Aetna Better Health® of Michigan
1333 Gratiot Avenue, Suite 400
Detroit, MI 48207
1-866-316-3784

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Dear Providers,

CMS clarifies guidance on coverage of skilled services in accordance with Jimmo v. Sebelius

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*. That settlement agreement set forth requirements for the Centers for Medicare and Medicaid Services (CMS) to clarify its coverage guidelines around skilled care services, which CMS subsequently carried out in a series of revisions to its benefit policy manuals. In early August 2017, CMS instructed Medicare insurers like Aetna to publish refresher training on the benefit policy clarifications made pursuant to the *Jimmo v. Sebelius* settlement agreement.

In accordance with the settlement agreement, CMS clarified that coverage of skilled nursing and skilled therapy services in the skilled nursing facility (SNF), home health (HH), and outpatient therapy (OPT) settings "… 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 current condition, to maintain the patient's current condition, or to prevent or slow further deterioration of the patient's condition.

Here's what you need to know

In their August 2017 communication, CMS reinforced the prohibition on basing coverage decisions on a beneficiary's lack of restoration potential. Rather, coverage of skilled care services depends upon an individualized assessment of the beneficiary's medical condition and the reasonableness and necessity of the treatment, care, or services in question. Moreover, when the individualized assessment demonstrates that skilled care is, in fact, needed in order to safely and effectively maintain the beneficiary at his or her maximum practicable level of function, such care is covered (assuming all other applicable requirements are met).

Conversely, coverage in this context would not be available in a situation where the beneficiary's maintenance care needs can be addressed safely and effectively through the use of non-skilled personnel.

CMS has 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. 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. In cases where an entity denies a new or continuing request for skilled services, the denial notice must include an explicit and detailed reason for the denial. The denial reason must be based on the beneficiary's need for skilled care, not on a lack of improvement for a beneficiary who requires skilled maintenance nursing services or therapy services as part of a maintenance program in the SNF, HH, or OPT settings.

More information is available

Below please find a link to educational resources regarding CMS' recent clarifications regarding the benefit policy changes made pursuant to the *Jimmo v. Sebelius* settlement agreement. Please distribute to any staff/personnel responsible involved in any processes around coverage decisions for skilled care services.

https://www.cms.gov/Center/Special-Topic/Jimmo-Center.html