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M E M O R A N D U M

TO: All Members

FROM: Patrick Cucinelli, Senior Director of Public Policy Solutions

DATE: January 29, 2013

SUBJECT: **Medicare Part B "Improvement Standard" Law Suit**

ROUTE TO: Administrator, CFO, Billing Director

Abstract: Judge takes next step in "Improvement Standard" law suit.

On January 24, 2013, the federal District Court approved the proposed settlement agreement in Jimmo v. Sebelius first entered into on October 16, 2012, finding the Settlement Agreement to be "fair, adequate, and reasonable."

Notably, the Court did not modify the terms of the proposed settlement agreement, and dismissed the action with prejudice. This case centers on the "Improvement Standard" in Medicare that requires that an individual show improvement in his or her condition or functional status in order to qualify for Medicare coverage of therapy services. The plaintiff in this case alleged that this standard wrongfully denies Medicare coverage to patients suffering from chronic conditions and who are in need of skilled nursing facility (SNF) care and home health (HH) care, as well as outpatient therapy (OPT).

In the Settlement Agreement, CMS is committed to revising the relevant portions of Chapters 7, 8, and 15 of the Medicare Benefit Policy Manual, within 1 year of the Court's approval of the Settlement Agreement, to "clarify" the coverage standards to include SNF, HH, and OPT benefits when a patient has no restoration or improvement potential, needs those skilled services. The manual is also be revised to clarify the coverage standards to include services performed in an inpatient rehabilitation facility ("IRF").

Additionally, CMS is required to engage in a nationwide educational campaign to communicate the clarified coverage standards. In light of the Court's "so ordering" the Settlement Agreement, CMS must now finalize and issue the revised manual provisions and carry out the educational campaign by January 23, 2014.

The Settlement Agreement also provides for a process for "re-review" of the denial of certain claims of class members (defined to include certain Medicare beneficiaries who received a denial of coverage, which became final and non-appealable on or after January 18, 2011). By February 4, 2013, CMS is required to inform the plaintiffs' lead counsel of the process of re-review, including to whom class members should identify themselves to obtain re-review. Notably, no "provider or supplier of Medicare services or Medicaid State Agency is permitted to receive re-review . . . on behalf of or by assignment from a class member."

To the extent that providers have taken a "wait and see" approach based on how CMS revises the manual, there does not appear to be anything in the final Settlement Agreement to warrant reconsideration, as the Court's approval did not effect an immediate change in CMS policy or practice. Otherwise, as previously discussed, to the extent that providers' internal billing policies have explicitly required an actual improvement as a condition to billing Medicare, they can revise their policies to strike that requirement and perhaps provide in-service training as necessary, but otherwise it is advisable to await further guidance from CMS or the Medicare Administrative Contractor.

For additional LeadingAge NY analysis, please click here.

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