A. General

1. **Question:** My therapist says I can’t get any more therapy because I have reached a plateau or I am not improving. How do I educate them about the Settlement?

**Answer:** You can refer your therapist to the *Jimmo* Fact Sheet at [www.cms.gov](http://www.cms.gov) and to a great deal of information regarding the Settlement at the Center for Medicare Advocacy’s website at [www.medicareadvocacy.org](http://www.medicareadvocacy.org). Your therapist may also want to contact his/her professional organization for more guidance on the *Jimmo* Settlement.

If you find that you need to appeal a denial, you can get help from the Center for Medicare Advocacy by using their Self-Help resources at [www.medicareadvocacy.org](http://www.medicareadvocacy.org).

2. **Question:** My therapist says I can’t get any more therapy because I have ALS (Amyotrophic Lateral Sclerosis). Does the *Jimmo* Settlement only apply to people with certain diseases, diagnoses, or conditions?

**Answer:** No, the Settlement is not limited to any particular condition or disease. It applies to anyone who requires skilled nursing or therapy to maintain or slow deterioration regardless of the underlying illness, disability or injury. ALS, stroke, and paralysis are just some examples of conditions that may require the skills of a therapist to provide therapy safely and effectively.

3. **Question:** Does the *Jimmo* Settlement apply to Medicare beneficiaries whose providers are in Accountable Care Organizations (ACO)?

**Answer:** Yes. Medicare beneficiaries who see providers that are participating in a Medicare ACO maintain all their Medicare rights, including application of the clarified standard for coverage of skilled care under *Jimmo*. Just as with any other Medicare beneficiary, no “rules of thumb” should be used to determine coverage. An individualized assessment of the beneficiary’s medical condition and the reasonableness and necessity of the treatment is required.

**Example:** After a hospitalization, a beneficiary receives skilled physical and occupational therapy in a skilled nursing facility (SNF) for 14 days. While she is no longer improving, she still requires daily skilled therapy to maintain and prevent deterioration, and otherwise meets all coverage requirements. It is appropriate for her to continue to receive Medicare coverage in the SNF, regardless of whether her providers are in an ACO. Just as for any other person in Medicare, there is no arbitrary cut-off for SNF coverage for patients in ACOS. An individualized assessment is necessary, and coverage may continue as long as the patient has a continuing need for skilled therapy or nursing. Note that the maximum of 100 days per benefit period still applies, and that the medical record should document the skilled nature of the therapy that the patient requires to maintain her condition.
4. **Question:** Does the *Jimmo* Settlement apply to beneficiaries in Medicare Advantage plans?

**Answer:** Yes. Medicare Advantage plans *must* cover the same Part A and Part B benefits as original Medicare, and must also apply the clarified standard for coverage of skilled care under *Jimmo*. Just as with any other Medicare beneficiary, no “rules of thumb” should be used to determine coverage. An individualized assessment of the beneficiary’s medical condition and the reasonableness and necessity of the treatment is required.

**Example:** After an acute episode a beneficiary in a Medicare Advantage plan is receiving skilled nursing home visits and home health aides covered by her plan. She has congestive heart failure, diabetes, leg and foot ulcers, and, after three weeks, is deemed to be “chronic.” The training and judgment of a skilled nurse are still necessary to monitor, manage, and assess her multiple serious conditions, *which have the reasonable potential to change and result in an adverse event*. It is appropriate for her plan to continue coverage. The fact that she is “chronic” or in a Medicare Advantage plan is not relevant. Note that all other coverage criteria, such as being “homebound,” must also continue to be met, and the documentation should reflect the reasons why the skilled nursing visits continue to be reasonable and necessary.


**B. Skilled Nursing Facility**

1. **Question:** My father was in a SNF following a 3-day hospital stay for a fractured hip. In the SNF, he received physical and occupational therapies for a week. After a week the SNF terminated the therapies because of his cognitive issues and Parkinson’s disease – stating that he was not going to improve and his condition was chronic. The physician continued the orders for daily physical therapy to maintain his condition and prevent and slow decline. Does the *Jimmo* Settlement apply to therapy services under a Part A stay in a SNF?

**Answer:** Yes, a patient who needs the skills of a therapist to maintain his condition should continue to receive daily skilled therapy even if the patient has cognitive problems or a chronic condition like Parkinson’s disease.

In fact, this case went before an Administrative Law Judge (ALJ) in October 2014 following an appeal by the family. The ALJ found that the physical therapy was covered by Medicare:

…The physician stated that the patient was in need of maintenance physical therapy to attempt to regain limited assisted ambulatory status. …Treatment modalities included therapeutic exercises for range of motion and strength training, gait training for ambulation, and transfer training. By August of 2014, the plan of care and maintenance therapy plan had to be adjusted to account for the Beneficiary’s unique medical complications. These services required the skills of a professional therapist. … The physical therapy SNF services provider to the Beneficiary after May 23, 2014, were reasonable and necessary…. [ALJ Fuller Decision dated 10/22/2014]
C. Home Health Care

1. **Question:** How does the maintenance coverage standard under the *Jimmo* Settlement apply to skilled observation and assessment of homebound Medicare beneficiaries?

**Answer:** Observation and assessment of the patient’s condition is covered where such skilled nursing services are necessary to maintain the patient’s current condition or prevent or slow further deterioration so long as the beneficiary requires skilled care for the services to be safely and effectively performed. Depending on the unique condition of the patient, these services may continue to be reasonable and necessary for a patient for so long as there is a reasonable potential for complications, and all other coverage requirements are met. Coverage does not depend on the patient’s restoration potential, and changes to the treatment plan or the patient’s condition are not required. A patient may appear to be chronic or stable, but because of a reasonable potential for complications the patient may continue to require skilled care to maintain their condition, or to prevent or slow their deterioration.

The determination of coverage for maintenance nursing should be made based on the individualized assessment of their overall medical condition, and the reasonableness and necessity of the treatment, care, or services in question.

**Cites:** *Jimmo* Settlement at pp. 12-13; Medicare Benefits Policy Manual (MBPM), Ch. 7 § 40.1 (skilled nursing services are covered where such skilled nursing services are necessary to maintain the patient’s current condition or prevent or slow further deterioration so long as the beneficiary requires skilled care for the services to be safely and effectively provided); MBPM Ch. 7 § 40.1.2.1 (“skilled observation services are still covered… so long as there remains a reasonable potential for such complications or further acute episode”).

2. **Question:** Is Medicare home health coverage available even if a patient has a condition that requires nursing care over the course of many months?

**Answer:** Yes. Medicare may continue to be available if the clinical documentation supports an ongoing need for medically reasonable and necessary intermittent skilled nursing care.

**Example:** A homebound, non-ambulatory beneficiary has non-healing leg ulcers. On occasion, the beneficiary has been hospitalized due to infection stemming from the site. Although the beneficiary’s family performs some wound care, the treating physician has ordered a home health nurse to observe and assess the wounds and the patient once or twice each month, to timely identify clinical issues that warrant either a change or addition to the ordered treatment, education, or other appropriate intervention.

**Cites:** MBPM, Ch. 7 § 40.1. (Although the beneficiary has chronic, non-healing ulcers, “coverage of skilled nursing care does not turn on the presence or absence of a patient’s potential for improvement from the nursing care, but rather on the patient’s need for skilled care.”) See also, Example 7 at MBPM, Ch. 7 § 40.1.2.1; 42 C.F.R. § 409.44(b)(3)(iii) (“The determination of whether skilled nursing care is reasonable and necessary must be based solely upon the beneficiary’s unique condition and individual needs, without regard
to whether the illness or injury is acute, chronic, terminal, or expected to last a long time.”) (Emphasis added.)

D. Outpatient Therapy

1. Question: If a physical therapist discontinues a Medicare beneficiary’s outpatient therapy because the patient’s improvement has plateaued after slight improvement and the patient is not expected to return to his or her prior level of function, can the physician prescribe additional therapy?

Answer: Yes. The Jimmo Settlement allows patients who are engaged in an outpatient therapy program to continue receiving coverage for those services, even if there is no improvement and if the patient will not return to his or her prior level of function if skilled therapy continues to be needed to maintain the individual’s condition or slow decline.

In addition, even though it may appear that the skills of a therapist are not ordinarily required to perform the specific procedures, skilled therapy is covered if the patient’s special medical complication requires the skills of a therapist to ensure proper healing and non-skilled individuals could not safely and effectively carry out the procedures.

The Jimmo Settlement specifically states that skilled therapy services are covered when the specialized judgment, knowledge, and skills of a qualified therapist are necessary for performance of a maintenance program. If the non-skilled personnel cannot ensure the maintenance of the patient’s condition, therapy is reasonable and necessary.

Example: A Medicare beneficiary who sustained orthopedic trauma in a car accident and who shows improvement over the first several weeks of outpatient therapy and then plateaus without returning to his or her prior level of function may continue therapy designed to ensure the compromised limbs are exposed to the necessary range of motion and remain in the correct alignment.

Cites: Jimmo Settlement at pp. 11-12; MBPM, Ch. 15, § 220.2.

2. Question: If a Medicare beneficiary exceeds the therapy cap for outpatient therapy services and requires those services to maintain his or her current function, can Medicare coverage continue?

Answer: Yes. The Jimmo Settlement allows patients to receive Medicare coverage for necessary outpatient therapy maintenance programs by skilled providers. Medicare is available when the therapy is required to maintain the patient’s functioning and requires a qualified therapist to be safe and effective. In such circumstances, the provider should seek an “Exception” to the therapy cap to continue therapy services. In addition, patients who exceed $3,700 in therapy expenditures can seek a further review to determine if the outpatient therapy services continue to be reasonable and necessary.

Example: A patient with Parkinson’s disease who maintains his current function through regular outpatient physical therapy and speech language pathology should seek an Exception to the therapy cap (through his provider) once the cap is reached.

3. **Question:** Can a one-time consultation with a skilled therapist regarding instructions for self-care be covered by Medicare?

**Answer:** Yes. The *Jimmo* Settlement states that the establishment of a maintenance program by a qualified therapist and the instruction of the beneficiary regarding a maintenance program is covered to the extent the specialized knowledge and judgment of the therapist is required. As there may be certain exercises and treatments the beneficiary can learn through the skills of the therapist, a one-time consultation would be covered.

**Example:** A patient with arthritis that causes difficulty with ambulation may require an outpatient therapy session to learn targeted exercises he can do on his own to improve his walking.

*Cites:* *Jimmo* Settlement at pp. 11-12; MBPM, Ch. 15, § 220.2.D.

4. **Question:** Can Medicare coverage continue for outpatient therapy if a physician prescribes the therapy to a Medicare beneficiary to prevent or slow further deterioration, even if after several weeks of therapy there is some slight deterioration?

**Answer:** Yes. Under the *Jimmo* Settlement, Medicare coverage for outpatient therapy depends on the beneficiary’s need for skilled care by a qualified therapist. The beneficiary’s potential for improvement is not the determining factor for coverage. Therapy to maintain a patient’s condition or to prevent or slow further deterioration is covered if the therapeutic procedures require a qualified therapist to be safe and effective. The issue to determine coverage is not whether the patient improves, but whether the patient requires skilled services.

**Example:** A patient with diabetic neuropathy and a recent lower limb amputation who receives outpatient therapy to prevent further decline in her mobility but still experiences a slight decline following initiation of the therapy services is still covered for the care under Medicare if, without the therapy, the patient’s mobility would decline more markedly or rapidly.

*Cites:* *Jimmo* Settlement at pp. 11-12; MBPM, Ch. 15, § 220.2.

5. **Question:** Can an evaluation of an already-established maintenance plan be covered for a Medicare beneficiary who needs to be assessed for assistive equipment and other therapies in order to prevent deterioration?

**Answer:** Yes. Under the *Jimmo* Settlement, necessary periodic reevaluations of maintenance programs by a qualified therapist are covered to the degree that the specialized knowledge and judgment of the therapist is required. A reevaluation of a maintenance program to assess for the need for assistive devices and prevent deterioration is a skill that requires the specialized knowledge of a therapist. If the therapist determines that the program needs revision based on the patient’s new developments, the establishment of a new maintenance program would also be covered.

**Example:** A patient with functional and cognitive deficits following a traumatic brain injury who carries out therapy on his own as part of a maintenance plan may have his therapy plan reevaluated either (1) on a periodic basis to ensure that it is properly addressing his needs or (2) following some change in his condition that may necessitate corresponding changes to the therapy program.
6. **Question:** If a physical therapist discontinues a Medicare beneficiary’s outpatient therapy because the patient’s improvement has plateaued after slight improvement and the patient is not expected to return to his or her prior level of function, can the physician prescribe additional therapy?

**Answer:** Yes. The Jimmo Settlement allows patients who are engaged in an outpatient therapy program to continue receiving coverage for those services, even if there is no improvement and if the patient will not return to his or her prior level of function. In addition, even though it may appear that the skills of a therapist are not ordinarily required to perform the specific procedures, skilled therapy is covered if the patient’s special medical complication requires the skills of a therapist to ensure proper healing and non-skilled personnel or caregivers would not safely and effectively carry out the procedures. Jimmo specifically states that skilled therapy services are covered when the specialized judgment, knowledge, and skills of a qualified therapist are necessary for performance of a maintenance program. If the non-skilled personnel cannot ensure the maintenance of the patient’s condition, therapy is reasonable and necessary.

**Example:** A Medicare beneficiary who sustained an orthopedic trauma in a car accident and who shows improvement over the first several weeks of outpatient therapy and then plateaus without returning to his or her prior level of function may continue therapy designed to ensure the compromised limbs are exposed to the necessary range of motion and remain in the correct alignment.

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Cites: Jimmo Settlement at pp. 11-12; MBPM, Ch. 15, § 220.2.

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**E. Inpatient Rehabilitation Facilities**

1. **Question:** Can an inpatient rehabilitation hospital (IRF) stay be covered if a patient is not able to return to his or her prior level of functioning but can achieve some improvement in function through IRF care?

**Answer:** Yes. Under the Jimmo Settlement, a Medicare beneficiary’s claim for inpatient rehabilitation hospital care cannot be denied simply because the patient is not expected to return to his or her prior level of functioning. While the IRF regulations do include a modified improvement standard, the patient must only be reasonably expected to make measurable improvement that will be of practical value to improve the patient’s functional capacity or adaptation to impairments. The expected improvement is to be accomplished within a reasonable period of time. Therefore, as long as there is a reasonable expectation that the patient can make some improvement in functional status, it is not required that the patient will not be able to return to his or her prior level of functioning.

**Example:** If a patient who required amputation of a lower limb is not expected to be able to return to her pre-amputation functional status, IRF care may still be reasonable and necessary if the rehabilitation physician believes that she will make measurable improvement of practical value.1


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1 Of course, the patient must also satisfy the other coverage criteria for IRF care in order for it to be covered. These FAQs assume that the other criteria are satisfied in each example given and, therefore, focus solely on the issues raised by the requirement for a reasonably expectation of measurable improvement.
2. **Question:** Can inpatient rehabilitation be covered for a Medicare beneficiary who is currently making improvement, but will never be able to independently care for him- or herself?

**Answer:** Yes. The *Jimmo* Settlement states that inpatient rehabilitation claims cannot be denied based simply based on the fact that a patient can never achieve complete independence with self-care. In an IRF, a patient’s medical record only needs to demonstrate a reasonable expectation that a measurable improvement will be possible within a reasonable period of time. The patient’s medical record must indicate the nature and degree of expected improvement and the expected length of time to achieve the improvement in order to properly track whether an inpatient rehabilitation stay is reasonable and necessary.

**Example:** If it is clear that a Medicare patient who has experienced a traumatic brain injury will not be able to be fully independent with self-care at the conclusion of therapy services, an IRF stay may still be medically reasonable and necessary, and covered by Medicare, if measurable improvement of practical value to the individual can be reasonably expected.

**Cites:** Jimmo Settlement at pp. 14; MBPM, Ch. 1, § 110.3.

3. **Question:** Are there different Medicare coverage standards for the amount of therapy an IRF can provide for a patient with one of the qualifying conditions under the “60% Rule” and for patients with conditions not on the 60% Rule list?

**Answer:** No. There are no distinctions between Medicare IRF coverage criteria applicable to patients with one of the 13 qualifying conditions for IRF classification versus other patients. *Jimmo* does not apply only to a particular set of diagnoses, conditions, injuries or illnesses.

**Example:** A patient with cancer of the spine (which is not one of the 60% qualifying conditions) may need inpatient rehabilitation, and Medicare coverage, to address deteriorating function in conjunction with his health issues. The premise of the *Jimmo* Settlement applies equally to such a patient as for patients who have a condition on the 60% list. The 13 qualifying conditions are intended to determine whether a hospital or unit qualifies for classification as an IRF not whether IRF care for a particular patient qualifies for Medicare coverage.

**Cites:** 42 C.F.R. §§ 412.29, 412.622(a) (3) (ii); Jimmo Settlement at p. 14; 74 Fed. Reg. at 39,793; MBPM, Ch. 1, § 110.3.

4. **Question:** Can an IRF continue to treat a patient if the patient has shown no improvement but the physician continues to believe there is a reasonable expectation that the patient will demonstrate measurable improvement?

**Answer:** Yes. In order for the patient to receive a Medicare-covered inpatient rehabilitation stay, the patient’s medical record must demonstrate ongoing and sustainable improvement that is of practical value to the patient. However, if the expectation for measurable improvement existed at the time of the patient’s admission and can realistically be documented in the medical record even after no initial improvement, it is possible the IRF stay may be covered.
Example: If a formerly independent, debilitated patient does not make measurable improvement within the first seven days of an IRF stay but the physician documents the continued expectation for measurable improvement of practical value, with support from the medical record, Medicare coverage can continue.

Cites: MBPM, Ch. 1, § 110.3; Jimmo Settlement at p. 14.

5. **Question:** If the patient does not improve at all over the entire period of his or her stay, must the entire stay be denied as a covered Medicare service?

**Answer:** No. The entire stay should not necessarily be denied coverage as long as, when the patient was admitted, the medical record demonstrated a reasonable expectation that there would be a measurable, practical improvement in the patient’s functional condition over a predetermined and reasonable period of time. If the patient does not achieve a measurable improvement by the expected period of time, and the physician no longer has an expectation that the patient would improve, any further inpatient care would no longer be covered. However, as long as there was an expectation of improvement during the inpatient stay, regardless of whether there was actual improvement at any time, the stay can be covered as necessary and reasonable.

**Example:** If a patient who had a stroke was initially determined to be appropriate for IRF care but then did not progress during the stay and was determined by the physician at the first team meeting to no longer have a reasonable expectation of improvement, subsequent days, but not the prior period, (following a reasonable amount of time to arrange for transfer or discharge) would no longer be covered.

Cites: MBPM, Ch. 1, § 110.3.

6. **Question:** Can inpatient rehabilitation continue to be covered for a Medicare beneficiary if he or she has achieved an improvement in functionality, will soon be discharged, but is undergoing instruction and observation over the last few days of their stay?

**Answer:** Yes. The Jimmo Settlement states that daily physical improvement is not required to retain covered services. This is true even in an inpatient rehabilitation setting, as the requirements for improvement are only measured over a prescribed period of time. During a long stay, many treatment plans will move from traditional therapeutic services to patient education, equipment training, and other similar instruction to prepare patients for the return home. The counseling and instruction towards getting the patient ready to go home is considered a part of the therapy and meets the end goal of enabling the patient to safely live at home.

**Example:** If a patient who had a stroke and was admitted to an IRF for treatment improves to the point of being medically and functionally ready for discharge, she may receive Medicare for several more days in the IRF if those days are necessary to counsel and instruct the patient (and his or her caregivers) regarding safely returning to home and home exercise programs or use of mobility equipment.

Cites: MBPM, Ch. 1, § 110.3

7. **Question:** Can an IRF admit a functionally impaired patient whose function is deteriorating in order to prevent further deterioration and teach the patient new skills?
Answer: Yes. Pursuant to the Jimmo Settlement, Medicare coverage for IRF care should not be denied because a patient is not expected to achieve complete independence in the domain of self-care or because a patient is not expected to return to his or her prior level of functioning. In addition, the IRF regulations state that Medicare will only cover an IRF claim if the patient is expected to make a measurable improvement that will be of practical value to improve the patient’s functional capacity or adaptation to impairments. Even though the IRF regulations require an expected measurable improvement, if the stay is for the purpose of the prevention of deterioration, the expected prevention of deterioration itself is a measurable improvement over what the patient’s function would have been if he or she had not been admitted for an inpatient stay. In addition, Medicare can be available if the patient makes an expected, measurable improvement to improve his or her adaptation to impairments. Therefore, assuming the other coverage criteria are met, the stay can be covered by Medicare.

Example: A medically compromised patient with a long-term spinal cord injury who starts to have increased difficulty performing activities of daily living despite a maintenance therapy program may be appropriate for IRF care if his physician has a reasonable expectation that inpatient therapy will prevent the patient’s further deterioration, thereby achieving measurable improvement of practical value for the patient.