

Medicare Outpatient Therapy Coverage and Appeals In Light of *Jimmo v. Sebelius*

You do not have to improve to qualify for Medicare coverage!

On January 24, 2013, the U.S. District Court for the District of Vermont approved a settlement agreement in *Jimmo v. Sebelius*, No. 5:11-CV-17 (D. VT). As a result of the *Jimmo* Settlement, the Centers for Medicare & Medicaid Services (CMS) was required to confirm that Medicare coverage is determined by beneficiaries' need for skilled care, not their potential for improvement. Medicare policy now clearly states that coverage "does not turn on the presence or absence of a beneficiary's potential for improvement, but rather on the beneficiary's need for skilled care. Skilled care may be necessary to improve a patient's condition, to maintain a patient's current condition, or to prevent or slow further deterioration of the patient's condition." ([CMS Transmittal 179, Pub 100-02, 1/14/2014](#)).

The *Jimmo* Settlement means that Medicare beneficiaries should not be denied coverage of outpatient therapy when skilled personnel must provide or supervise the care for it to be safe and effective. Medicare-covered skilled therapy includes therapy that improves, or maintains, or slows the decline of a patient's condition. Medicare coverage should not be denied solely because an individual has an underlying condition that will not get better, such as MS, ALS, Parkinson's disease or paralysis.

Unfortunately, the Center for Medicare Advocacy still hears from beneficiaries and their families about coverage denials for skilled therapy based on some variation of an "Improvement Standard." The Center has created this Checklist Toolkit to assist individuals in responding to unfair terminations of therapy and Medicare denials. Each of the Checklists below provide valuable information on the rights of beneficiaries in regards to outpatient therapy coverage, appeals in traditional Medicare, and appeals in Medicare Advantage. Although challenging a Medicare termination or denial may seem daunting, beneficiaries and their representatives can win appeals when equipped with the right information.

**Coverage Criteria in
Light of *Jimmo***

**Appeals in
Traditional Medicare**

**Appeals in
Medicare Advantage**

Medicare Outpatient Therapy Coverage In Light of *Jimmo v. Sebelius*

Coverage Criteria → **You do not have to improve to qualify!**

No Improvement Standard

Medicare coverage “does not turn on the presence or absence of a beneficiary’s potential for improvement, but rather on the beneficiary’s need for skilled care. Skilled care may be necessary to improve a patient’s condition, to maintain a patient’s current condition, or to prevent or slow further deterioration of the patient’s condition.” [CMS Transmittal 179, Pub 100-02, 1/14/2014](#); Medicare Benefit Policy Manual, Medicare Benefit Policy Manual, Chapter 15, Sections 220, 220.2-.3, 230.1-.2; See also, 42 CFR § 409.32(c).

Medical Necessity

- ✓ Your outpatient therapy services must be medically reasonable and necessary.
- ✓ A qualified therapist must provide or, in some instances, directly supervise your therapy.

Plan of Care

- ✓ A physician, non-physician practitioner, or therapist providing outpatient therapy services must establish your plan of care. Additionally, a physician or non-physician practitioner must periodically review your plan of care.
- ✓ Your plan of care must include, at a minimum, the diagnoses, long-term treatment goals, and type, amount, duration and frequency of therapy services.

Physician

- ✓ You must be under the care of a physician at the time you receive outpatient therapy services.

Certification

- ✓ The physician or non-physician practitioner must certify the preceding conditions have been met by certifying your plan of care.
- ✓ Certification requirements are met when the individual’s physician certifies your plan of care. If a signed order includes a plan of care, no further certification is required.

Claims

- ✓ Outpatient therapy claims must have your certifying physician’s National Provider Identifier (NPI).
- ✓ Outpatient therapy claims must have the required functional reporting. Your functional limitations must be consistent with the limitations identified by your plan of care and included in your long-term goals.

Appeals in Traditional Medicare For Outpatient Therapy Services In Light of *Jimmo v. Sebelius*

You do not have to improve to qualify for Medicare coverage!

No Improvement Standard

Restoration potential is not necessary. Medicare coverage “does not turn on the presence or absence of a beneficiary’s potential for improvement, but rather on the beneficiary’s need for skilled care. Skilled care may be necessary to improve a patient’s condition, to maintain a patient’s current condition, or to prevent or slow further deterioration of the patient’s condition.” [CMS Transmittal 179, Pub 100-02, 1/14/2014](#); Medicare Benefit Policy Manual, Chapter 15, Sections 220, 220.2-.3, 230.1-.2; See also, 42 CFR § 409.32(c).

Medicare Summary Notice

- ✓ Your [Medicare Summary Notice](#) (MSN) constitutes your “initial determination” and will briefly explain what Medicare will pay on a claim.
- ✓ If you have been held financially responsible for outpatient therapy services, you can appeal by following the instructions on the last page of your MSN.

Redeterminations

- ✓ You have 120 days to file an appeal. The [Medicare Administrative Contractor](#) (MAC) must make a determination within 60 days of receiving your request.
- ✓ Take this time to request your medical records. Ask the physician who ordered your care to submit a written statement explaining why the services were medically reasonable and necessary. Ask your physician to give you copies of published articles or treatment guidelines supporting your argument. If possible, ask your treating therapist to write a letter supporting the claim. Send a copy of all supporting documents along with your appeal.

Reconsiderations

- ✓ If the MAC decides against you, you have 180 days to request a reconsideration with the [Qualified Independent Contractor](#) (QIC). The QIC must generally make a determination within 60 days of receiving your request.
- ✓ Your appeal request should highlight that you are appealing the denial because your therapy was medically reasonable and necessary. Send copies of any additional supporting documents along with your request.

**Administrative
Law Judge
Hearing**

- ✓ If the QIC decides against you, you have 60 days to request a hearing before an [administrative law judge](#) (ALJ).
- ✓ For beneficiary-initiated appeals, the ALJ should make a decision within 90 days of receiving the request for a hearing.
- ✓ You can contact the [Beneficiary Help Line](#) at (844) 419-3358 to ensure that your appeal receives priority processing.
- ✓ You must submit your evidence with the request for hearing, by the date specified in the request for hearing, or, if a hearing has been scheduled, within 10 days of receiving the notice of hearing.

**Medicare Appeals
Council**

- ✓ If the ALJ decides against you, you may request a review by the [Medicare Appeals Council](#) within 60 days of receiving the ALJ's decision.
- ✓ For beneficiary-initiated appeals, the Appeals Council should make a decision within 90 days of receiving the request for a hearing.

**Federal District
Court**

- ✓ If the Appeals Council decides against you, follow the directions in the denial to file for judicial review in [federal district court](#).
- ✓ You must file within 60 days of receiving the Appeals Council's decision.
- ✓ You must meet the amount in controversy requirement. The amount in controversy is adjusted annually.

Remember

- A decision to terminate your Medicare-covered care based on an erroneous "Improvement Standard" is a violation of your rights under Medicare.
- If you do not win your appeal or decide not to take further action, you will be responsible for the portion of your care not covered by Medicare.
- Congress repealed Medicare [outpatient therapy caps](#) in 2018. Therapy caps were removed for all physical therapy, occupational therapy, and speech-language pathology services provided after December 31, 2017. Medicare beneficiaries are no longer required to seek additional coverage, beyond a set dollar amount, through an exceptions process.

Appeals in Medicare Advantage For Outpatient Therapy Services In Light of *Jimmo v. Sebelius*

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No Improvement Standard

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Organization Determination

- ✓ You may request an “[organization determination](#)” from your Medicare Advantage (MA) plan to ask for the payment of outpatient therapy you think should be covered, provided, or continued. Your plan may take up to 14 days to make a determination.
- ✓ You can ask your plan for a fast decision. The plan must make a decision within 72 hours if it determines, or your physician tells your plan, that the standard timeframe may seriously jeopardize your life, health, or ability to regain maximum function.
- ✓ If your MA plan decides not to pay for requested or completed services, the plan must provide you with written notice of its decision regarding coverage of the services and instructions on how to appeal the decision.
- ✓ Take this time to request your medical records and ask the physician who ordered your care to submit a written statement explaining why your outpatient therapy was medically reasonable and necessary. Ask your physician to also give you copies of published articles or treatment guidelines supporting your argument. If possible, ask your treating therapist to write a letter supporting the claim. Send a copy of all supporting documents along with your appeal.

Reconsideration

- ✓ You have 60 days to request a [reconsideration](#). Your plan must respond within 72 hours for expedited requests, 30 days for standard service requests, and 60 days for payment requests.

Independent Review Entity

- ✓ If your plan decides against you, your appeal is automatically sent to the [Independent Review Entity \(IRE\)](#). The IRE must respond within 72 hours for expedited requests, 30 days for standard service requests, and 60 days for payment requests.
- ✓ You may send the IRE information supporting your case. Send all supporting documents within 10 days of receiving the IRE notice

Administrative Law Judge Hearing

- ✓ If the IRE decides against you, you have 60 days to request a hearing before an [administrative law judge \(ALJ\)](#).
- ✓ For beneficiary-initiated appeals, the ALJ should make a decision within 90 days of receiving the request for a hearing.
- ✓ You can contact the [Beneficiary Help Line](#) at (844) 419-3358 to ensure that your appeal receives priority processing.
- ✓ You must submit your evidence with the request for hearing, by the date specified in the request for hearing, or, if a hearing has been scheduled, within 10 days of receiving the notice of hearing.

Medicare Appeals Council

- ✓ If the ALJ decides against you, you may request a review by the [Medicare Appeals Council](#) within 60 days of receiving the ALJ's decision.
- ✓ For beneficiary-initiated appeals, the Appeals Council should make a decision within 90 days of receiving the request for a hearing.

Federal District Court

- ✓ If the Appeals Council decides against you, follow the directions in the denial to file for judicial review in [federal district court](#).
- ✓ You must file within 60 days of receiving the Appeals Council's decision.
- ✓ You must meet the amount in controversy requirement. The amount in controversy is adjusted annually.

Remember

- A decision to terminate your Medicare-covered care based on an erroneous "Improvement Standard" is a violation of your rights under Medicare.
- If you do not win your appeal or decide not to take further action, you will be responsible for the portion of your care not covered by your Medicare Advantage plan.
- With only limited exceptions, MA plans must provide their enrollees with all basic benefits covered under traditional Medicare and may not impose limitations that are not present in traditional Medicare.