Jimmo vs. Sebelius is the class action lawsuit that challenged the interpretation of the "improvement standard" in Medicare coverage. January 24, 2013, the lawsuit was settled in favor of the plaintiff. The Centers for Medicare & Medicaid Services (CMS) is working on clarifying the Medicare Benefit Policy Manual, Chapter 8, and other guidance to reflect the correct interpretation. Additionally, CMS will also develop and implement a nationwide education campaign for all who make Medicare determinations. They have been given one year to complete the task.

For decades, the "improvement standard" has been interpreted to mean that in order for a beneficiary to continue to receive rehabilitative Medicare services, improvement must be shown. Many beneficiaries with chronic illnesses and conditions such as MS, Alzheimer's, ALS, and Parkinson's were denied therapy and other coverage by government contracted reviewers since the beneficiaries did not meet the improvement standard.

Medicare law has not changed as a result of Jimmo vs. Sebelius. What will change is that the interpretation of the "improvement standard" can no longer be used to deny Medicare services. Physicians may order therapy for maintenance as long as it is shown that the services are medically necessary and will help maintain the current condition or prevent or slow deterioration.

The decision to provide services must be made based on the individual's need for skilled care that must be performed or supervised by a professional nurse or therapist. The decision is not based on whether or not there is potential for improvement or actual improvement.

The settlement applies to the following Medicare provider settings: Skilled nursing facilities (Part A), home health agencies, outpatient therapy (Part B). The settlement applies to both traditional Medicare and Medicare Advantage programs.

The Settlement Agreement goes back to the date the case was filed, January 18, 2011. The Agreement establishes a process called "re-review" for Medicare beneficiaries who received a denial of skilled nursing facility care, home health care, or out-patient therapy services. After CMS completes the clarification of the manual and the education of Medicare decision-makers, beneficiaries will be able to get a re-review of these claims. The denial must have come from Medicare and must be for services that were actually received, but not paid for by Medicare. The Medicare denial must have become final and non-appealable after January 18, 2011, and before the end of the educational campaign. This means that claims must have been submitted to Medicare and denied, and the normal deadline for further appeal must have expired. The beneficiary may have tried appealing the denial through the regular Medicare appeal system. It does not matter at which level the beneficiary stopped as long as the outcome is a denial and the deadline for further appeal has passed. CMS will explain how beneficiaries can involve the re-review process. Providers and Medicaid agencies are not eligible for re-review of claims under the Settlement Agreement.

It is important to note that the Settlement Agreement standards for Medicare coverage of skilled maintenance services apply now while CMS works on policy revisions and its education campaign. Beneficiaries can appeal Medicare denials for skilled maintenance nursing or therapy because they are not improving.

The Center for Medicare Advocacy has compiled frequently asked questions on the lawsuit, the settlement, and the expected implications at [http://www.medicareadvocacy.org/hidden/highlight-improvement-standard/#FAQ](http://www.medicareadvocacy.org/hidden/highlight-improvement-standard/#FAQ).

Pathway Health recommends providers re-examine their compliance with all documentation and certification requirements. Does documentation by therapists and nurses truly show the need for skilled services – the observation skills, the assessment skills, and the critical thinking skills necessary for the optimum care of residents and clients? Does your organization conduct a pre-billing review of all Medicare claims and supporting documents to ensure compliance? Does your organization follow QAPI and corporate compliance standards mandated by the Affordable Care Act? Pathway Health is ready to assist you with audits, education, and tools to manage your organization in this era of health care reform and change. Contact us today consult@pathwayhealth.com