CALIFORNIA HEALTH ADVOCATES

Ending the "Improvement Standard"

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Our Focus

California Health Advocates
provides quality Medicare and related healthcare coverage information, education and policy advocacy.

www.cahealthadvocates.org

- **Policy** – Conduct public policy research to support recommendations for improving rights and protections for Medicare beneficiaries and their families
- **Training** – Provide timely and high-quality information on Medicare through our website, fact sheets, workshops and webinars
- **Advocacy** – Bring the experiences of Medicare beneficiaries to the public, and especially legislators and their staff at federal and state levels, through media and educational campaigns

Our Projects

- **Senior Medicare Patrol, 1-855-613-7080**
  - *Empowering Seniors to Prevent Fraud*
- **Counseling Tools**
  - *Fact sheets*
  - *Comparison charts*
- **California Medicare Coalition**
  - *Provides a forum for all who serve Medicare beneficiaries to get updates on Medicare and to improve education and outreach*

Outline

- What is the *Jimmo* settlement agreement?
- What is the “improvement standard”?
- What is the “maintenance standard”?
- How did *Jimmo* end the “improvement standard”?
- What can beneficiaries and advocates do now?

Jimmo v. Sibelius

- Five beneficiary plaintiffs and six organization plaintiffs; filed Jan 18, 2011
- Beneficiary plaintiffs
  - Received an adverse administrative decision
  - Services denied based on the “Improvement Standard”
    - Beneficiary did not show improvement
    - Beneficiary had no restorative potential
- **Reference: Center for Medicare Advocacy at www.medicareadvocacy.org**

Jimmo Settlement Agreement

see www.medicareadvocacy.org

- Nationwide class
  - all beneficiaries who received an adverse administrative decision
    - based on the Improvement Standard
    - became final and non-appealable on or after Jan 18, 2011
  - entitled to have their claims re-reviewed

Jimmo Settlement Agreement

see www.medicareadvocacy.org

- No a change in Medicare law or regulations but clarification
  - No change in eligibility, criteria or benefit
- CMS will revise chapters 7, 8 and 15 of Medicare Benefit Policy Manual
  - Clarify “maintenance standard”
    - Based on beneficiary’s need for skilled care
    - Not whether beneficiary demonstrated improvement or beneficiary’s restorative potential

Jimmo Settlement Agreement

see www.medicareadvocacy.org

- CMS Educational Campaign
  - communicate maintenance standard
  - providers, contractors and adjudicators
- CMS Review of Claims
  - Random sample of Qualified Independent Contractors' decisions
  - Was the maintenance standard correctly applied to SNF, HH and outpatient therapy coverage decisions?
  - Corrective actions

Skilled Nursing Facility Care
Criteria

- Beneficiary was hospitalized (admitted as an inpatient) for ≥3 consecutive days within 30 days prior to entering the SNF.
- “Extended care services” – Medicare covers care in SNF for condition treated in the hospital.
- The SNF must be certified by Medicare.
- Doctor, NP or CNS certifies that beneficiary needs skilled services.
- Beneficiary must need “skilled” nursing or therapy services on a daily basis.

All criteria must be met for Medicare to cover a SNF stay.

Skilled Nursing Facility Coverage

- Semi-private room
- Meals
- Skilled nursing care
- Physical, occupational, and speech-language therapy
- Medical social services
- Medications, medical supplies/equipment
- Ambulance transportation
- Dietary counseling

SNF Care Costs

- Medicare covers a maximum of 100 days of SNF care in each benefit period.
- Must meet all criteria for Medicare to cover a SNF stay.

SNF	Medicare pays	Beneficiary pays
Days 1-20	All	Nothing
Days 21-100	All after copayment	$148 per day copayment (2013)
After 100 days	Nothing	All

Home Health Care

Criteria for Medicare coverage

- Beneficiary is homebound
- Beneficiary is under care of a physician who develops a plan of care
- Physician certifies that beneficiary needs at least one of the following skilled services:
  - Physical therapy, speech therapy, occupational therapy, or intermittent skilled nursing care; and
- Home health agency (HHA) is certified by Medicare

Home Health Care

Criteria for coverage under Medicare Part A

- Home health care is covered by Part A if the following criteria are met. If not, Part B may cover.
  - Beneficiary had a prior stay of ≥3 days in a hospital or, following a hospital stay, in a SNF;
  - Home health services are provided within 14 days of discharge from hospital or SNF; and
  - Home health services will not exceed 100 visits per benefit period (or “spell of illness”).

What home health services does Medicare cover?

- Skilled nursing care (intermittent or part-time)
- Home health aide services (intermittent or part-time)
- PT, OT or speech therapy
- Medical social services
- Medical supplies (other than drugs and biologicals)
- Durable medical equipment

Outpatient Therapy

Criteria for Medicare coverage

- Services provided
  - While beneficiary is under care of a physician
  - Under a plan of care established by physician or therapist before treatment began
  - By appropriate therapist (e.g. PT, OT, speech pathologist)
  - Medically reasonable and necessary

Regulations

Skilled nursing facility benefit	Part A
	Nursing services, therapy services
	42 CFR §409.32
Home Health Care benefit	Part A and Part B
	Nursing services, therapy services
	42 CFR §409.44(c)(2)(iii)
Outpatient therapy benefit	Part B
• Physical therapy	42 CFR §410.60
• Occupational therapy	42 CFR §410.59
• Speech therapy	42 CFR §410.62

“Improvement Standard”

- Basis for denying or discontinuing services
  - Is the patient’s condition improving or expected to improve?
  - Any restorative potential?
  - Any signs of deterioration?
  - Will patient recover from loss or reduction of function spontaneously?
- Where did this standard come from?
  - Possibly 42 CFR 409.44(c)(2)(iii)(A)
    - Therapy services under home health care

"Maintenance Standard"

- Patient's **unique clinical condition** requires skilled therapist
  - To design or establish a safe and effective maintenance program, or
  - To perform or deliver complex and sophisticated therapy to maintain function
- **Reference 42 CFR §409.44(c)(2)(iii)(B) and (C)**
  - Therapy services under home health care

Prevent deterioration

- Skilled services will be covered
  - If needed to prevent deterioration or preserve current capabilities
  - Restorative potential not the deciding factor
  - Even if full recovery or medical improvement not possible
- **Reference 42 CFR §409.32(c)**
  - Skilled services under SNF care

Examples

- Blind, diabetes → leg amputated; needs wheelchair
- Multiple sclerosis
- Paralysis → in a wheelchair
- Parkinson's disease; injury from fall
- Alzheimer's disease

Was the correct standard applied?

- Was the decision based solely on beneficiary
  - Not showing improvement?
  - Having no restorative potential?

Was the correct standard applied?

- Does beneficiary need skilled services
  - Maintain function?
  - Prevent further deterioration?
  - Preserve current capabilities?
- Does the beneficiary meet the criteria for home health care or SNF care?

Advocacy tips

- Work with the doctor
- Educate the provider
  - Show *Jimmo* settlement agreement
- Ask for a written notice of non-coverage
  - Don’t accept verbal assertions
- Ask provider to submit claim for formal Medicare coverage determination

How to appeal a termination of services?

Beneficiary is in a SNF or CORF or receiving care from a HHA or hospice agency. Given written notice that benefit will no longer to covered after a certain date, but he/she believes benefit should continue and be covered.

Notice of Medicare Provider Non-Coverage

- SNF, HHA, hospice agency, and CORF required to issue
- Notice to beneficiary that Medicare coverage will end
- Termination date
- Includes information about beneficiary's right to appeal
- Instructs beneficiary how to appeal

Physician's certification

- If beneficiary receiving home health care or in a CORF disagrees with decision to end coverage, and he/she is requesting an expedited determination, he/she must ask a licensed doctor to certify that failure to continue services may place his/her health at significant risk.

Appealing termination of coverage

- Contact Quality Improvement Organization. In California, QIO is
  - **Health Services Advisory Group (HSAG), 1-800-841-1602 www.hsag.com**
- SNF, HHA, hospice agency or CORF must give Detailed Notice of Non-Coverage

How to File an Appeal – Expedited Redetermination

- Appeal is filed with the QIO after receipt of a notice of discharge or termination
- Appeal is filed by noon of the next calendar day
- No minimum AIC
- Appeal can be filed by telephone or in writing

How to File an Appeal – Expedited Reconsideration

- Appeal is filed with the QIC after the QIO has made its decision
- Appeal is filed by noon of the next calendar day after the QIO decision
- No minimum AIC
- Appeal can be filed by telephone or in writing

Resources

- Center for Medicare Advocacy, www.medicareadvocacy.org, for *Jimmo*
- Medicare appeals at Medicare.gov
  - Click on “Claims & Appeals”
    - Click “My right to a fast appeal”
      - Click “Fast appeals in a non-hospital setting”
- HICAP at 1-800-434-0222

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