Long-Term Care Survey Alert

SNF Coverage Determinations: Landmark Legal Case Favors Nursing Homes' Ability To Provide "Skilled Care"

Be in-the-know in 2014 □ or risk sanctions and denied claims.

Last January long-term care providers scored a legal victory in the settlement of Jimmo vs. Sebelius.

But be careful: You risk survey and reimbursement losses if you don't stay abreast of the feds' latest communications related to the case.

Background: Last January, the **U. S. District Court for the District of Vermont** approved a settlement in the case of Jimmo vs. Sebelius. The plaintiffs in the case had alleged that Medicare contractors inappropriately applied an "improvement standard" when deciding the validity of claims for Medicare-covered skilled care, such as that provided in nursing facilities and by home health agencies. The settlement paved the way for fairer payment for medically necessary skilled services for the chronically ill, whose condition in some cases could not be expected to "improve."

"The settlement will clarify existing policy that claims should not be denied solely based on a rule-of-thumb determination that a beneficiary's condition is not improving," said **Centers for Medicare and Medicaid Services** (CMS) spokesman **Brian Cook** in an email message to Congressional Quarterly soon after the January 24, 2013, ruling.

Although the **American Health Care Association**, **Leading Age**, the **Alzheimer's Association**, and other industry leaders see the settlement as favorable to patients and providers, facilities must advocate for fairness in claims determination by keeping abreast of related, just-released communications from CMS, experts say.

Required reading: On December 6, the agency issued a transmittal titled "Manual Updates to Clarify Skilled Nursing Facility (SNF), Inpatient Rehabilitation Facility (IRF), Home Health (HH), and Outpatient (OPT) Coverage Pursuant to Jimmo vs. Sebelius." Available at www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R175BP.pdf, the manual revisions clarify that "improvement" is not required to obtain Medicare coverage.

Although providers have been free to resubmit claims for consideration since the settlement, the new CMS transmittal carries an effective date of January 7, 2014.

What's the same? Keep in mind that the Jimmo case does not change any key Part A or B provisions. For example, the Part-A requirement for a prior 3-day hospital stay and the 100-day limit on benefits remain. And, for Part B, coverage is still subject to the therapy-cap limitation, medical manual review, and the Multiple Procedure Payment Reductions.

What's new? Red ink in the manual's new section 20.1.2 (Determination of Coverage) clearly highlights the central point of Jimmo settlement: "Coverage of skilled nursing care or therapy to perform a maintenance program does not turn on the presence or absence of a patient's potential for improvement from the nursing care or therapy, but rather on the patient's need for skilled care."

Furthermore, this "clarification" applies to skilled maintenance services provided under Medicare in all three care settings: home health, outpatient therapy, and skilled nursing facilities.

To ensure that claims are processed efficiently □ and medical records pass muster at survey time □ be sure that documentation clearly outlines the care provided and the medical necessity for skilled services.

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Remember: Medical necessity not patient outcome is now most relevant in Medicare claims contractors' eyes.

Document Medical Necessity

The manual update emphasizes and re-emphasizes the need for careful documentation, notes **David Lipschutz**, policy attorney for the **Center for Medicare Advocacy Inc**.

Consider the new section 30.2.2.1 within the manual's revised Chapter 8, which stresses the new role of documentation in helping the Medicare Administrative Contractor or other claims adjudicator in assessing the need for skilled care:

"Although the presence of appropriate documentation is not, in and of itself, an element of the definition of a 'skilled' service, such documentation serves as the means by which a provider would be able to establish and a contractor would be able to confirm that skilled care is, in fact, needed and received in a given case."

This section goes on to say: "Taken as a whole, then, the documentation in the patient's medical record should illustrate the degree to which the patient is accomplishing the goals as outlined in the care plan. In this way, the documentation will serve to demonstrate why a skilled service is needed."

Facilities will also do well to note subtle but important additions (in italics below) to the manual in section 30.2.2 (Principles for Determining Whether a Service is Skilled): "In these cases, the complications and special services involved must be documented by physicians' orders and notes as well as nursing or therapy notes."

Translated: Both physicians' and nurses' notes will be scrutinized by contractors looking for evidence that services are medically necessary.

Health care providers should take a holistic approach when making the determination of what services are medically necessary, the manual urges: "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. A patient's diagnosis should never be the sole factor in deciding that a service the patient needs is either skilled or not skilled."

Don't do this: CMS also tells SNFs what not to do if they want claims for skilled care to be paid: "... terminology such as the following would not adequately describe the need for skilled care: Patient tolerated treatment well, caregiver instructed in medication management, continue with POC."

New Year's Resolution

Training and policy revisions should both be priorities in 2014, says **Amie Martin**, a consultant with **Proactive Medical Review and Consulting LLC** in Evansville, Indiana.

Put in writing your facility's guidance for determining how to ensure that skilled criteria are continually met throughout the Medicare Part-A stay, she suggests. In addition, providers should implement a detailed clinical decision-making process to guide therapy service intensity.

A weekly Medicare team meeting can be a good way to review residents on therapy caseload, Martin says. Topics to cover include whether skilled requirements continue to be met and how therapy needs will be supported by physician-approved plans of care. Recording meeting minutes can also bolster documentation of the Medicare stay and rehab RUG level, notes Martin.

Appeal If Necessary

Although the settlement and subsequent clarification are positives, don't expect totally smooth sailing, says Lipschutz. CMS's efforts to re-educate claims adjudicators may take some time. He recommends expedited appeal, and, if

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necessary, subsequent appeals for reconsideration.

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