LONG TERM CARE COMMUNITY COALITION

Advancing Quality, Dignity & Justice

Fact Sheet:
Medicare Coverage of Skilled Nursing & Skilled Therapy Services

Background. Accessing physical therapy and other skilled services can be a challenge for nursing home residents and the families, LTC Ombudsmen and advocates who work with them. Too often, we have been told, services are denied or terminated because a determination has been made that the individual is no longer improving or has "plateaued." As noted by the Center for Medicare Advocacy (CMA), a nonprofit organization which has led in the fight to improve access to therapy services, "For decades, Medicare beneficiaries – particularly those with long-term or chronic conditions – have been denied necessary care based on an illegal 'Improvement Standard.' This practice resulted in thousands of individuals being denied Medicare and access to care on the grounds that their condition was stable, chronic, not improving, or that the necessary services were for 'maintenance only.'"

JUSTIFICATION FOR MEDICARE THERAPY SERVICES: "skills of a therapist are necessary to maintain, prevent, or slow further deterioration of the patient's functional status."

Actions. CMA sued the federal government to fight this practice of denying skilled nursing or therapy care to Medicare beneficiaries because they were identified as not improving and, therefore, ineligible for these services. In 2013, CMA and the U.S. Centers for Medicare & Medicaid Services (CMS) reached a settlement agreement, in which CMS agreed to clarify that **improvement is not required to obtain Medicare coverage for skilled nursing and skilled therapy services**, including physical therapy.

Despite this settlement, many people continued to be denied coverage for these vital services. To address this, CMA went back to court. On August 18, 2016, Chief Judge Christina Reiss, who oversees the settlement, ordered CMS to comply with the 2013 settlement agreement by taking stronger action to clarify for nursing homes and other providers that the "Improvement Standard" is not, and was never, legal.

Clarification of Policy. CMS has issued clarifications to relevant providers of Medicare services.

1. **Who are the Providers?** Relevant providers include nursing homes, inpatient rehabilitation facilities, home health providers and outpatient therapy providers (such as therapists in private practice).

2. **What has the Federal Government (CMS) Told Providers?**
   - *No "Improvement Standard" is to be applied in determining Medicare coverage for maintenance claims that require skilled care.*
   - *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).*
   - *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.*
   - *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.*
   - *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 [Skilled Nursing Facility, Home Health or Outpatient] settings.*

   [CMS Manual System, Pub 100-02 Medicare Benefit Policy. Available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R179BP.pdf.]

Resources for more information.

1. Center for Medicare Advocacy, http://www.medicareadvocacy.org/medicare-info/improvement-standard/.
2. U.S. Centers for Medicare and Medicaid Services fact sheet on the *Jimmo v. Sebelius* Settlement Agreement, https://www.cms.gov/medicare/medicare-fee-for-service-payment/SNFPPS/downloads/jimmo-factsheet.pdf. [Note: *Jimmo v. Sebelius* (sometimes just called *Jimmo*) is the name of the case filed by the Center for Medicare Advocacy.]
3. *The New York Times*, "Failure to Improve Is Still Being Used, Wrongly, to Deny Medicare Coverage," (September 12, 2016) http://www.nytimes.com/2016/09/13/health/medicare-coverage-denial-improvement.html?_r=1.