

## REQUEST FOR RE-REVIEW OF MEDICARE CLAIMS RELATED TO THE SETTLEMENT AGREEMENT IN JIMMO V. SEBELIUS

### BACKGROUND

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 (Jimmo). As part of the Jimmo settlement agreement, Medicare clarified that maintenance coverage under the skilled nursing facility (SNF) and home health (HH) benefits, and skilled therapy under the SNF, HH, and outpatient therapy (OPT) benefits does not depend on whether the patient can improve, but on whether skilled care is required and whether the services themselves are reasonable and necessary. The Jimmo vs. Sebelius case fact sheet is available online at:

<http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/Jimmo-FactSheet.pdf>.

### RE-REVIEW OF DENIED CLAIMS

The Jimmo settlement agreement also provides for the re-review of certain Medicare claims under clarified maintenance coverage standards for the SNF, HH, and OPT benefits, applicable when a patient has no restoration or improvement potential, but that patient requires skilled SNF, HH, or OPT services to maintain, or to prevent or slow further deterioration of, his or her clinical condition.

### DOES YOUR CLAIM QUALIFY FOR RE-REVIEW UNDER THE JIMMO SETTLEMENT AGREEMENT?

In order to qualify for re-review under the Jimmo settlement agreement, your claim must meet certain criteria. Please answer the following questions about your claim to determine whether it qualifies to be re-reviewed.

<p>1. Are you a Medicare beneficiary (or an appointed or authorized representative of a beneficiary)?</p> <p><b>Note:</b> Providers, suppliers, Medicaid state agencies, or other insurers may not request re-review on behalf of a beneficiary under the terms of the settlement agreement.</p>	YES <input type="checkbox"/>	NO <input type="checkbox"/>	DON'T KNOW <input type="checkbox"/>
<p>2. Did you receive skilled nursing or therapy services in a skilled nursing facility (SNF) or home health setting, or skilled therapy services in an outpatient setting?</p>	YES <input type="checkbox"/>	NO <input type="checkbox"/>	DON'T KNOW <input type="checkbox"/>
<p>3. Were services that you actually received denied by Medicare because you were not improving or no longer had the potential to improve (i.e., become chronic, plateaued, or needed maintenance services only)?</p>	YES <input type="checkbox"/>	NO <input type="checkbox"/>	DON'T KNOW <input type="checkbox"/>
<p>4. Was your failure to improve or to have the potential to improve the ONLY reason for denying part or all of your claim?</p> <p><b>Note:</b> If this denial also included a separate and independent reason, such as failure to satisfy any Medicare eligibility or threshold requirement for coverage (for example, a 3-day inpatient hospital stay for SNF, meeting "homebound" status for HH, or therapy caps for outpatient therapy) or failure to satisfy any procedural requirement (such as filing your appeal late) you must answer "No" to this question.</p>	YES <input type="checkbox"/>	NO <input type="checkbox"/>	DON'T KNOW <input type="checkbox"/>
<p>5. Did your maintenance care denial become final and non-appealable January 18, 2011 through January 23, 2014?</p> <p><b>Note:</b> The term non-appealable means that the claim has been denied by Medicare and is not eligible for further appeal (e.g., the normal deadline for further appeal has passed).</p>	YES <input type="checkbox"/>	NO <input type="checkbox"/>	DON'T KNOW <input type="checkbox"/>
<p>6. Have you paid for or do you still owe money for the services that are the subject of the maintenance care denial, or were covered by Medicaid and you are personally or financially liable or subject to recovery? (Any claims for services that were covered or paid for by any third-party payor or insurer or Medicare are not eligible for re-review.)</p> <p><b>Note:</b> This does NOT include co-pays or deductibles</p>	YES <input type="checkbox"/>	NO <input type="checkbox"/>	DON'T KNOW <input type="checkbox"/>

**If you answered “YES” or “DON’T KNOW” to all of the questions above,** you may request a re-review of your final, non-appealable maintenance claim denial. Please complete the re-review request form below, submit the requested documentation, and certify that the information included on the form is accurate to the best of your knowledge. If a telephone number is provided, you may be contacted further to clarify any information that is not sufficient to identify the Medicare appeal. If you want further information or assistance, consult the website of the Center for Medicare Advocacy, Inc., which is [www.medicareadvocacy.org](http://www.medicareadvocacy.org). The Center’s site has information about the right to re-review under *Jimmo*.

#### TIMEFRAME FOR REQUESTING A RE-REVIEW

IF YOUR MAINTENANCE CARE DENIAL BECAME FINAL AND NON-APPEALABLE:	YOUR REQUEST FOR RE-REVIEW MUST BE POSTMARKED NO LATER THAN:
January 18, 2011 through January 24, 2013	July 23, 2014
January 25, 2013 through January 23, 2014	January 23, 2015

#### FORM SUBMISSION

FACSIMILE	MAIL
(571) 266-3141	JIMMO Review - Q2 Administrators PO BOX 23039 Columbia, SC 29224

**REQUEST FOR REVIEW OF MEDICARE CLAIMS RELATED TO THE SETTLEMENT AGREEMENT**

Beneficiary's Name (first name, last name)	Health Insurance Claim Number
Item or Service at Issue (Please Describe)	Date Item or Service was Received
Requester's Name (If Different from Beneficiary)	Relationship to Beneficiary
Address of Person Requesting Re-Review of Claim	Telephone # of Person Requesting Re-Review of Claim
Medicare Contractor that Made the Final Decision (May Include a Copy of Decision)	Appeal or Correspondence Number of the Final Decision

**REASON(S) FOR DISAGREEMENT WITH THE FINAL CLAIM DECISION**

Do you have additional evidence that you would like Medicare to consider? (If yes, attach to form)	YES	NO
I hereby certify that the foregoing information is true, accurate, and complete, to the best of my knowledge.	DATE	

Signature of Person Requesting Re-Review of Claim

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**PRIVACY STATEMENT:** The legal authority for the collection of information on this form is authorized by section 1869 (a)(3) of the Social Security Act. The information provided will be used to further document your appeal. Submission of the information requested on this form is voluntary, but failure to provide all or any part of the requested information may affect the determination of your request. Information you furnish on this form may be disclosed by the Centers for Medicare & Medicaid Services to another person or government agency only with respect to the Medicare Program and to comply with Federal laws.