Jimmo: The Maintenance Standard Applied to Skilled Nursing Facility Services

By: Moriah Adamo

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In 2011 six aggrieved Medicare recipients joined seven national advocacy organizations to allege that the Centers for Medicare and Medicaid Services (CMS) routinely and systematically engaged in a clandestine scheme to deprive beneficiaries of skilled care.[1] The seminal *Jimmo* class action case triggered an ongoing saga that has been likened to a Dickens novel.[2] In sum, the *Jimmo* plaintiffs alleged that CMS contractors and adjudicators improperly based skilled services authorizations on an "Improvement Standard" rather than the appropriate "Maintenance Standard." Despite the court's ultimate approval of a settlement agreement, and subsequent enforcement litigation,[3] eight years later, the pervasive use of the "Improvement Standard" persists. Medicare contractors continue to deny skilled care on the basis that a patient has not demonstrated functional improvement or has a medical condition that inhibits progress.[4]

The *Jimmo* controversy arises from the misapplication of federal regulation. The governing rule states: "The restoration potential of a patient is not the deciding factor in determining whether skilled services are needed. Even if full recovery or medical improvement is not possible, a patient may need skilled services to prevent further deterioration or preserve current capabilities."[5] CMS conceded the applicability of this Maintenance Standard in the *Jimmo* settlement agreement, which was approved by the court in January 2013.[6] Indeed, as agreed, CMS updated the *Medicare Benefit Policy Manual* (MBPM) to clarify its policy regarding approval of skilled care services. The January 14, 2014 transmittal letter that CMS circulated upon publication of the revised MBPM states:

> **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.[7] (emphasis in original)

Still, even with CMS's helpful and relatively clear guidance, the familiar refrains that Medicare coverage is being terminated because a patient has "plateaued" or is "unable to progress" to a higher level of function continue to sound through the halls of skilled nursing facilities (SNF).

To effectively advocate for our clients and secure those coveted "100 days" of SNF coverage,[8] we must understand the application of the Maintenance Standard in the nursing home setting. This requires scrutiny of the Maintenance Standard in the broader context of general qualification for SNF services.

Now, it should be noted that Medicare-approved skilled services can be delivered in various environments: hospitals, SNFs, homes, and outpatient facilities. The setting matters as different criteria apply to each. Perhaps contributing to confusion, authorization of skilled rehabilitation services in a *hospital* remain subject to the Improvement Standard.[9] The Maintenance Standard governs authorizations for skilled services in other settings, but delivery of skilled care in a nursing home necessitates additional criteria.

Many practitioners are familiar with the requirement that a Medicare beneficiary receive a three-day "qualifying" hospital stay prior to admission to a SNF.[10] In addition, a beneficiary must also "require skilled nursing or skilled rehabilitation services, or both, on a daily basis"[11] and such services "as a practical matter, can only be provided in a SNF, on an inpatient basis."[12] These additional conditions for the delivery of skilled services in a nursing home evoke the Maintenance Standard.

Thus, assuming a qualified hospital stay, to justify Medicare reimbursement of SNF services providers must document that (1) the patient needs a skilled service in order to improve, maintain function or prevent deterioration; (2) the need arises daily; and (3) the services cannot be delivered practically in the community at home or on an outpatient basis. The totality of the patient's conditions must support each element to substantiate the claim for SNF coverage. A deeper review of each is warranted.

First, what constitutes skilled services? Simply, skilled services are those ordered by a physician and

provided by a technical professional, therapist, nurse, or physician.[13] The regulations provide a list of covered skilled services, together with qualifying examples.[14] Skilled rehabilitation services are enumerated to include: ongoing assessment, therapeutic exercises or activities; gait evaluation and training; range of motion exercises; various heat treatments, and services of a speech pathologist or audiologist.[15] Notably, maintenance therapy is specifically listed as a covered rehabilitation service.[16] According to the regulatory definition, a reimbursable maintenance program requires the specialized knowledge and judgment of a therapist to develop and monitor a care plan designed to support a current level of functioning.[17]

For a maintenance plan to pass muster, monitoring is key.[18] If rehabilitation care is the *primary* skilled service, the focus cannot be the patient's ability to recover, but rather whether the services require the skills of a therapist or an unskilled aide.[19] The totality of the individual's condition will determine whether ongoing management by skilled personnel is required. Comorbidities must be assessed and documented to determine if skilled oversight of the maintenance plan is necessary. CMS provides the example of a patient with a circulatory problem who requires the administration of a whirlpool bath. While a whirlpool bath in isolation does not require skilled oversight, due to the complicating circulatory problem ongoing skilled assessment is required.[20]

While physical therapy and/or occupational therapy services are most often associated with Medicare-covered SNF stays, an advocate should consider that the beneficiary may need other qualifying skilled services. These services include professional case management, observation and assessment, education, and skilled nursing services.[21] The need for any one of these services to improve, maintain or prevent deterioration will meet the first prong of the SNF analysis.

Once the need for a skilled service to improve, maintain or prevent decline is established, we turn to the "daily need" requirement. This element may seem intuitive, but subtleties exist. The requisite skilled services must be needed *and* provided seven days a week.[22] If rehabilitation services are not available seven days a week, then they must be provided at least five days a week.[23] Exception may be made for one or two days lapses in rehabilitation services if the physician affirmatively orders the break.[24] Note: conspicuously absent from this exception is a patient's temporary refusal or inability to participate in rehabilitation therapy. The need and provision of the skilled care must be consistent, and the patient must participate as ordered.

The final criterion presents a restrictive obstacle to Medicare-covered SNF care. To qualify for SNF benefits the "daily skilled services must be ones that, as a practical matter, can *only* be provided in a SNF, on an inpatient basis."[25] The individual's condition must be considered in light of the availability and feasibility of more cost-effective delivery methods.[26] Unfortunately, the personal cost to the patient of these alternative models may *not* be considered.[27] For example, if outpatient rehabilitation services are available, but can be accessed only by significant private payment, as a "practical matter" the services can still be delivered outside the SNF. Of course, if it is more economical to the *Medicare* program to deliver the care in a SNF, then cost matters.[28] For instance, if a person would have to be transported to an outpatient rehabilitation center by ambulance (a Medicare-covered service), as a practical matter the SNF care is necessary.[29] Practically speaking, CMS utilizes this prong to minimize the overall costs of skilled services within the Medicare program.

To conclude, armed with a better understanding of the Maintenance Standard in the context of SNF services will allow us to more effectively advocate for maximization of our client's benefits. We should communicate with SNF staff, who often remain uneducated about the appro-

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priate standards, to assure that medical records accurately reflect all of the client's conditions to support the need for skilled services. When faced with the all too common discontinuance of Medicare based on the Improvement Standard, we should challenge the determinations applying the appropriate criteria to the medical records. Perhaps grass roots advocacy will yield the cumulative effect of systematic change.

Endnotes

1. *Jimmo v. Sebelis*, No. 5:11-CV-17, 1 (D. Vt. October 25, 2011) .
2. Dana Shilling, *Jimmon and the Improvement Standard*, 316 Elder Law Advisory NL 1.
3. *Jimmo v. Sebelis*, No. 5:11-CV-17, 1 (D. Vt. August 17, 2016).
4. Center for Medicare Advocacy, Toolkit Medicare Skilled Nursing Facility Coverage and *Jimmo v. Seblis,* https://www.medicareadvocacy.org/wpcontent/uploads/2018/01/Medicare%20SNF%20Coverage%20and%20Jimmo%20v.%20Sebelius%20Toolkit.pdf.
5. 42 C.F.R. § 409.32(c).
6. *Jimmo v. Sebelis*, No. 5:11-CV-17, 1 (D. Vt. January 24, 2013).
7. CMS Manual System Pub 100-2 Medicare Benefit Policy, Transmittal 179 (January 14, 2014), *available at* https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R179BP.pdf.
8. 42 C.F.R. 409.61(b) (Days 1-20 are paid in full and day 21-100 are subject to the prevailing co-pay).
9. Medicare Benefit Policy Manual 110.2 (Issued January 14, 2014), *available at* https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c01.pdf.
10. Medicare Benefit Policy Manual 20.1 (Issued November 2, 2018), available at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c08.pdf.
11. 42 C.F.R. § 409.31(b)(1).
12. 42 C.F.R. § 409.31(b)(3).
13. 42 C.F.R. § 409.31(a).
14. 42 C.F.R. § 409.33.
15. 42 C.F.R. § 409.33(c).
16. 42 C.F.R. § 409.33(c)(5).
17. *Id.*
18. A beneficiary may receive approval for a maintenance plan if other skilled services are also needed.
19. Medicare Benefit Policy Manual 30.2.2 (Issued January 14, 2014), *available at* https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c07.pdf.
20. *Id.*
21. 42 C.F.R. § 409.33(a).
22. 42 C.F.R. § 409.34(a)(1).
23. 42 C.F.R. § 409.34(a)(2).
24. 42 C.F.R. § 409.34(b).
25. 42 C.F.R. § 409.31(b)(3)(emphasis added).
26. 42 C.F.R. § 409.35(a).
27. *Id*.
28. 42 C.F.R. § 409.35(b).
29. *Id*.