Arnall Golden Gregory LLP

Client Alert

Contact Attorneys Regarding This Matter:

Glenn P. Hendrix
404.873.8692 - direct
glenn.hendrix@agg.com

Lanchi N. Bombalier
404.873.8520 - direct
lanchi.bombalier@agg.com

Arnall Golden Gregory LLP
Attorneys at Law

171 17th Street NW
Suite 2100
Atlanta, GA 30363-1031

1 Biscayne Tower
Suite 2690
2 South Biscayne Boulevard
Miami, FL 33131

1775 Pennsylvania Avenue NW
Suite 1000
Washington DC 20006

www.agg.com

Proposed Settlement in *Jimmo* Case to Clarify Medicare Coverage Standards for Post-Acute Skilled Care and Allow for Re-Review of Certain Claim Denials

On October 16, 2012, a proposed settlement was filed with the Federal U.S. District Court in Vermont in the case of *Jimmo et al. v. Sebelius*,[1] a class action complaint initially submitted against the Secretary of the Department of Health and Human Services ("DHHS" or the "Secretary") by five individual plaintiffs and five institutional plaintiffs represented by attorneys from the Center for Medicare Advocacy, Inc. and Vermont Legal Aid. The initial complaint noted that, contrary to the standards for coverage, DHHS and its contractors employed an unlawful "rule of thumb" to terminate, limit, or deny certain skilled services provided to Medicare beneficiaries, particularly those with chronic conditions, who fail to make measurable functional improvements or who require such services in order to maintain function (*i.e.*, "maintenance services"). The complaint further alleged that DHHS and its contractors applied this improper standard, commonly referred to as the Medicare "Improvement Standard," to deprive thousands of Medicare beneficiaries of coverage for reasonable and necessary services in violation of the federal statute and regulations.

If the proposed settlement agreement is approved by the court, the Centers for Medicare & Medicaid Services ("CMS") will be required to clarify its payment policies for the coverage of skilled services in the skilled nursing facility ("SNF"), home health ("HH"), outpatient therapy ("OPT"), and inpatient rehabilitation facility ("IRF") settings. The proposed settlement agreement includes three injunctive provisions designed to ensure that providers, contractors, and other CMS stakeholders understand the appropriate coverage standards for skilled services in these settings. Specifically, these injunctive provisions require CMS to:

1. revise the Medicare Benefit Policy Manual provisions (and other applicable manual provisions) to clarify the SNF, HH, OPT, and IRF coverage standards for skilled services;

2. undertake a nationwide educational campaign to address the SNF, HH, OPT, and IRF coverage standards for skilled services; and

3. develop claim review protocols to assess contractor coverage

1 Civil Action No. 5:11-CV-17-CR.

decisions and ensure correct application of the SNF, HH, OPT, and IRF coverage standards for skilled services.

Although it is not included as part of any injunctive provision, the proposed settlement agreement also provides that certain class members may be eligible for re-review of their claim denials under certain circumstances. Class members are defined as Medicare beneficiaries who received skilled services in a SNF, HH, or OPT, received a final denial of coverage, on or after January 18, 2011, either in part or in full for such skilled services based on a lack of improvement potential, and who seek Medicare coverage on his or her own behalf.[2] Class members seeking re-review are required to identify themselves and their final, non-appealable denials to CMS no later than six months after the end of the CMS nationwide educational campaign. However, this provision excludes providers, suppliers or Medicaid state agencies from seeking re-review of Medicare claims on behalf of or by assignment from a class member.

Although the parties expect that judicial approval of the proposed settlement agreement will take several months, DHHS denies the existence of any covert Improvement Standard being used to deny coverage for skilled "maintenance" services. In responding to the class action suit, DHHS has noted that the underlying Medicare statute and regulations have always allowed for the provision of such services when reasonable and necessary. In light of such statements by DHHS, it does not appear that providers would need to wait for judicial approval of the proposed settlement agreement in order to apply the coverage standards for skilled maintenance services. As a result, the proposed settlement in *Jimmo* is expected to have a significant impact on Medicare beneficiary access to skilled services in multiple post-acute settings regardless of the date of court approval.

2 Because a class member may seek re-review if he or she received a "final and non-appealable" denial as of January 18, 2011, an initial determination dated as far back as September 20, 2010 is potentially eligible for re-review as an initial determination becomes "final and non-appealable" 120 days after the date of the initial determination letter.