CZEPIGA DALY LLC
ESTATE PLANNING, PROBATE & ELDER LAW

NewsFLASH
Ideas to help you plan for tomorrow

Medicare to End Practice of Requiring Patients to Show Progress to Receive Nursing Coverage

In a major change in Medicare policy, the Obama administration has provisionally agreed to end Medicare's longstanding practice of requiring that beneficiaries with chronic conditions and disabilities show a likelihood of improvement in order to receive coverage of skilled care and therapy services. The policy shift will affect beneficiaries with conditions like multiple sclerosis, Alzheimer's disease, Parkinson's disease, ALS (Lou Gehrig's disease), diabetes, hypertension, arthritis, heart disease, and stroke.

For decades, home health agencies and nursing homes that contract with Medicare have routinely terminated the Medicare coverage of a beneficiary who has stopped improving, even though nothing in the Medicare statute or its regulations says improvement is required for continued skilled care. Medicare has long used a "covert rule of thumb" to illegally deny coverage to such patients. Once beneficiaries failed to show progress, Medicare quit paying.

In January 2011, the Center for Medicare Advocacy and Vermont Legal Aid filed a class action lawsuit, *Jimmo v. Sebelius,* against the Obama administration in federal court, aimed at ending the government's use of the improvement standard. The parties recently decided to settle.

As part of the proposed settlement, Medicare will revise its manual to make clear 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 depends on whether or not the beneficiary needs skilled care, even if it would simply maintain the beneficiary's current condition or slow further deterioration.

What does this mean to you or your clients? The possibility of now receiving, if you are a nursing home resident, up to the full 100 days of Medicare coverage instead of having Medicare arbitrarily cut off your benefits if your progress has "plateaued."

BUT beware…

In order to qualify for the 100 day Medicare benefit at the nursing home, the patient must first have a 3 day at a hospital. In order to have the requisite 3 day stay, the patient must be formally admitted to the hospital. "Observation" status does not count, nor does any time count for being in the ER. You may think you were in the hospital for the requisite 3 days only to be told by the nursing home that you did not have the needed 3 day hospital stay.

What is going on? Hospitals are financially penalized by the federal government if a patient, once formally admitted and then discharged, is readmitted within 30 days. The solution to the potential financial penalty from the hospital's perspective is to NOT admit a high risk patient the first time they show up, even if it means having them under "observation" status for many days. This way if a patient is in the hospital for any length of time but not formally admitted, and the patient goes home and then comes back within 30 days and is formally admitted, the formal admission is the 1st admission and consequently the hospital is not penalized.

What you should you do? **Have your doctor fight for you to have you admitted** and make sure you know exactly what your status is—observation or formal admission. Not being admitted could end up with you being denied Medicare benefits upon discharge to a nursing home and you will not get post-hospital rehabilitation therapy.