DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

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Manual Updates to Clarify Skilled Nursing Facility (SNF), Inpatient Rehabilitation Facility (IRF), Home Health (HH), and Outpatient (OPT) Coverage Pursuant to *Jimmo vs. Sebelius*

Note: This article was revised on December 16, 2013, to reflect the revised CR8458 issued on December 13. In the article, the CR release date, transmittal number, and the Web address are revised. All other information remains the same.

Provider Types Affected

This MLN Matters® Article is intended for Skilled Nursing Facilities (SNFs); Inpatient Rehabilitation Facilities (IRFs); Home Health Agencies (HHAs); providers and suppliers of therapy services under the Outpatient Therapy (OPT) Benefit – including Critical Access Hospitals (CAHs), hospitals, rehabilitation agencies, SNFs, HHAs, physicians, certain non-physician practitioners, and therapists in private practice – submitting claims to Medicare contractors (Parts A/B Medicare Administrative Contractors (MACs) and Medicare Advantage Organizations) for services to Medicare beneficiaries, including physical therapy, occupational therapy, and speech-language pathology services.

What You Need to Know

This article is based on Change Request (CR) 8458, which updates portions of the "Medicare Benefit Policy Manual" (MBPM) to clarify key components of SNF, IRF, HH, and OPT coverage requirements pursuant to the settlement agreement in the case of *Jimmo v. Sebelius*. Nothing in this settlement agreement modifies, contracts, or expands the existing eligibility requirements for Medicare coverage.

Background

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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.

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Accordingly, these revisions to the 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

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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.

Additional Information

The official instruction, CR 8458, issued to your Medicare contractor regarding this change, may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R176BP.pdf on the CMS website. All of the revised portions of the "Medicare Benefit Policy Manual" are a part of CR8458.

If you have any questions, please contact your Medicare contractor at their toll-free number, which may be found at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html on the CMS website.

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