

## JIMMO VS. SEBELIUS



Clarification to Medicare Coverage  
of the  
Home Health Benefit - Jimmo vs. Sebelius

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## LAW SUIT AGAINST CMS

- o Law suit alleged that CMS was requiring standards that were against the laws governing Medicare
- o Recipients with chronic diseases were being excluded from receiving Medicare covered home health



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- o “Improvement Standard”—under which a claim would be summarily denied due to a beneficiary’s lack of restoration potential, even though the beneficiary did in fact require a covered level of skilled care in order to prevent or slow further deterioration in his or her clinical condition.
- o Examples:
- o ALS patient who naturally would never get better – short term therapy only, no improvement could be shown
- o CHF patient who stabilizes, but hx shows he is a frequent flyer – repeated episodes denied because “stable”. No Home Health, patient is re-hospitalized.



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Defendant(s)

Department of Health and Human Services

Plaintiff Description

Five Medicare beneficiaries and 6 advocacy organizations (National Committee to Preserve Social Security and Medicare, National Multiple Sclerosis Society, Parkinson's Action Network, Paralyzed Veterans of America, American Academy of Physical Medicine and Rehabilitation, United Cerebral Palsy)

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**Who Is Jimmo?**

**Jimmo sues over Improvement Standard**

- Glenda Jimmo, the lead plaintiff, is an elderly woman who lost a leg and most of her remaining toes to diabetes and has been blind since age 19. She is now confined to a wheelchair.
- Jimmo was repeatedly denied Medicare coverage for home health care—or home visits by nurses and physical therapy. These costs were not covered by Medicare due to the Improvement Standard, i.e., she was denied because none of these services would improve her condition.

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- Jimmo filed her class action lawsuit challenging the standard in January 2011.
- The plaintiffs and the federal government reached an out of court settlement, subject to the court's approval, in October 2012. The court approved the settlement on Jan. 24, 2013.

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### What Jimmo Settlement Means:

Medicare denials based on improvement standard are inappropriate

- Medicare coverage for skilled services in SNF, HH, Outpatient should not be denied because:
  - Individual is "stable or chronic"
  - Not expected to improve in a reasonable period of time
- Services can be skilled and covered even if:
  - Individual has "plateaued"
  - Services are "maintenance only"




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### Let's Look at Requirements for Benefit

- Be confined to the home;
- Under the care of a physician;
- Receiving services under a plan of care established and periodically reviewed by a physician;
- Be in need of skilled nursing care on an intermittent basis or physical therapy or speech-language pathology; or
- Have a continuing need for occupational therapy.




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- Intermittent "part-time or intermittent" means skilled nursing and home health aide services furnished any number of days per week as long as they are furnished (combined) less than 8 hours each day and 28 or fewer hours each week (or, subject to review on a case-by-case basis as to the need for care, less than 8 hours each day and 35 or fewer hours per week)
- A patient must meet each of the criteria specified in this section. Patients who meet each of these criteria are eligible to have payment made on their behalf for services discussed.




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Statement from 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.”

The Real Truth

Medicare intermediaries denied payment because “no improvement evident.”



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“A beneficiary’s lack of restoration potential cannot, in itself, serve as the basis for denying coverage, without regard to an individualized assessment of the beneficiary’s medical condition and the reasonableness and necessity of the treatment, care, or services in question.”

The Real Truth

This occurred every time a case did not show progress.



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“Conversely, coverage in this context would not be available in a situation where the beneficiary’s care needs can be addressed safely and effectively through the use of *nonskilled* personnel.”

The Real Truth

This has always been true. Only patients needing skilled service can receive the benefit.

The settlement will not expand the benefit to include services such as home health aide or attendant care only.



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“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 Real Truth

A major “C” change that will provide improved coverage for patients.

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CMS Never Accepted Blame for Denials

“Any actions undertaken in connection with this settlement do not represent an *expansion* of coverage, but rather, serve to **clarify existing** policy so that Medicare claims will be adjudicated consistently and appropriately.”

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Forthcoming Activities:

- Clarifying Policy – Updating Program Manuals - January 23, 2014
- Educational Campaign – Informing Stakeholders
- Claims Review

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**COVERED SERVICES UNDER A QUALIFYING HOME HEALTH PLAN OF CARE**

- Part-time or intermittent skilled nursing care (other than solely venipuncture for the purposes of obtaining a blood sample);
- Part-time or intermittent home health aide services;
- Physical therapy;
- Speech -language pathology;
- Occupational therapy;
- Medical social services;
- Aide – personal care

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**COVERED SERVICES UNDER A QUALIFYING HOME HEALTH PLAN OF CARE**

- Medical supplies (including catheters, catheter supplies, ostomy bags, supplies related to ostomy care, and a covered osteoporosis drug but excluding other drugs and biologicals)
- Services at hospitals, skilled nursing facilities, or rehabilitation centers when they involve equipment too cumbersome to bring to the home.

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**ADDITIONS TO MANUAL**

(Rev. 179, Issued: 01-14-14, Effective: 01-07-14, Implementation: 01-07-14)

*Coverage of skilled nursing care does not turn on the presence or absence of a patient's potential for improvement from the nursing care, but rather on the patient's need for skilled care.*

*If all other eligibility and coverage requirements under the home health benefit are met, skilled nursing services are covered when an individualized assessment of the patient's clinical condition demonstrates that the specialized judgment, knowledge, and skills of a registered nurse or, when provided by regulation, a licensed practical (vocational) nurse ("skilled care") are necessary.*

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Skilled nursing services are 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.

When, however, the individualized assessment does not demonstrate such a necessity for skilled care, including when the services needed do not require skilled nursing care because they could safely and effectively be performed by the patient or unskilled caregivers, such services will not be covered under the home health benefit.



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Skilled nursing care is necessary only when

(a) the particular patient's **special medical complications** require the skills of a registered nurse or, when provided by regulation, a licensed practical nurse to perform a type of service **that would otherwise be considered non-skilled**; or

(b) (b) the needed **services** are of such **complexity** that the skills of a registered nurse or, when provided by regulation, a licensed practical nurse are required to furnish the services.



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To be considered a skilled service, the service must be 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.

If a service can be safely and effectively performed (or self-administered) by an unskilled person, **without the direct supervision** of a nurse, the service cannot be regarded as a skilled nursing service although a nurse actually provides the service.

The **unavailability** of a competent person to provide a non-skilled service, regardless of the importance of the service to the patient, **does not make it a skilled service** when a nurse provides the service.



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A service that, by its nature, requires the skills of a nurse to be provided safely and effectively **continues to be a skilled service even if it is taught** to the patient, the patient's family, or other caregivers.

A patient's **overall medical condition**, without regard to whether the illness or injury is acute, chronic, terminal, or expected to extend over a long period of time, should be considered in deciding whether skilled services are needed.

Skilled care may, depending on the unique condition of the patient, continue to be necessary for patients whose condition is **stable**.

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### DOCUMENTATION TO PROVE SKILLED NEED

Home health records for **every visit** will reflect the need for the skilled medical care provided.

- The history and physical exam **pertinent to the day's visit**, (including the response or changes in behavior to previously administered skilled services) and the skilled services applied on the current visit
- The patient/caregiver's response to the skilled services provided
- The plan for the next visit based on the rationale of prior results

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### DOCUMENTATION TO PROVE SKILLED NEED

- Detailed rationale that explains the need for the skilled service in light of the patient's overall medical condition and experiences
- The complexity of the service to be performed
- Any other pertinent characteristics of the beneficiary or home
- Adequately describe the reaction of a patient to his/her skilled care
- Provide a clear picture of the treatment, as well as "next steps" to be taken.

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DOCUMENTATION TO PROVE  
SKILLED NEED

*Objective measurements of physical outcomes of treatment should be provided and/or a clear description of the **changed behaviors** due to education programs should be recorded in order that all concerned can follow the results of the applied services*

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EXAMPLE

The presence of a plaster cast on an extremity generally does not indicate a need for skilled nursing care. However, the patient with a preexisting peripheral vascular or circulatory condition might need skilled nursing care to observe for complications, monitor medication administration for pain control, and teach proper skin care to preserve skin integrity and prevent breakdown.

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EXAMPLE

The condition of a patient, who has irritable bowel syndrome or is recovering from rectal surgery, may be such that he or she can be given an enema safely and effectively only by a nurse. If the enema were necessary to treat the illness or injury, then the visit would be covered as a skilled nursing visit

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EXAMPLE

A physician has ordered skilled nursing visits for teaching of self-administration and self-management of the medication regimen for a patient, newly diagnosed, with diabetes mellitus.



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EXAMPLE

A patient with advanced multiple sclerosis undergoing an exacerbation of the illness needs skilled teaching of medications, measures to overcome urinary retention, and the establishment of a program designed to minimize the adverse impact of the exacerbation.



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EXAMPLE

A patient with malignant melanoma is terminally ill, and requires skilled observation, assessment, teaching, and treatment. The patient has not elected coverage under Medicare's hospice benefit.



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EXAMPLE

A frail 85-year old man was hospitalized for pneumonia. The infection was resolved, but the patient, who had previously maintained adequate nutrition, will not eat or eats poorly.

The patient is discharged to the HHA for monitoring of fluid and nutrient intake and assessment of the need for tube feeding. Observation and monitoring by skilled nurses of the patient's oral intake, output and hydration status is required to determine what further treatment or other intervention is needed



Seven horizontal lines for notes or additional information.

EXAMPLE

A patient has chronic non-healing skin ulcers, Diabetes Mellitus Type I, and spinal muscular atrophy. In the past, the patient's wounds have deteriorated, requiring the patient to be hospitalized. Previously, a skilled nurse has trained the patient's wife to perform wound care. The treating physician orders a new episode of skilled care, at a frequency of one visit every 2 weeks to perform observation and assessment of the patient's skin ulcers to make certain that they are not worsening.



Seven horizontal lines for notes or additional information.

SKILLED THERAPY SERVICES

*To be covered as skilled therapy, the services must require the skills of a qualified therapist and must be reasonable and necessary for the treatment of the patient's illness or injury as discussed below. Coverage does not turn on the presence or absence of an individual's potential for improvement, but rather on the beneficiary's need for skilled care*

**The mandates are the same as skilled nursing previously discussed**



Seven horizontal lines for notes or additional information.

EXAMPLES

A patient who has received gait training has reached their maximum restoration potential, and the physical therapist is teaching the patient and family how to safely perform the activities that are a part of the maintenance program. The visits by the physical therapist to demonstrate and teach the activities (which by themselves do not require the skills of a therapist) would be covered since they are needed to establish the program.

Maintenance must be done by a therapies, not a therapy assistant

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EXAMPLE

*Further, where the particular patient's special medical complications require the skills of a qualified therapist to perform a therapy service safely and effectively that would otherwise be considered unskilled, such services would be covered physical therapy services*

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EXAMPLE

A Parkinson's patient or a patient with rheumatoid arthritis who has not been under a restorative physical therapy program may require the services of a physical therapist to determine what type of exercises are required to maintain the patient's present level of function or to prevent or slow further deterioration

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### WHAT NEW PROBLEMS WILL OCCUR

- Major increase in ADR (additional documentation required) – payments held
- Denials for “incomplete” documentation (remember the list of requirements from previous discussion)
- Physician orders not detailed enough
- Medicare recipients not understand the “skilled care” requirement – believing he/she is entitled to home health services that do not meet “skilled”

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### DOCUMENTATION TO PROVE SKILLED NEED

*Home health records for every visit will reflect the need for the skilled medical care provided.*

- *The history and physical exam **pertinent to the day’s visit**, (including the response or changes in behavior to previously administered skilled services) and the skilled services applied on the current visit*
- *The patient/caregiver’s response to the skilled services provided*
- *The plan for the next visit based on the rationale of prior results*

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### HOW WILL THIS DECISION INTERFACE WITH MEDICAID COVERED SERVICES?

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### HOW WILL DECISION INTERFACE WITH MEDICAID COVERED SERVICES?

- o Aide only services for extended hours will not be changed
- o Patients with ventilator, G-tube feeding, terminal illness needing sever pain control – cases may be Medicare/Medicaid combined
- o This is a learning process for all providers.
- o Must remember the “intermittent definition”

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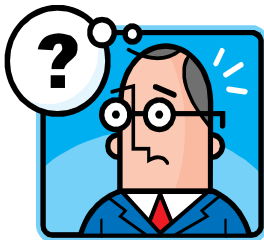
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### ARE YOU CONFUSED YET?




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