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January 5, 2014

Death of Medicare improvement standard now official

Traditionally, it has been rare that a Medicare beneficiary who entered a facility for rehabilitation after a three day hospital stay was able to access Medicare to pay for the full 100 days of the purported benefit. Now, thanks to the Center for Medicare Advocacy and Vermont Legal Aid, who working together won a class action settlement in *Jimmo v. Sebelius,* more complete Medicare coverage for rehab is more likely. The Centers for Medicare and Medicaid (CMS) have updated the Medicare manuals to clarify the standard that Medicare providers are to use when determining if Medicare coverage should continue for rehab or home care.

It has always been clear that Medicare will only pay for care if the care needed is classified as "skilled care," and even then, it is for a limited period of time (generally no more than 100 days). Furthermore, the Medicare benefit for care in a facility can only be accessed if the beneficiary has been hospitalized for three days or more (actually admitted to the hospital, not under "observation"), and requires rehabilitation or some other type of skilled care. The rules for care at home are different, in that the care must be skilled, is intermittent, and the beneficiary cannot leave home regularly without taxing effort and/or significant assistance. However, obtaining Medicare coverage for care in a facility has long been the issue, since an "improvement standard" that was never an *actual* standard was widely applied. The settlement in *Jimmo* in January, 2013 required CMS to update their manuals to clarify the actual standard as whether skilled care is needed to maintain a patient's condition or to prevent decline rather than turning on an improvement standard that required cessation of coverage if the patient hit a plateau.

Elder Law Answers (www.elderlawanswers.com) reports that the CMS transmittal announcing the Manual revisions 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. The manual revisions now being issued will serve to reflect and articulate this basic principle more clearly. [Emphasis in original.]

The manual revisions are an important step in helping Medicare beneficiaries access the care that they need to hopefully return home and prevent frequent re-admissions. The next step is an educational campaign to explain this settlement to Medicare contractors, providers, adjudicators, patients, and caregivers. In the meantime, patients and their loved ones can educate themselves to make sure that the patient is receiving all of his or her proper Medicare benefits.