AHCA Memorandum

To: AHCA Members

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Subject: **CMS Issues Program Guidance Related to Nursing and Therapy Skilled Maintenance Services in Accordance with the January 24, 2013 *Jimmo v. Sebelius* Settlement**

Date Tuesday, December 24, 2013

Last week, the Centers for Medicare and Medicaid Services (CMS) released the long anticipated revised program manual guidance in accordance with the *Jimmo v. Sebelius* (hereinafter *Jimmo*) settlement agreement. CMS issued Change Request (CR) 8458 to the Medicare Benefit Policy Manual with an accompanying MLN Matters article #MM8458 on December 6, 2013. These documents were subsequently revised on December 13. In addition, CMS held a one-hour National Provider call on December 19 to provide an overview of the clarifications to the Medicare program manual.

1. Jimmo v. Sebelius

On January 24, 2013, the U. S. District Court for the District of Vermont approved a settlement agreement in the *Jimmo* case in which the plaintiffs alleged that Medicare contractors were inappropriately applying an "Improvement Standard" in making claims determinations for Medicare coverage involving skilled care (e.g., the skilled nursing facility (SNF), home health (HH), and outpatient therapy (OPT) benefits).

The settlement agreement set forth a series of specific steps for the Centers for Medicare & Medicaid Services (CMS) to undertake, including issuing clarifications to existing program guidance and new educational material on this subject. The goal of this settlement agreement was 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 program manuals, used by Medicare contractors, including those pertaining to skilled nursing services and outpatient therapy services, now unequivocally state 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 conditions, or to prevent or slow further deterioration of the patient's condition.

2. Key Points

Significant aspects of the manual clarifications recently issued include the following:

- **An "Improvement Standard" is not to be applied in determining Medicare coverage for maintenance claims that require skilled care.**

CMS indicates that Medicare has long recognized that even in situations where no improvement is possible, skilled care may nevertheless be needed for maintenance purposes (i.e., to prevent or slow a decline in condition). According to CMS, the Medicare statute and regulations have 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 serve to reflect, articulate and emphasize this basic principle.

- **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, CMS provides that 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, though the *Jimmo* settlement does not explicitly reference documentation requirements, CMS has nevertheless decided to introduce additional guidance in this area, both generally and as it relates to particular clinical scenarios.

- **CMS position is that there is no expansion of coverage.**

The *Jimmo* 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, according to CMS, 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.

By contrast, 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. As such, CMS takes the position that the revised manual material 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.

3. Issues Raised on the National Provider Call

Key issues raised during the December 19 National Provider Call included the following:

- The new manual language inconsistently describes what a therapist can do versus what a therapy assistant can do related to maintenance program. CMS indicated that it has not changed the requirements. However, only a "qualified therapist" can establish and perform a therapy maintenance program.

- Some Medicare administrative contractor (MAC) local coverage determination (LCD) policies still contain "improvement Standard" language. CMS indicated that contractors have been properly

educated and that any remaining inconsistent contractor materials pertaining to the improvement standard will be corrected.

- CMS, in the new manual language, discussed "skilled services" pertaining to nursing and therapy. CMS indicated that the requirements for skilled nursing or therapy maintenance services are similar. The patient's medical condition demonstrates that the specialized judgment, knowledge and the skills of the nurse or therapist are necessary. The new manual language provides more extensive examples for both nursing and therapy services.

- CMS reiterated that in regard to the *Jimmo* settlement, only the maintenance services coverage requirement was addressed. Other coverage requirements remain (e.g., the 3-day qualifying stay and 100 day benefit limit per spell of illness for SNF Part A, or the therapy caps for Part B).

- The scope of the *Jimmo* settlement extends beyond Medicare Part A and Part B. CMS indicated that Medicare Advantage plans need to offer the same maintenance benefits as fee-for-service Medicare at a minimum.

- There is a fairly extensive expansion of documentation requirements in the new manual language. CMS indicated that while the new manual language does not explicitly add any new reporting frequency requirements, or any specific forms, the documentation needs to be sufficient in order for a Medicare contractor to:

  - Understand that the provider is meeting the skilled coverage requirement;
  - Know and communicate what the treatment goals are and the progress being made towards achieving them;
  - Understand that the patient's needs are complicated, and that the necessary skills are complex.

- The new manual language differentiates between "restorative" and "maintenance" services. CMS indicated that while there is no specific coding requirement to differentiate "restorative" from "maintenance" on the claim, the clinical documentation should clearly identify whether the treatment goals are "restorative" or "maintenance" in nature.

- Also, in cases where the patient's needs change over the course of care from a "restorative" to a "maintenance" program, the documentation, goals, and plan should clearly demarcate that transition. CMS also noted that it would not be acceptable for a provider to retroactively reclassify a patient's plan of care from "restorative" to "maintenance."

- Advocacy assistance for beneficiaries. CMS indicated that providers could direct patients and their families/representatives to the CMS Ombudsman or the local LTC Ombudsman office for assistance in understanding the *Jimmo* provisions.

4. AHCA Activities

AHCA staff is currently reviewing the detailed provisions of the updated program manual instructions, the related MLN matters article, the National Provider Call material, as well as questions and answers posed during the call. In addition, we are conferring with AHCA member therapy experts in our effort to thoroughly understand the impact of these program manual changes. AHCA will be issuing a detailed analysis in the near future. Below are links to the pertinent *Jimmo* documents.

5. Pertinent Documents

- **Jimmo v Sebilius Settlement Agreement:** http://www.ahcancal.org/facility_operations/therapyservices/Documents/FINAL%20Jimmo-Settlement-Agreement.pdf
- **AHCA February 7, 2013 Letter to the Membership:** http://www.ahcancal.org/facility_operations/therapyservices/Documents/AHCA%20Jimmo%20Memo.pdf
- **AHCA September 6, 2014 Comments to CMS related to the CY 2014 Physician Fee Schedule Proposed Rule** http://www.ahcancal.org/facility_operations/therapyservices/Documents/PhysicianFeeLetterto%20TavneratCMS.pdf
- **CR 8458: Manual Updates to Clarify Skilled Nursing Facility (SNF), Inpatient Rehabilitation Facility (IRF), Home Health (HH), and Outpatient (OPT) Coverage Pursuant to Jimmo vs. Sebelius** http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R176BP.pdf
- **MLN Matters Article #8458:** http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8458.pdf
- **12/19/13 - National Provider Call Slide Deck:** http://www.cms.gov/Outreach-and-Education/Outreach/NPC/Downloads/121913-Jimmo-Slideshow.pdf