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Medicare "improvement standard" settlement approved

Many Medicare beneficiaries and their families and friends are familiar with the "improvement standard" applied to permit continued Medicare coverage at home or in a nursing home. If the patient is deemed to be not improving or has "plateaued," Medicare coverage ceases even if only a fraction of the benefit (often up to 100 days) has been used. There seemed to be no way around this pronouncement for those with chronic conditions, although it seemed clear that the patient would benefit from continued skilled care to prevent deterioration. Now, a federal judge has approved a class action settlement that will end "Medicare's long standing practice of requiring beneficiaries to show a likelihood of improvement in order to receive coverage of skilled care and therapy services" (as reported in www.elderlawanswers.com on January 24, 2013).

In January, 2011, the Center for Medicare Advocacy (the Center) along with Vermont Legal Aid filed a class action lawsuit against the Obama administration in federal court. On January 24, 2013, the federal judge announced a settlement. The Center stresses that this coverage takes effect *now* for people who need "skilled maintenance care and meet any other qualifying Medicare criteria" such as entering an nursing facility after a three day hospital stay or being certified as needing home care by a physician. The Centers for Medicare and Medicaid Services (CMS) is required to revise its Medicare Benefit and Policy Manual and other policies, guidelines and instructions to clearly indicate that Medicare coverage of skilled nursing and therapy services "does not turn on the presence or absence of an individual's potential for improvement" but rather on the current condition of the beneficiary or if it is needed to slow further deterioration. Furthermore, CMS is required to launch a nationwide education campaign to inform all who make such Medicare coverage decisions of the "death" of the improvement standard.

The so-called "improvement standard" has been applied to Medicare beneficiaries receiving care at home or in a skilled nursing facility for decades despite the fact that there are no regulations in place to support this standard. Medicare beneficiaries have been routinely told that once they stopped improving (which was an arbitrary and subjective decision), they no longer qualified for Medicare for their care, even if the beneficiary had many days left in their benefit period. Little regard was given to the beneficiary's need for care to prevent deterioration. Sometimes the sole reason for suspending care was that the beneficiary had dementia, and was not expected to improve medically. Peter Thomas, Esquire, a lawyer in private practice who is the outside counsel for the American Academy of Physical Medicine and Rehabilitation has been quoted as saying, "I think that the settlement opens coverage up to pretty much any condition that creates functional impairment. In that respect, it's probably a much more expansive settlement than some people might think."

Opponents may argue eliminating the improvement standard will be very costly at a time that Medicare is struggling financially. However, repeat hospitalizations for beneficiaries who were denied full rehabilitation are also costly. Allowing beneficiaries to obtain the care that they need the first time should reduce the number of costly hospital stays, and allow many to receive the care that they need at home to keep people out of nursing homes.

If you or someone you know is denied further rehabilitation or skilled care at home or in a nursing facility due to "failure to progress," be sure to appeal the decision in a timely manner. As the personnel at the Center for Medicare Advocacy have stated, the new standard is now the "law of the land."