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Practice Group:
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Prospective and Retrospective Implications of the *Jimmo* Settlement Agreement for Skilled Care Providers

By Ruth E. Granfors, Jan E. Murray, Kathleen M. Burch, Lauren G. Perry

On January 24, 2013, the U.S. District Court for the District of Vermont approved a Settlement Agreement in the so-called Medicare Improvement Standard case, *Jimmo v. Sebelius*.¹ In addition to its impact on Medicare reimbursement, the Settlement Agreement marks a significant change in the standard for determining eligibility for Medicare coverage of skilled maintenance care.

Skilled Care Medicare Coverage Standard After the *Jimmo* Settlement

In the Settlement Agreement, the Secretary of Health and Human Services (“HHS”) clarifies the standard for determining Medicare coverage of skilled nursing facility (“SNF”), home health (“HH”), and outpatient therapy (“OPT”) services (collectively, “Skilled Care”) for both Medicare Parts A and B. Under the Settlement Agreement, Skilled Care is covered for those services that are necessary “to maintain the patient’s current condition or to prevent or slow further deterioration”; this standard is known as the “maintenance coverage standard.” This new standard is meant to clarify the original intent of the law.

Medicare payment contractors formerly used the alleged requirement known as the “improvement standard” to determine coverage of Skilled Care, even though it was never officially part of the HHS or Centers for Medicare & Medicaid Services (“CMS”) policy, according to CMS. Effective immediately, the Settlement Agreement clarifies that denial of Skilled Care coverage should not be based on the inability to restore or improve the beneficiary’s health or condition. Instead, Medicare payment contractors must apply the maintenance standard to determine eligibility for coverage of services.

Under the maintenance coverage standard, the beneficiary must undergo an individualized assessment to determine whether skilled nursing or skilled therapy services are necessary for the safe and effective performance of a maintenance program, that is, a program to maintain or prevent deterioration of the beneficiary’s condition. Skilled Care will be deemed necessary if the beneficiary’s special medical complications or the complexity of services require the skills of a qualified therapist or registered nurse, or in some instances, a licensed practical nurse. A skilled service is defined as a service that is “so inherently complex that it can be safely and effectively performed only by, or under the supervision of, professional or technical personnel as provided by regulation.”²

¹ *Jimmo v. Sebelius*, No. 5:11-CV-17-CR (D. Vt. filed Jan. 18, 2011).

² The Settlement Agreement further states that the maintenance coverage standard for therapy or nursing services does not apply in an inpatient rehabilitation facility or a comprehensive outpatient rehabilitation facility.

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The Prospective Impact of *Jimmo*

The maintenance coverage standard as clarified in the Settlement Agreement is effective immediately and should be applied to claims for Skilled Care now. In addition, CMS is now required to revise the Medicare Benefit Policy Manual to reflect the coverage standards set forth in the Settlement Agreement. CMS is also tasked with implementing a nationwide educational campaign that includes written materials outlining the revisions to effectively communicate the maintenance coverage standards. The maintenance coverage standard should immediately change how Medicare payment contractors determine coverage of Skilled Care providers.

Skilled Care providers should take the following steps to integrate the new standard into the provider's admission, discharge and billing practices:

- (1) Assign a point person to monitor CMS announcements regarding revisions to the Medicare Benefit Policy Manual and any other guidance issued by CMS as CMS implements the *Jimmo* decision;
- (2) Track potential announcements that may be issued by the provider's applicable Medicare payment contractor on implementation of any new CMS policy or guidance;
- (3) Educate admissions, discharge and billing staff, at a minimum, of the new maintenance standard and its application to new admissions and current residents effective immediately;
- (4) Review and revise any provider policies that may have included the erroneous "improvement standard"; and
- (5) Review and consider challenging any payment or coverage denial that is based solely on the failure of the Skilled Care services to improve the condition of the beneficiary.

In addition, the settlement includes a review process for denied claims from the time the lawsuit was filed until the end of the educational campaign. That process is explained below. Skilled Care providers should keep in mind, however, that *Jimmo* does not change other eligibility requirements for these services. For example, Medicare coverage rules require an admission to a SNF to be within 30 days of a hospital stay that has lasted at least 3 days. In addition, the 100-day limit for Medicare coverage of a SNF stay still applies. Likewise, therapy caps still apply for OPT, and a physician's certification of need is required for HH Skilled Care services.

Retrospective Impact of the *Jimmo* Settlement

The Re-Review Process for Beneficiaries

The Settlement Agreement establishes a re-review process for each class member who was wrongfully denied coverage of SNF, HH, or OPT services on the basis that the beneficiary failed to satisfy the improvement standard. For class members, the re-review process involves identifying themselves to CMS, along with their denial of coverage decision that became final and non-appealable on or after January 18, 2011.³ Then, CMS will direct the contractor to re-review the claim under the maintenance coverage standard and CMS will reimburse the beneficiary for Skilled Care that was erroneously denied.

³ January 18, 2011 is the date the *Jimmo* lawsuit was filed.

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As discussed above, applied prospectively, the Settlement Agreement's clarification of the coverage standard benefits Skilled Care providers. However, the available retrospective re-review process outlined in the Settlement Agreement is only applicable to individual beneficiaries, as set forth in the class definition section of the agreement.⁴

Given the limitation of the Settlement Agreement's process to beneficiaries, Skilled Care providers could review their accounts for unpaid coverage denials that became final and non-appealable on or after January 18, 2011. If a provider has a large number of unpaid claims for beneficiaries who were denied services based on the improvement standard, the provider could work with the beneficiaries to submit a request for re-review of claims. Alternatively, the Skilled Care provider may want to consider reopening a claim through the Medicare regulatory reopening process described below. However, if a provider decides to seek reopening, it should coordinate with the beneficiary for any claims that were final and non-appealable after January 18, 2011 to make certain that the beneficiary is not seeking recovery of those denied claims through the re-review process.

Reopening of Skilled Care Coverage Denials After Jimmo

While the *Jimmo* Settlement Agreement does not offer a process of recovery to Skilled Care providers for past wrongfully denied coverage claims, a regulatory process of reopening through the Medicare claims appeal procedures offers a potential path for Skilled Care providers to recoup denied claims that were provided and never reimbursed for a period even prior to the January 18, 2011 deadline time frame for beneficiary re-review. The first two steps in a Medicare claims appeal are: (1) an initial determination by the Medicare payment contractor and (2) a redetermination by the Medicare payment contractor. Under 42 C.F.R. § 405.980, a provider may seek to reopen either an initial determination or redetermination by the Medicare contractor for (a) any reason, (b) good cause, or (c) a clerical error.

To reopen a determination or redetermination for any reason, the provider must make the request within one year from the date of the initial final determination or redetermination. However, the provider may also request a reopening for "good cause." In that case, the provider may challenge determinations or redeterminations that became final within four years prior to the date of filing a request to reopen.

"Good cause" may be established when:

- (1) [t]here is new and material evidence that (i) [w]as not available or known at the time of the determination or decision; and (ii) [m]ay result in a different conclusion; or

⁴ Under the settlement, the class consists of all Medicare beneficiaries who "(a) received skilled nursing or therapy services in a skilled nursing facility, home health setting, or outpatient setting; and (b) received a denial of Medicare coverage (in part or in full) for those services described in the previous paragraph based on a lack of improvement potential in violation of the SNF, HH, or OPT maintenance coverage standards ... and that denial became final and non-appealable on or after January 18, 2011; and (c) seek Medicare coverage on his or her own behalf." Furthermore, "the definition of class members specifically excludes providers or suppliers of Medicare services or a Medicaid State Agency."

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(2) [t]he evidence that was considered in making the determination or decision clearly shows on its face that an obvious error was made at the time of the determination or decision.⁵

The interpretation of the good cause standard is within the discretion of the payment contractor, and there is little in the way of guidance provided by CMS. For example, the Medicare Claims Processing Manual, Chapter 34, at Section 10.11.3 provides: "Error on the face of the evidence exists if it is clear that the determination or decision was incorrect based on all evidence in file on which the determination or decision was based." The regulations provide that a decision by a Medicare contractor not to reopen an initial determination or redetermination may not be appealed.⁶

Conclusion

Skilled Care providers should monitor developments by CMS and the applicable Medicare payment contractor on the maintenance coverage standard. Effective immediately, Medicare payment contractors may no longer deny claims on the basis that the beneficiary lacked improvement potential. The Settlement Agreement provides a limited re-review process for beneficiaries whose coverage for Skilled Care was wrongfully denied. The Medicare Appeals process could be an option for those Skilled Care providers who wish to pursue a previously denied claim.

Authors:

Ruth E. Granfors

ruth.granfors@klgates.com
+1.717.231.5835

Jan E. Murray

jan.murray@klgates.com
+1.617.261.3191

Kathleen M. Burch

kathleen.burch@klgates.com
+1.617.951.9042

Lauren G. Perry

lauren.perry@klgates.com
+1.717.231.4500

⁵ 42 C.F.R. § 405.986.

⁶ 42 C.F.R. § 405.980(a)(5).

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