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Proposed Settlement Would Prevent Medicare Denials for Chronically Ill and Disabled Due to Lack of Improvement

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A proposed settlement [PDF] has been reached between CMS and the plaintiffs in a national class action involving the denial of benefits to chronically ill and disabled Medicare beneficiaries. Many of these patients have had skilled nursing and therapy care denied on the grounds that they cannot show a likelihood of improvement or increase in functional capability.

While CMS has denied that any "improvement standard" exists, CMS has agreed under the proposed settlement to revise relevant portions of the Medicare Benefit Policy Manual (MBPM) to clarify the coverage standards for the skilled nursing facility (SNF), home health (HH), and outpatient therapy (OPT) benefits, as well as for services in an inpatient rehabilitation facility (IRF). Specifically, these revisions will clarify:

- that SNF, HH, and OPT coverage of therapy to perform a maintenance program does not turn on the presence or absence of a beneficiary's potential for improvement from the therapy, but rather on the beneficiary's need for skilled care;
- that SNF and HH coverage of nursing care does not turn on the presence or absence of an individual's potential for improvement from the nursing care, but rather on the beneficiary's need for skilled care; and
- that an IRF claim could never be denied for the following reasons: (1) because a patient could not be expected to achieve complete independence in the domain of self-care or (2) because a patient could not be expected to return to his or her prior level of functioning.

The terms of the proposed settlement make clear that all other Medicare coverage requirements remain in effect, such as the need for skilled care and 3 days of hospitalization prior to SNF coverage.

CMS is also required to engage in an extensive educational campaign to ensure that the standards are being appropriately applied by its contractors.

The proposed settlement has been filed with the federal district court in Vermont. It could take several months to finalize and obtain the court's approval.

Ober|Kaler's Comments

The members of the class of beneficiaries in the lawsuit are those who received denials of coverage that became final and non-appealable on or after January 18, 2011. Specifically excluded as members of the class are Medicare providers and suppliers and Medicaid state agencies. Nevertheless, CMS's agreement to revise the MBPM means that all providers and suppliers of these services will benefit in the future. In addition, providers and suppliers should be sure that appeals are filed for any denials that they now receive on the basis of the beneficiary's failure to improve, so that the appeals are alive when the manual provisions are revised.