An outside counsel with an inside track on healthcare compliance

an interview with Daniel Gospin
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In January of 2013, a settlement agreement1 in the matter of Jimmo v. Sebelius in the U.S. District Court (Vermont) was approved. The agreement set forth a series of steps that CMS was to undertake in order to ensure that claims are “correctly adjudicated in accordance with existing Medicare policy, so that Medicare beneficiaries receive the full coverage to which they are entitled.”2 The settlement is directed at CMS and its application of the mythical “improvement standard” by its contractors, including Medicare Administrative Contractors (MACs), Recovery Auditors (RAs), and adjudicators throughout the appeals process. However, beneficiaries and their caregivers must be aware of the differentiation of restorative care, rehabilitative therapy, and maintenance therapy in the context of this settlement, particularly as it relates to the utilization of this existing benefit, now that it has been clarified (see Table 1).

A complete understanding of Medicare’s updated guidelines for the Medicare Benefits Policy Manual is critical for providers, because it will be provider documentation of beneficiary evaluation, continuing assessment, coding, and billing for nursing and rehabilitative therapies and clinical indicators that will be a key determining factor in medical review of therapy claims in home health, skilled nursing, and outpatient therapy.

Background of the lawsuit
Some brief context is in order to set the stage for provider response and engagement with Medicare beneficiaries and/or their representatives over skilled maintenance nursing and therapy. Plaintiffs were represented by the Center for Medicare Advocacy, Inc., Vermont Legal Aid, and Wilson Sonsini Goodrich & Rosati. Plaintiffs in the lawsuit included six named individual Medicare beneficiaries as well as six organizations (a seventh organization was dismissed for lack of standing) including:

- Alzheimer’s Association
- National Multiple Sclerosis Society
- National Committee to Preserve Social Security & Medicare
- Paralyzed Veterans of America
- Parkinson’s Action Network
- United Cerebral Palsy

At hand in the lawsuit was a long-standing practice in which CMS, review contractors, and even providers often determined that beneficiary evaluation, continuing assessment, coding, and billing for nursing and rehabilitative therapies and clinical indicators that will be a key determining factor in medical review of therapy claims in home health, skilled nursing, and outpatient therapy.

CMS has clarified coverage of skilled nursing and skilled therapy in accordance with the Jimmo v. Sebelius settlement agreement.

No “improvement standard” is to be applied in determining Medicare coverage for maintenance therapy that requires skilled care.

Coverage for skilled maintenance relies on the beneficiary’s need for skilled care, not on the potential for improvement.

CMS has provided enhanced documentation guidelines in updates to the Medicare Benefits Policy Manual.

Manual revisions by CMS do not represent an expansion of coverage, but rather clarification of existing coverage.
a beneficiary was no longer a candidate for continued skilled care due to lack of progress. The provider community may recognize terms often utilized in documentation that serves to end skilled nursing or skilled therapy services, such as “patient has plateaued,” “chronic condition, slow improvement,” “patient is terminal, no progress expected,” “skilled care no longer medically necessary,” or “therapy cap reached and does not qualify for exception.”

An integral part of the settlement agreement is the CMS educational campaign targeted to CMS review contractors, adjudicators, and Medicare Advantage Plans, as well as beneficiaries and providers. This campaign commenced following updated and clarified instructions to the Medicare Benefits Policy Manual. Updated call scripts have been implemented at the 1-800-MEDICARE phone line. Providers can access pertinent materials related to this educational campaign at the CMS website, as well as materials from the National Provider Call on December 19, 2013.3 The focus in this article is to provide information and guidance to the provider community on updated CMS Manual information on skilled nursing and therapy in home health, skilled nursing care, and outpatient therapy; and to highlight the need for compliance oversight in risk assessment, policy revision, and educational offerings.

Throughout the December (2013) educational campaign to providers, CMS made it clear that no improvement standard is to be applied in determining Medicare coverage for maintenance claims in which skilled care is required. The Medicare Learning Network article (MM8458) indicates that 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). Another strong statement appearing in the CMS materials clarifies 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.4

### Table 1: Restorative/Rehabilitative therapy vs. Maintenance therapy

<table>
<thead>
<tr>
<th>Type of therapy</th>
<th>Objective evidence or clinically supported statement of expectation</th>
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<tbody>
<tr>
<td>Restorative or Rehabilitative</td>
<td>…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.</td>
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<tr>
<td>Maintenance</td>
<td>…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.</td>
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Source: MLN Matters’ Number MM8458

### Skilled nursing, home health, and outpatient coverage of skilled maintenance

Appropriate chapters of the Medicare Benefits Policy Manual that were updated reflect CMS guidance on skilled vs. maintenance in home health (Chapter 7), skilled nursing (Chapter 8) and outpatient therapy (Chapter 15). The changes, including a small update for inpatient rehab facilities (IRFs) (Chapter 1), were collectively released.
as Transmittal 179 (originally Transmittal 176). Table 2 (on page 66) identifies documents which providers will find helpful in understanding CMS clarifications under the settlement agreement, and to help guide in updated risk assessment, policy updates and staff education.

Although not required under the terms of the settlement agreement, CMS has provided numerous scenarios and documentation examples to help the provider glean greater insight into skilled maintenance nursing and therapy. Scenarios also describe non-skilled services and situations where the individual needs of the patient dictate, in the judgment of the nurse or therapist, that skilled care is medically necessary to perform the service or provide oversight. Updates in the home health, skilled nursing, and outpatient therapy chapters are essential compliance elements moving forward, particularly when assessing the medical necessity of either skilled or maintenance services.

All updated chapters provide snippets and updated scenarios to guide clinicians. A sampling from Chapter 15 (outpatient therapy) shows five examples given to assist therapists in problem-solving approaches to determining clinical recommendations for rehabilitative therapy or skilled maintenance:

1. Patient is receiving ongoing physical therapy and therapist begins to establish a maintenance program prior to the patient discharge.
2. Patient has not been receiving therapy, but needs a maintenance plan.
3. Skilled services of a therapist are necessary to actually carry out the services under the maintenance plan (orthopedic example).
4. Skilled services of a therapist are necessary to actually carry out the services under the maintenance plan (multiple sclerosis example).
5. A patient under a maintenance plan needs periodic review, which may include the development of a new and/or revised maintenance plan.

Documentation to support the needs for skilled maintenance services will assist review contractors when assessing claims for coverage to determine whether the skills of a therapist were necessary in order to maintain, prevent, or slow the functional status deterioration, as well as to document why therapy cannot be effectively carried out by the patient or with the assistance of non-skilled care (including family, if they so choose to assist). As part of the settlement agreement and as noted in the National Provider Call, CMS will be reviewing a random sampling of claims from skilled nursing facility (SNF), home health (HH), and outpatient therapy (OPT) coverage decisions. The intent is to determine overall trends and identify problems. The contractors will also review individual claims determinations that may not have been made in accordance with the settlement agreement. Outpatient therapy providers know the challenges inherent with the manual medical review of therapy outpatient claims over the $3,700 threshold, and will likely keep a keen eye, not only on individual determinations in the MAC medical review process, but also the review of maintenance therapy claims under 100% manual medical review by the recovery auditors (RACs).

A note about IRFs and comprehensive outpatient rehabilitation facilities (CORFs): Chapter 1 of the Medicare Benefits Policy Manual was updated to clarify the coverage standards for services performed in the IRF setting. Coverage should never be denied because a patient cannot be expected to achieve complete independence in the domain of self-care, or because a patient cannot be expected to return to his/her prior level of functioning. Additionally for CORFs, it should be noted that maintenance program provisions detailed in updates for outpatient therapy do not apply to physical therapy, occupational therapy, or speech-language pathology services furnished in a CORF, as the statute specifies that CORF services are rehabilitative.
Learning points
The key takeaway for providers is the focus that CMS places on the fact that coverage for skilled maintenance care for nursing and therapy “does not turn on the presence or absence of an individual patient’s potential for improvement, but rather on the patient’s need for skilled care” to improve or maintain the patient’s current condition, or to prevent or slow further deterioration. SNFs, HHA, and OT providers must have a clear understanding of Medicare’s updated Manual guidance as a result of the Jimmo v. Sebelius settlement. They should prepare accordingly for not only admission, continuing stay, and maintenance therapy individualized care plans, but also for the ability to respond to inquiries from patients and their representatives. The settlement agreement as well as these documents represent compliance opportunities for internal monitoring and auditing and, perhaps more significantly, an ad-hoc compliance educational program to ensure provider employees are up to date on the skilled maintenance standard.

Providers need a clear understanding of how CMS sample documentation can assist them in making statements in the medical record that support skilled maintenance therapy and interventions. It is likely that the documentation examples themselves will be guides for CMS Medicare Administrative Contractors (MACs) in updating local coverage determinations and well as contextually in documentation reviews.

Provider action steps
The Jimmo v. Sebelius settlement agreement provides plenty of opportunity for compliance engagement. Facility risk assessments should be updated, policies and procedures reviewed, and educational programs initiated. Most therapy clinicians want to help their patients, whether they are patients coming through an inpatient rehab program with a spinal cord injury, or those frequent outpatients who need intermittent therapy for progressive conditions. With the bright light shining on skilled maintenance, providers will be thinking of patients who should be called to come back in for an evaluation and therapy program, former patients who will show up at our doorstep with a newspaper clipping about maintenance therapy (hoping and praying they are eligible), as well as current patients who wonder, “Why do I have to be discharged, if I can continue with therapy under maintenance?”

It’s a new world. Are you prepared?

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4. Department of Health and Human Services: Medicare Learning Network: MLN Matters’ Number MM8458
5. CMS Slide presentation available at http://go.cms.gov/lo7CRkJx