basis. If the beneficiary requires skilled care for the services to be safely and effectively provided and all other coverage criteria are met, such skilled care services would be covered if those services are reasonable and necessary to maintain the patient’s current condition or prevent or slow further deterioration.

How to Evaluate Efficacy of Maintenance Therapy

Contractors asked how they can determine if treatment is actually preventing or slowing decline without removing the patient from that treatment. When a patient has “plateaued” for two weeks, that plateau is a measureable entity. On the other hand, without stopping the therapy, clinicians cannot measure whether the patient is deteriorating.

CMS Response: This will also depend on the beneficiary’s medical record. In cases where maintenance services are delivered, there must be documentation in the record that demonstrates why *not* providing

the services would accelerate the beneficiary's natural rate of decline, based on the provider's clinical knowledge and experience or other evidence. Decisions and justifications should be evidence-based. For instance, when maintenance program is intended to slow further deterioration, efficacy could be demonstrated by showing natural rate of decline that has been interrupted. Maintenance services must still have specific treatment goals. If a person is continuously going downhill or declining, the services may not be meeting their goals.

How to Distinguish Between Maintenance and Restorative Therapy — Response Revised May 2017

Contractors asked how to distinguish claims where the goal is restorative or rehabilitative from claims where the goal is maintaining or preventing decline in condition.

CMS Response: There is nothing specific in terms of coding on the claim that CMS uses to classify the services being provided as either restorative/rehabilitative or for maintenance. The documentation in the individual's medical record should indicate the nature of the services being provided and support the patient's need for skilled care, whether the goal of the care is to improve the patient's condition or to maintain, or prevent or slow further deterioration of, the patient's current condition.

Appropriate Language for Denials — Response Revised May 2017

Contractors requested some examples from the settlement of where a claim was denied inappropriately. Contractors also asked what sort of language would be appropriate for them to use when denying claims.

CMS Response: Denials stating that maintenance care is a non-covered service or that coverage requires an expectation of improvement are inappropriate. As stated previously, coverage of nursing and therapy services under the Medicare skilled nursing facility, home health, and outpatient therapy benefits does not turn on the presence or absence of a beneficiary's potential for improvement from those services, but rather on the beneficiary's need for skilled care.

We believe that there have been instances where a contractor used shorthand phrases when the actual basis for making the denial was that the patient did not have (or no longer had) a need for skilled care. In that instance, the contractor's use of a shorthand phrase is improper not only because it conveys the incorrect coverage policy, but also because it does not accurately analyze the claim. A beneficiary's restoration potential is not the deciding factor in determining whether skilled services are needed. So long as all other coverage criteria are met, coverage depends, not on the beneficiary's restoration potential, but rather depends on whether skilled care is required (along with the underlying reasonableness and necessity of the services themselves). Instead, in the event of a claim denial, contractors and adjudicators need to utilize precise language to describe why a claim is being denied using the correct coverage standards.

Can a patient now qualify for maintenance therapy for life assuming that therapy is necessary to prevent or slow deterioration? — Response Revised May 2017

CMS Response: Patients aren't evaluated once, with a determination that they are to receive skilled services indefinitely (i.e. "for life"). Rather the health care provider must continually evaluate the individual's need for skilled care and make such determinations on a continual basis in order to

determine coverage. Assuming the need for skilled care exists, and the individual continues to meet all other coverage and eligibility requirements, including any statutory limits on the amount and duration of benefits, services would be covered.

When and how will the reviews of past claims be conducted? — Response Revised May 2017

CMS Response: The Settlement Agreement provided for review of past claims in several forms, including through the sampling of certain administrative appeals decisions, re-review of certain claims presented by individual beneficiaries, and review of individual claims that plaintiffs' counsel brought to the agency's attention. The timing and content of those reviews varied, but are specified in the Settlement Agreement in Sections IX.17 and XI. 2-11. Other reviews of past claims are conducted through the normal Medicare appeals process for individual benefit determinations.

Added May 2017:

The Centers for Medicare & Medicaid Services (CMS) reminds the Medicare community of the *Jimmo* Settlement Agreement (January 2014), which clarified that the Medicare program covers skilled nursing care and skilled therapy services under Medicare's skilled nursing facility, home health, and outpatient therapy benefits when a beneficiary needs skilled care in order to maintain function or to prevent or slow decline or deterioration (provided all other coverage criteria are met). Specifically, the *Jimmo* Settlement required manual revisions to restate a "maintenance coverage standard" for both skilled nursing and therapy services under these benefits:

Skilled nursing services would be covered where such skilled nursing services are necessary to maintain the patient's current condition or prevent or slow further deterioration so long as the beneficiary requires skilled care for the services to be safely and effectively provided.

Skilled therapy services are covered when an individualized assessment of the patient's clinical condition demonstrates that the specialized judgment, knowledge, and skills of a qualified therapist ("skilled care") are necessary for the performance of a safe and effective maintenance program. Such a maintenance program to maintain the patient's current condition or to prevent or slow further deterioration is covered so long as the beneficiary requires skilled care for the safe and effective performance of the program.

The *Jimmo* Settlement may reflect a change in practice for those providers, adjudicators, and contractors who may have erroneously believed that the Medicare program covers nursing and therapy services under these benefits only when a beneficiary is expected to improve. The Settlement is consistent with the Medicare program's regulations governing maintenance nursing and therapy in skilled nursing facilities, home health services, and outpatient therapy (physical, occupational, and speech) and nursing and therapy in inpatient rehabilitation hospitals for beneficiaries who need the level of care that such hospitals provide.