Jimmo v. Sebelius Settlement Agreement Fact Sheet

Overview: On January 24, 2013, the U. S. District Court for the District of Vermont approved a settlement agreement in the case of Jimmo v. Sebelius, in which the plaintiffs alleged that Medicare contractors were inappropriately applying an "Improvement Standard" in making claims determinations for Medicare coverage involving skilled care (e.g., the skilled nursing facility (SNF), home health (HH), and outpatient therapy (OPT) benefits). The settlement agreement sets forth a series of specific steps for the Centers for Medicare & Medicaid Services (CMS) to undertake, including issuing clarifications to existing program guidance and new educational material on this subject. The goal of this settlement agreement is to ensure that claims are correctly adjudicated in accordance with existing Medicare policy, so that Medicare beneficiaries receive the full coverage to which they are entitled.

Background: In the case of Jimmo v. Sebelius, the Center for Medicare Advocacy (CMA) alleged that Medicare claims involving skilled care were being inappropriately denied by contractors based on a rule-of thumb "Improvement Standard"—under which a claim would be summarily denied due to a beneficiary's lack of restoration potential, even though the beneficiary did in fact require a covered level of skilled care in order to prevent or slow further deterioration in his or her clinical condition. In the Jimmo lawsuit, CMS denied establishing an improper rule-of-thumb "Improvement Standard." The Court never ruled on the validity of the Jimmo plaintiffs' allegations.

While an expectation of improvement would be a reasonable criterion to consider when evaluating, for example, a claim in which the goal of treatment is restoring a prior capability, Medicare policy has long recognized that there may also be specific instances where no improvement is expected but skilled care is, nevertheless, required in order to prevent or slow deterioration and maintain a beneficiary at the maximum practicable level of function. For example, in the regulations at 42 CFR 409.32(c), the level of care criteria for SNF coverage specify that 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."

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. A beneficiary's lack of restoration potential cannot, in itself, serve as the basis for denying coverage, without regard to an individualized assessment of the beneficiary's medical condition and the reasonableness and necessity of the treatment, care, or services in question. Conversely, coverage in this context would not be available in a situation where the beneficiary's care needs can be addressed safely and effectively through the use of nonskilled personnel.

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. Any Medicare coverage or appeals decisions concerning skilled care coverage must reflect this basic principle. In this context, it is also essential and has always been required that claims for skilled care coverage include sufficient documentation to substantiate clearly that skilled care is required, that it is in fact provided, and that the services themselves are reasonable and necessary, thereby facilitating accurate and appropriate claims adjudication.