

Failure to Improve Is Still Being Used, Wrongly, to Deny Medicare Coverage



Edwina Kirby, right, with her daughter Deanna at home in Livonia, Mich. After a fall that broke Edwina's leg, the Kirbys spent about \$100,000 out of pocket on a nursing facility and on at-home care afterward. Credit Laura McDermott for The New York Times

By Paula Span

- Sept. 12, 2016

Edwina Kirby was having a hard time. She had tripped over a rug in her home in Livonia, Mich., and the fall broke a femur. After she had surgery and rehabilitation, an infection sent her back into the hospital. Her kidneys failed, requiring dialysis; she was also contending with diabetes and heart disease.

By the time she entered Glacier Hills Care and Rehabilitation Center, a nursing facility in Ann Arbor, "she couldn't even feed or dress herself," said her daughter Deanna Kirby, 55. "She was basically bedridden."

For months, physical therapists worked with Mrs. Kirby, a retired civil servant who is now 75, trying to help her regain enough mobility to go home. Then her daughter received an email from one of the therapists saying, "Edwina has reached her highest practical level of independence."

Translation: Mrs. Kirby wouldn't receive Medicare coverage for further physical therapy or for the nursing home. If she wanted to stay and continue therapy, she'd have to pay the tab herself.

Medicare beneficiaries often hear such rationales for denying coverage of skilled nursing, home health care or outpatient therapy: They're not improving. They've "reached a plateau." They're "stable and chronic," or have achieved "maximum functional capacity."

Deanna Kirby wasn't buying it. "I knew they couldn't refuse you, even if you're not improving," she said.

She's right. A federal judge last month [ordered the federal Centers for Medicare and Medicaid Services](#) to do a better job of informing health care providers and Medicare adjudicators that the so-called [improvement standard](#) was no longer in effect.

What matters, as the 2013 settlement of a class-action lawsuit specified, is maintenance. Medicare must cover skilled care and therapy when they are **"necessary to maintain the patient's current condition or prevent or slow further deterioration."**

A bit of background: Because the Centers for Medicare and Medicaid Services doesn't publish statistics on why claims were denied, nobody knows how many millions of beneficiaries have been wrongly told that Medicare can't cover continued services because the patients failed to improve. But providers invoked the improvement standard so frequently that "one way or another, most people who had coverage denied were affected," said Gill Deford, litigation director of the [Center for Medicare Advocacy](#), a nonprofit legal organization.

Though never part of Medicare regulations, the improvement standard was written into the C.M.S. manuals that providers and claims administrators relied on. "It was a policy they followed for 30 years," Mr. Deford said.

The lawsuit brought by the Center for Medicare Advocacy and [Vermont Legal Aid](#) in 2011 became known as the Jimmo case, after Glenda Jimmo, an elderly Vermont plaintiff. A settlement reached in 2013 required C.M.S. to rewrite its manuals and [to begin an educational campaign to publicize the change](#).

Advocates for older adults and people with disabilities cheered; a New York Times editorial [praised the settlement](#) as "clearly the humane thing to do."

Patricia Dudek, an elder law and disability law lawyer in suburban Detroit who represented the Kirbys in their appeal, started printing out relevant sections of the settlement agreement to show nursing home and home care administrators that the improvement standard was "an old wives' tale."

Older patients with chronic and progressive diseases — dementia, Parkinson's, heart failure — are particularly vulnerable to that now-discredited criterion. They're unlikely to improve over time.

Yet therapy might help them stave off decline and hold on to their ability to function a while longer. Edwina Kirby, for instance, used a wheelchair, but hoped to be able to walk the eight steps into her bathroom at home.

By early this year, however, the Center for Medicare Advocacy was hearing from many sources that despite the settlement, providers and the contractors reviewing Medicare claims were still denying coverage when beneficiaries didn't demonstrate improvement.

"It's like saying, 'We've been holding you up, but now we're going to let you fall,'" said an exasperated Dr. Michael Wasserman, a California geriatrician and board member of the American Geriatrics

Society's [Health in Aging Foundation](#). "For a frail 95-year-old, not continuing therapy and letting her decline only leads to readmission to the hospital, readmission to skilled nursing."

The Centers for Medicare and Medicaid Services showed no inclination to take further steps, so the plaintiffs' lawyers went back to court, seeking enforcement of the agreement. The federal judge in Vermont who oversees the settlement ruled in August that C.M.S. didn't have to further revise its manuals, but did have to mount a better educational campaign.

By early next month, it has to explain how it plans to do that. A C.M.S. spokeswoman said the agency had reviewed the court's order, but would make no other comment.

Of course, patients and families [have the same right to appeal coverage denials](#) that they've always had. (A notice to this effect is buried somewhere in the paperwork they sign.) They also have the same odds of prevailing they've always had: very low, said Judith Stein, the executive director of the Center for Medicare Advocacy.

Patients generally have 72 hours to appeal, a process that involves seeking a "redetermination" and then, if that fails, a "reconsideration." If families go all the way to a hearing before an administrative law judge, Ms. Stein said, they have a good shot.

But most families don't persevere, in part because they can't afford to pay for care while the appeal proceeds. (If they do spend their own money, though, they can appeal for reimbursement.)

"It's so frustrating that families are still going through this," said Ms. Dudek, the lawyer. "They told Deanna the most ridiculous things, all this inaccurate information."

The Kirbys won their appeal, but still didn't get the full number of days of skilled nursing care and therapy Edwina Kirby was entitled to, Ms. Dudek said. As a result, the Kirbys spent about \$100,000 out of pocket on the nursing facility and on at-home care afterward.

And despite her therapist's earlier prediction, Edwina Kirby did improve. She still uses a wheelchair in her ranch-style house, but she can stand and transfer to a chair or use the toilet. She can feed herself and wash the dishes.

She goes to a dialysis center three times a week and spends much of her time crocheting afghans and watching television. She especially cherishes shopping shows on QVC and reruns of "Everybody Loves Raymond."

Deanna Kirby, who lives next door, stays with her mother a few nights a week. But most of the time, Edwina Kirby is on her own, as she wants to be.

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PAULA SPAN IS REPLYING TO COMMENTS

[Donna J commented September 13, 2016](#)



Donna J

AtlantaSept. 13, 2016

It actually does apply to hospice. We were told that Medicare would no longer pay because our family member had not died in the required six weeks. The physician who admitted our family member to the hospice was admonished by Medicare.

Paula Span commented September 13, 2016

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Paula Span

New Old Age columnist Sept. 13, 2016

Patients can indeed be discharged from hospice care, which Medicare covers, if they have stabilized and their terminal disease is no longer progressing. I wrote about this issue a few years back:

<http://newoldage.blogs.nytimes.com/2014/01/07/bounced-from-hospice/>

But the Medicare hospice benefit is separate from the skilled nursing and therapy benefit involved in the Jimmo case I discussed here.