

## Debunking the Myth:

### *Medicare's Improvement v. Maintenance Standard*

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## Papciak Case

Plaintiff was 81 years old. She had undergone a hip replacement in April 2008 in western Pennsylvania. She receive twenty days of therapy and was discharged home. Subsequently, she developed an infection and was readmitted to the hospital.

On June 2, 2008, she was discharged to a SNF. Upon admission, she was unable to ambulate and could not use her walker due to carpal tunnel syndrome.

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## Papciak Case

She had a history of cellulitis, anemia, atrial fibrillation, hypertension, anxiety, and depression.

She received therapy from June 3, 2008 through July 19, 2008.

Medicare paid for her stay from June 3 through July 9, but denied payment from July 10 to July 19.

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## Papciak Case

She received therapy 5 days a week for the entire period. Her progress was slow. The therapy included PT and OT, treatment, self care, therapeutic exercises and therapeutic activities.

It was determined by July 10 she no longer needed skilled care because she had made only minimal progress in some areas, regressed in other areas, and had met her maximum potential for her PT and OT.

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## Papciak Case

Medicare denied payment for 9 days on the basis she was only receiving “custodial care,” not skilled care.

She appealed, but was denied by Quality Insights of PA. She appealed again and the Administrative Law Judge again denied Medicare coverage. She appealed again and the Medicare Appeal Counsel upheld the prior denials.

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## Papciak Case

She was represented by the Elder Law Clinic of the University of Pittsburg law school.

She exhausted her administrative remedies and was then able to proceed in federal court, which she did in the United States District Court for the Western District of Pennsylvania.

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## Papciak Case

District Court

Analyzed Medicare coverage concepts:

Resident must require skilled nursing or skilled rehabilitation services, on a daily basis, that as a practical matter can only be provided in a SNF.

Personal care services are generally not covered.

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## Papciak Case

“Custodial care” is any care that does not meet the requirements of skilled care as defined in the regulations.

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## Papciak Case

Courts look at two general principles when trying to distinguish between custodial and skilled:

First: a common sense, non-technical consideration of the resident's condition as a whole.

Second: the Social Security Act is to be construed in favor of the beneficiaries.

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## Papciak Case

Purpose of custodial care disqualification:

“Not to disentitle old, chronically ill and basically helpless, bewildered and confused people from the broad remedy which Congress intended to provide for our senior citizens. Rather, the provision was intended to stop cold-blooded and thoughtless relatives from relegating an oldster who *could* care for him or herself to the care of a [SNF] merely so that the oldster would have a place to eat, sleep, or watch television.”

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## Papciak Case

Cont'd:

“When a person is sick, ...and when those who love that person are not skilled enough to take care of that person, Congress has provided a remedy in the Medicare Act, and that remedy should not be eclipsed by an application of the law and findings of fact which are blinded buy bureaucratic economics to the purpose of Congress.”

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## Papciak Case

As a result, courts interpret ‘custodial care’ to be care that can be provided by a lay person, without special skills, and not requiring or entailing the continued attention of trained or skilled personnel.

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## Papciak Case

Resident's arguments:

1. ALJ only considered whether resident's condition would no longer materially improve with additional skilled care. Resident argued ALJ must consider whether additional skilled care was required to maintain resident's level of functioning.
2. ALJ failed to consider resident's condition as a whole.

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## Papciak Case

District court agreed and reversed the ALJ decision.

Court reviewed the statute, regulations, and CMS guidelines found in the Medicare Skilled Nursing Facility Manual.

FYI: SNF Manual sections are interpretive guidelines and do not have the effect of law.

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## Papciak Case

Court did rely on SNF Manual § 214.3, which states:

“The services must be provided , based on the assessment made by the physician of the patient’s restoration potential, that the condition of the patient will improve materially in a reasonable and generally predictable period of time, or the services must be necessary for the establishment of a safe and effective maintenance program.”

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## Papciak Case

ALJ concluded the resident was no longer eligible because it was apparent that no matter how much more therapy was provided she was not going “to achieve a higher level of function.”

Further, the lower tribunals stated the resident “made little or no progress in therapy” during her time at the SNF.

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## Papciak Case

District court:

ALJ erred by not considering whether the services were required to maintain her level of functioning after the hip replacement.

Even if full recovery or medical improvement is not possible, a resident may need skilled services to prevent further deterioration or preserve current capabilities.

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## Papciak Case

Second reason for reversal:

ALJ concluded the resident was unmotivated and resistant to therapy during her entire stay, which contributed to the conclusion the resident had reached her maximum functional capacity.

ALJ erred by not taking into consideration other factors limiting her ability to make progress (depression and situational anxiety)

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## Anderson Case

Home health care case-decided in 2010

ALJ had concluded skilled services are not covered when a patient's condition is stable and unlikely to change.

Plaintiff challenged the denial, arguing the intermediary was using a 'stability presumption.' (i.e., coverage is denied for patients whose conditions are stable during the coverage period) and a retrospective analysis.

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## Anderson Case

District Court of Vermont:

A patient's chronic or stable condition is not a basis for automatically denying coverage for skilled services. Skilled care may, depending on the unique condition of the patient, continue to be necessary for patients whose condition is stable.

"Stabilization" is an improper limitation on coverage.

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## Anderson Case

District Court also rejected the use of ‘hindsight’ or a retrospective analysis to deny coverage.

The determination of whether services are reasonable and necessary must be viewed from the physician’s perspective of the condition of the patient at the time when the services were ordered and what was reasonably expected to be appropriate treatment for the certification period.

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## Class Action

*Jimmo v. Sebelius, No. 5:11-CV-17*

Center for Medicare Advocacy and the Vermont Legal Aid filed a class action lawsuit against the Secretary of Health & Human Services on January 18, 2011.

Suit challenges the use of the “Improvement Standard” being used to deny coverage for Medicare.

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## Class Action

Challenging denials based on standards such as lack of improvement, stable, plateau, chronic, not improving, or for maintenance only.

Status: Federal government filed a Motion to Dismiss.

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## Class Action

Other organizations now involved:

- Alzheimer's Association United Cerebral Palsy,
- National Committee to Preserve Social Security and Medicare,
- National Multiple Sclerosis Society,
- Parkinson's Action Network,
- Paralyzed Veterans of America, and
- American Academy of Physical Medicine and Rehabilitation.

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## Impact

1. Residents
2. Skilled Nursing Facilities
3. Medicaid
4. Medicare

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## SNF Defined

A facility primary engaged in providing:

- 1) skilled nursing care and related services for residents who require medical or nursing care; or
- 2) rehabilitation services for the rehabilitation of injured, disabled, or sick persons.

42 U.S.C.A 1395i-3(a).

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## Medicare Coverage

### Criteria and Need for SNF Skilled Services

1. The service must be so inherently complex it can only be performed by or under the supervision of professional or technical personnel.
2. A condition not normally requiring skilled services may qualify for coverage because of other special medical complications.

## Medicare Coverage

### Criteria and Need for SNF Skilled Services

3. The restoration potential of the patient is not the deciding factor in determining the necessity of the service. Even if full recovery or medical improvement is not possible, a patient may need skilled services to prevent further deterioration or preserve current capabilities.

42 C.F.R. §409.32

## Medicare Coverage

Examples of services are in the regulations.  
(42 C.F.R. § 409.33).

Skilled Nursing

Rehabilitation Services

Both

Personal Care

## Both SNS and SRS

1. Overall management and evaluation of care plan if the involvement of technical or professional personnel is required to meet the resident's needs, promote recovery, and ensure medical safety.

### Both SNS and SRS

2. Observation and assessment of patient's changing condition if the involvement of technical or professional personnel is required to identify and evaluate the resident's need for modification of treatment or for additional procedures until the condition is stabilized.

### Both SNS and SRS

3. Patient education services if the involvement of technical or professional personnel is required to teach a resident self-maintenance.

## Medicare Eligibility

### Statutory Exclusion:

No payment will be made under Part A or Part B for custodial care.

42 U.S.C.A 1395y(a)(9)

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## Skilled Nursing

The regs identify 9 types of services, relating to:

1. IV injections and feeding;
2. Enteral feeding;
3. Aspiration;
4. Irrigation/catheters;
5. Dressings w/medications;
6. Decubitus ulcers;
7. Heat treatments;
8. Regimen involving medical gases;
9. Rehabilitation nursing procedures.

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## Skilled Rehabilitation Services

The regs identify 8 types of services, relating to:

1. Ongoing assessment of rehabilitation needs and potential.
2. Therapeutic exercises or activities which must be performed by or under the supervision of a therapist.
3. Gait evaluation and training.
4. Range of motion exercises.

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## Skilled Rehabilitation Services

The regs identify 8 types of services, relating to:

5. Maintenance therapy when a therapist is required to design and establish a maintenance program.
6. Ultrasound, short wave, and microwave therapy by a therapist;
7. Hot pack, paraffin baths, whirlpool, etc. when a therapist is required; and
8. Speech pathologist and audiologist.

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## Skilled Services

### Daily Basis Requirement (42 C.F.R. §409.34)

Skilled nursing or skilled rehabilitation services must be needed and provided 7 days a week.

If rehab is not available 7 days a week, they must be needed and provided 5 days a week.

For rehab, a break of one or two days will not preclude coverage if discharge is not practical for the one or two days (e.g.: doctor suspends therapy due to extreme fatigue).

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## Skilled Services

### As a Practical Matter

The daily services must be ones that, as a “practical matter”, can only be provided by a SNF.

Consideration must be given to the resident's condition and the availability and feasibility of using more economical alternative facilities and services.

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## Personal Care Services

The regs list 13 categories of services, which unless there are complicating factors, are not skilled.

Some examples:

1. Administration of oral medication;
2. Change of dressings;
3. Prophylactic and palliative skin care;
4. Assistance in dressing, eating, and going to the toilet.

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## Personal Care Services

General supervision of exercises taught to the resident, including the actual carrying out of the maintenance program.

Specifically, the performance of the repetitive exercises required to maintain function do not require a therapist and would not be skilled rehabilitation services.

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## Personal Care Services

Similarly, repetitious exercises to improve gait, maintain strength, or endurance; passive exercises to maintain range of motion in paralyzed extremities, and assistive walking are not considered skilled.

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