AN INTRODUCTION TO MEDICARE HOME HEALTH COVERAGE AND APPEALS

A QUICK SCREEN TO AID IN IDENTIFYING MEDICARE COVERABLE HOME HEALTH CASES

Home Health Claims Are Suitable For Medicare Coverage, And Appeal If They Have Been Denied, If They Meet The Following Criteria:

1. A physician has signed or will sign a care plan.

2. The patient is homebound. This criterion is met if leaving home requires a considerable and taxing effort which may be shown by the patient needing personal assistance, or the help of a wheelchair or crutches, etc. Occasional but infrequent "walks around the block" are allowable. Attendance at an adult day center or religious services is not an automatic bar to meeting the homebound requirement.

3. The patient needs skilled nursing care on an intermittent basis (from as much as every day for recurring periods of 21 days - if there is a predictable end to the need for daily care - to as little as once every 60 days) or physical or speech therapy.

4. The care must be provided by, or under arrangements with, a Medicare-certified provider.

Coverable Home Health Services

If the triggering conditions described above are met, the beneficiary is entitled to Medicare coverage for home health services. There is no coinsurance or deductible. Home health services include:

1. Part-time or intermittent nursing care provided by or under the supervision of a registered professional nurse;

2. Physical, occupational, or speech therapy;

3. Medical social services under the direction of a physician and;

4. Part-time or intermittent services of a home health aid.
Advocacy Tips:

1. Medicare coverage should not be denied simply because the patient’s condition is "chronic" or “stable”. "Restorative potential" is not necessary.

2. Resist arbitrary caps on coverage imposed by the intermediary. For example, do not accept provider or intermediary assertions that aide services in excess of one visit per day are not covered, or that daily nursing visits can never be covered.

3. There is no legal limit to the duration of the Medicare home health benefit. Medicare coverage is available for necessary home care even if it is to extend over a long period of time.

4. The doctor is the patient’s most important ally. If it appears that Medicare coverage will be denied, ask the doctor to help demonstrate that the standards above are met. *Home care services should not be ended or reduced unless it has been ordered by the doctor.*

5. In order to be able to appeal a Medicare denial, the home health agency must have filed a Medicare claim for the patient's care. You should request, in writing, that the home health agency file a Medicare claim even if the agency told you that Medicare will deny coverage.
MEDICARE HOME HEALTH COVERAGE & APPEALS

INTRODUCTION

The Medicare home health benefit is a crucial source of health care financing for Medicare beneficiaries struggling to live independently in the community. When properly implemented, the Medicare home health benefit can provide coverage for necessary services, even if the patient has a chronic condition and even if the services are expected to extend over a long period of time. Increasingly, these services are the central component of long-term care, and are not one service, but a constellation of skilled and non-skilled services that allows a Medicare beneficiary to remain at home.

When Medicare coverage is unfairly denied, beneficiaries may be unable to afford the home health care they need. Unable to live safely in the community, they may be forced to enter a nursing home. Vigorous advocacy can protect these patients' rights to coverage and care.

Starting in 1998, with the implementation of Balanced Budget Act of 1997 (BBA '97), Medicare beneficiaries began experiencing increased uncertainty about the nature and extent of covered services under the Medicare home health benefit, due in large part to significant changes in the Medicare reimbursement system for home care providers that were introduced at that time.

Although the Medicare home health care benefit was thrown into turmoil with the passage of the BBA '97, leading to inappropriate terminations, denials, and reductions of necessary home health services, other aspects of the home health benefit remain unchanged, e.g., services covered and approaches to advocacy. Thoughtful, informed advocacy continues to help beneficiaries obtain the Medicare coverage to which they are entitled.
COVERAGE

Generally

The Medicare home health benefit is available under Parts A and B. The substantive coverage criteria are identical regardless of whether the beneficiary seeks coverage under Part A or Part B. As described below, however, pursuant to BBA '97, Part A coverage is sometimes limited to 100 visits and sometimes hinges on a prior hospital or skilled nursing facility stay.

Medicare provides for coverage of home health services under Parts A and B when the services are medically "reasonable and necessary," and when:5

1. The individual is confined to his or her home (or "homebound");
2. The individual needs skilled nursing care on an intermittent basis, or physical or speech therapy or, in the case of an individual who has been furnished home health services based on such a need, but no longer needs such nursing care or therapy, the individual continues to need occupational therapy;
3. A plan for furnishing the services has been established and is periodically reviewed by a physician; and
4. Such services are furnished by, or under arrangement with, a Medicare-certified home health agency (HHA).6

Coverage Concerns Specific to Part A

In addition to the coverage criteria described above, BBA '97 added a prior-institutionalization requirement, established a "home health spell of illness" benefit period, and created a 100-visit coverage limitation per spell of illness for most beneficiaries seeking coverage under Part A.7 These provisions were effective for services on or after January 1, 1998. Additional coverage for home care services that do not meet these Part A "prior-institutionalization" criteria and visit limitations is available under Part B for beneficiaries enrolled in Part A and Part B. The prior-institutionalization requirement and 100-visit limitation do not apply to individuals enrolled only in Part A or only in Part B.8

Home Health Spell of Illness Defined

The BBA '97 created and defined several new concepts applicable to the Medicare home health care benefit, these include the following:9

1. Post-institutional home health services. Defined as home health services furnished to an individual:10

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5 42 U.S.C. §1395f(a)(2)(C); 42 C.F.R. §§409.42 et seq.
6 42 U.S.C. §1395x(m).
7 42 U.S.C. §1395d.
8 42 U.S.C. §1395d.
9 42 U.S.C. §1395x.
After discharge from a hospital in which the individual was an inpatient for not less than three consecutive days before such discharge if such home health services were initiated within 14 days after the date of such discharge; or

After discharge from a skilled nursing facility in which the individual was provided post-hospital extended care services if such home health services were initiated within 14 days after the date of such discharge.

2. **Home health spell of illness.** Defined as a period of consecutive days:

- For individuals who have Part A and Part B, coverage is available under Part A for only 100 visits per spell of illness and only if the services are provided within 14 days of a prior hospital stay or a skilled nursing facility stay of any duration. (Additional services are available to these individuals under Part B.) The new home health spell of illness concept is similar to that which exists for hospital and skilled nursing facility care. It begins with the first day in which the beneficiary receives home health services and ends after the 60th consecutive day in which he or she is neither a hospital nor skilled nursing facility (SNF) patient, nor provided home health services.
- Coverage is available under Part B for all services not covered under Part A, including those provided to individuals who do not meet the prior institutional requirement and those who have received coverage for the maximum 100 visits under Part A.

3. Individuals who only have Part A will receive all coverage under Part A, with or without a prior institutionalization. Individuals who only have Part B receive all coverage under Part B.

**Home Health Services Described**

If the triggering conditions described above are satisfied, the beneficiary is entitled to Medicare coverage for home health services. Home health services include:

1. Part-time or intermittent nursing care provided by or under the supervision of a registered professional nurse;
2. Physical, occupational, or speech therapy;
3. Medical social services under the direction of a physician; and
4. Part-time or intermittent services of a home health aide.  

In practice, the requirements that a patient be confined to his or her home (usually called the "homebound" rule) and needs intermittent skilled nursing care, or physical or speech therapy, are of fundamental importance. Generally, if these preconditions can be met, the beneficiary will be able to establish eligibility for home health coverage.

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11 42 U.S.C. §1395x(m)(1)—(4).
THRESHOLD REQUIREMENTS FOR COVERAGE

The Homebound Rule

The requirement that a patient be homebound (confined to home) is described in detail in the Medicare statute as follows:

An individual shall be considered to be "confined to his home" if the individual has a condition, due to an illness or injury, that restricts the ability of the individual to leave his or her home except with the assistance of another individual or the aid of a supportive device (such as crutches, a cane, a wheelchair, or a walker), or if the individual has a condition such that leaving his or her home is medically contraindicated. While an individual does not have to be bedridden to be considered "confined to his home," the condition of the individual should be such that there exists a normal inability to leave home, that leaving home requires a considerable and taxing effort by the individual, any absence of an individual from the home attributable to the need to receive healthcare treatment, including regular absences for the purpose of participating in therapeutic, psychosocial, or medical treatment in an adult day-care program that is licensed or certified by a State, or accredited, to furnish adult day-care services in the State shall not disqualify an individual from being considered "confined to his home." Any other absence of an individual from the home shall not so disqualify an individual if the absence is of infrequent or of relatively short duration. For purposes of the preceding sentence, any absence for the purpose of attending a religious service shall be deemed to be an absence of infrequent or short duration.12

As a careful reading will disclose, the statutory definition of homebound status is ambiguous. While the statute states, for example, that a patient is considered homebound if unable to leave home "except with the assistance of another individual or the aid of a supportive device," it also states that the "condition of the individual should be such that there exists a normal inability to leave home." The question, therefore, often arises whether a patient in a wheelchair is homebound if he leaves home in a wheelchair on a regular basis. 13 Advocates often find themselves quoting one section of the statute to support such a patient's homebound status, while Medicare decision makers attempt to justify denials with different language.

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13 See also Morris v. N. Haw. Community Hosp., 37 F. Supp. 2d 1181 (D. Haw. 1999) (denying home health to a quadriplegic who could not leave his home without considerable assistance and effort would cause irreparable harm and violate the public interest in providing benefits to those who qualify for them); Richardson v. Shalala, 1995 WL 441956 (D. Vt. 1995) (three trips a week to an adult day care program shows that an individual is not homebound and can seek medical care outside the home); Dennis v. Shalala, 1994 WL 708166 (D. Vt. 1994) (infrequent trips to an adult day care program and to local supermarket held within the definition of homebound); Burgess v. Shalala, 1993 WL 327764 (D. Vt. 1993) (must consider both physical and mental effort of leaving home in determining homebound status); Labossiere v. Secretary of HHS, 1991 WL 531922 (D. Vt. 1991) (must show considerable and taxing effort in leaving the home, also must have strong evidentiary support of the nature of the assistance needed, including assistive devices); Pope v. Secretary of HHS, 1991 WL 236173 (D. Vt. 1991) (merely using a walker or wheelchair is not enough to trigger homebound status). The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), Pub. L. No. 108-173 (Dec. 8, 2003), §702, authorized a demonstration project to study and clarify the definition of homebound. Titled "Medicare Home Health Independence Demonstration," the project lasted 2 years. See <www.cms.hhs.gov/DemoProjectsEvalRpts/> (site visited Apr. 30, 2008).
Changes to the Medicare statute enacted in 2000 clarify the threshold "homebound" criteria, making clear that individuals who attend adult day care services may also qualify for Medicare home health coverage. While advocates have been widely successful in winning coverage on appeal for beneficiaries who attend day care, the law change creates the potential for coverage without appeal.

The Centers for Medicare & Medicaid Services' (CMS's) Medicare Benefit Policy (MBP) Manual, Home Health Services chapter, provides examples of homebound patients and should be of use to advocates attempting to establish homebound status. According to the manual, the following patients qualify as homebound:

- A beneficiary paralyzed from a stroke who is confined to a wheelchair or who requires the aid of crutches in order to walk;
- A beneficiary who is blind or senile and requires the assistance of another person in leaving his or her place of residence;
- A beneficiary who has lost the use of his or her upper extremities and, therefore, is unable to open doors, use handrails on stairways, etc., and, therefore, requires the assistance of another individual in leaving his or her place of residence;
- A patient with a psychiatric problem if the patient's illness is manifested in part by a refusal to leave his or her home environment or is of such a nature that it would not be considered safe for the patient to leave the home unattended, even if the patient has no physical limitations; and
- A patient in the late stages of ALS or a neurodegenerative disability.

**Skilled Nursing Care on an Intermittent Basis, or Physical or Speech Therapy**

**Generally**

The second principal criterion for home health coverage under Medicare is the requirement that the patient need skilled nursing care on an intermittent basis or physical or speech therapy. If the patient requires physical or speech therapy, the test is satisfied. More often, however, an attempt to establish home health coverage is defeated by the beneficiary's inability to show a

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14 See §703 of the MMA, creating a three-year demonstration project in five states that will provide adult day care services as part of a home health plan of care. Activity under this project was to begin in July 2006. For an update on the status of demonstration projects, see <www.cms.hhs.gov/ActiveProjectReports/> (site visited Apr. 30, 2008).


16 42 U.S.C. §1395n(a)(F), as amended by BIPA.

17 42 U.S.C. §1395f(a)(2)(C); Medicare General Information, Eligibility and Entitlement (MGIEE) Manual, CMS Pub. 100-01, Ch. 4, §30.3; MBP Manual, Ch. 7, §30.4. CMS reorganized its system of manuals with the majority of Paper-Based Manuals transitioned to Internet-Only Manuals (IOMs) in 2003. The IOMs incorporate almost all applicable manual provisions for all health care providers (Pubs. 15-1, 15-2, and 45 are the exceptions). Paper-Based Manuals and IOMs may be viewed at <www.cms.hhs.gov/manuals/> (site visited Apr. 30, 2008).
need for intermittent skilled nursing care. Either the patient requires no skilled care, or the patient requires too much skilled nursing care, exceeding the intermittent level.\(^{18}\)

### Defining Skilled Care

The MBP Manual defines skilled nursing services as those of a registered nurse or a licensed practical (vocational) nurse under the supervision of a registered nurse, necessary to treat the illness of a patient,\(^ {19}\) as defined in the regulations for SNFs.\(^ {20}\) Those regulations provide that a skilled service must be so inherently complex that it can be safely and effectively performed only by, or under the supervision of, professional or technical personnel, \(^{21}\) and include numerous examples of skilled services, such as the management of wound care or the administration of intravenous medications.\(^ {22}\)

**CMS Medicare Benefit Policy (MBP) Manual, Home Health Services, Chapter 7**

### Skilled Home Care

The MBP Manual defines skilled home health care in a way that parallels the skilled nursing facility regulations. The manual also provides numerous examples to help in determining whether patients require skilled care, including the following:\(^ {23}\)

1. A service that, by its nature, requires the skill of a licensed nurse to be provided safely and effectively continues to be a skilled service even if it is taught to the patient, the patient's family, or other caregivers. For example, wound care is a skilled service, even when it is taught to a family member.\(^ {24}\)

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\(^{18}\) In this context, the patient may require care that exceeds the part-time or intermittent requirement. Under this standard, a patient may receive skilled nursing and home health aide services furnished any number of days per week for less than eight hours per day and 28 or fewer hours each week (or, on a case-by-case basis, additional hours may be obtained with proper physician certification). Intermittent care is defined as skilled care needed or provided less than seven days a week, or less than eight hours a day for periods of 21 or fewer days. 42 U.S.C. §1395x(m) (effective Oct. 1, 1997). Note, the "part-time or intermittent" requirement must be met, as described above, in addition to the "intermittent" requirement. They are two interrelated requirements. 42 U.S.C. §1395x(m) (effective Oct. 1, 1997).

\(^{19}\) MBP Manual, Ch. 7, §40.1.2 (skilled nursing care). See also "Skilled Nursing Care under the Medicare Home Care Benefit" (Apr. 7, 1998), a memorandum to all Regional Administrators and all Medical Directors in Regional Home Health Intermediaries (RHHIs), from the directors of CMS's Chronic Care Purchasing Policy Group, CHPP, and its Program Integrity Group M. This memorandum reiterates CMS's view that observation and assessment, management of a care plan, and patient education are covered skilled care services for Medicare home care patients.

\(^{20}\) CMS has adopted, for purposes of defining skilled nursing in the home health care context, the skilled nursing examples and definitions contained in 42 C.F.R. §409.33, applicable to Medicare-certified skilled nursing facilities (SNFs). See 42 C.F.R. §409.44(b) (Dec. 20, 1994) (HHA Regulations) (effective Feb. 21, 1995). These regulations contain critical examples of skilled nursing services (§409.33(a), (b)) and are relied upon extensively by home health care providers and beneficiaries. See also note 20.

\(^{21}\) 42 C.F.R. §409.32(a) (SNF regulations).

\(^{22}\) 42 C.F.R. §409.33(a), (b) (SNF regulations). The skilled services listed in the SNF regulations include overall management and evaluation of the patient's care plan, observation and assessment of the patient's changing condition, and patient education services, as well as specific skilled treatments such as injections, tube feedings, irrigation of an indwelling Foley catheter, changing a dressing on a wound, and suctioning a tracheotomy.

\(^{23}\) MBP Manual, Ch. 7, §40.1.1.

\(^{24}\) MBP Manual, Ch. 7, §40.1.1(3).
2. A beneficiary's diagnosis should never be the sole factor in deciding that a service the beneficiary needs is either skilled or non-skilled.25

3. The determination whether a beneficiary needs skilled nursing care should 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 stable.26

4. Observation and assessment of a patient's condition constitutes a skilled nursing service when the likelihood of change in the patient's condition requires skilled nursing personnel to identify and evaluate the patient's need for possible modification of a treatment or initiation of additional medical procedures until the beneficiary's treatment regimen is essentially stabilized.27

5. Skilled nursing visits for management and evaluation of the patient's care plan are also reasonable and necessary and covered under the Medicare program where underlying conditions or complications require that only a registered nurse can ensure that essential non-skilled care is achieving its purpose, for example, the services of a skilled nurse to oversee family care-giving efforts involving clients with multiple health problems.28

6. A service is not considered a skilled nursing service merely because it is performed by or under the direct supervision of the nurse. Where a service can be safely and effectively performed by the average non-medical person, this service cannot be regarded as skilled although a skilled nurse actually provides the service.29

**Intermittent Skilled Nursing Care**

Although a need for skilled nursing care may be identified, if the patient does not also require skilled therapy, the question remains whether the patient needs *intermittent* skilled nursing care as required and defined by the statute. For many years, Medicare claims were routinely denied on the basis that the patient needed more than intermittent skilled nursing care. The meaning of the term "intermittent" was nowhere adequately described.

On August 1, 1988, the United States District Court for the District of Columbia issued a decision clarifying this point.30 This decision in *Duggan v. Bowen* establishes that intermittent means "less than daily."31 In other words, a patient will need intermittent skilled care if he or she needs skilled care visits on six or fewer days per week. If the patient requires daily skilled care on a seven-day-per-week basis, however, the patient will be found to have violated the intermittent rule, and will be considered ineligible for continued home health coverage unless the patient can show that he or she will require daily skilled care for only a relatively short time (three weeks, for example), or that the need for daily skilled care will end at a certain predictable time in the future.32

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25 MBP Manual, Ch. 7, §40.1.1(4).
26 MBP Manual, Ch. 7, §40.1.1(4).
27 MBP Manual, Ch. 7, §40.1.2.1.
28 MBP Manual, Ch. 7, §40.1.2.2.
29 MBP Manual, Ch. 7, §40.1.1(2).
31 691 F. Supp. 1487, 1511.
32 MBP Manual, Ch. 7, §50.7.
Congress, in BBA '97, amended the Medicare statute for purposes of Section 1861(m) of the Social Security Act, to define "part-time or intermittent services" as:

Skilled nursing and home health aide services furnished any number of days per week as long as they are furnished (combined) less than 8 hours each day and 28 or fewer hours each week (or subject to review on a case-by-case basis as to the need for care, less than 8 hours each day and 35 or fewer hours per week). 34

In this amendment, Congress went on to define "intermittent" for purposes of Sections 1814(a)(2)(C) and 1835(a)(2)(A) of the Social Security Act as skilled nursing care that is either provided or needed on fewer than 7 days each week, or less than 8 hours of each day for periods of 21 days or less (with extensions in exceptional circumstances when the need for additional care is finite and predictable). 37

Together, these BBA '97 amendments codified Health Care Financing Administration (HCFA, now CMS) manual standards and other internal guidelines, which have been used by providers and fiscal intermediaries for years to define the amount and frequency of home health nursing and aide services that are covered by Medicare.

Skilled Therapy

A patient's need for physical therapy services will, assuming the patient is homebound, trigger home health coverage even where the patient does not require skilled nursing services. In order to qualify, therapy must be skilled. The MBP Manual provides that the service of a physical, speech, or occupational therapist is a skilled therapy service if the inherent complexity of the service is such that it can be performed safely and/or effectively only by or under the supervision of a skilled therapist. 39 To be considered reasonable and necessary, the therapy must be consistent with the nature and severity of the illness or injury and the beneficiary's particular needs. The amount, frequency, and duration of the services must be reasonable, and the services must be considered, under accepted standards of medical practice, to be specific and effective treatment for the patient's condition. 40

Many Medicare denials are based on the lack of expectation of a significant improvement in the patient's condition within a reasonable and predictable period of time. However, "restoration potential" is not required by law, and a maintenance program can be covered if skilled services

33 42 U.S.C. §1395x(m).
34 42 U.S.C. §1395x(m).
35 See 42 U.S.C. §1395f(a) (conditions and limitations for payment).
36 See 42 U.S.C. §1395n (payment of claims of providers of service).
37 42 U.S.C. §1395x(m). CMS policy has carved out a specific exception to this requirement for insulin-dependent diabetics who cannot self-administer insulin injections and for whom no one else can be found who is willing to inject the patient: that the need for daily skilled nursing services have a predictable and finite end is not required. See MBP Manual, Ch. 7, §40.1.2.4. A.2.
38 Note that CMS is moving to the term "Medicare Administrative Contractor" as descriptive of the entity that presently performs fiscal intermediary and carrier functions.
39 MBP Manual, Ch. 7, §40.2.1.a, b.
40 MBP Manual, Ch. 7, §40.2.1.a, b.
are necessary to prevent further deterioration or preserve current capabilities. This includes visits by the therapist to provide or supervise a maintenance program. 41

The following types of skilled therapy are covered by the Medicare home health benefit:

1. Assessment by a physical therapist to determine a beneficiary's rehabilitation needs and potential, or to develop and implement a physical therapy program;42
2. Therapeutic exercises that must be taught by or under the supervision of a qualified physical therapist to ensure the safety of the beneficiary and the effectiveness of the treatment;43
3. Gait training furnished a beneficiary whose ability to walk has been impaired by neurological, muscular, or skeletal abnormality;44
4. Range of motion tests and range of motion exercises, if they are part of an active treatment for a specific disease, illness, or injury that has resulted in a loss or restriction of mobility.45

Part-Time or Intermittent Services

Once a patient has satisfied the definition of being homebound and established a need for skilled nursing care on an intermittent basis, or physical or speech therapy, home health coverage under Medicare is available for the therapy and for part-time or intermittent services of a home health aide or nurse. As discussed above, intermittent services are services delivered less than daily, that is, fewer than seven days per week. Part-time services are services delivered fewer than eight hours per day.46

Reading the part-time and intermittent standards together, a patient should be able to obtain coverage for home health aide or nursing service seven days a week but fewer than eight hours each day (part-time services), or six or fewer times a week for as many as 24 hours per day (intermittent services). In practice, however, do not assume the availability of this heavy degree of coverage on an ongoing basis. Current law and Medicare guidelines provide that coverage may be available for up to 28 hours of aide and nurse services combined each week without the necessity of special documentation. Coverage is available for aide and nurse services totaling as many as 35 hours per week if additional medical justification is shown.47 Thus, even using the government's own guidelines, application of the part-time or intermittent rule should allow for very extensive coverage of home health nursing and aide services.

Advocates should be aware that although Medicare home health coverage should be available for extended periods of care, the Medicare reimbursement system works to discourage the actual delivery of long periods of care. Fearing inadequate reimbursement, HHAs may resist serving patients who require long-term care, or numerous, or extended visits. Excuses used may include

41 42 C.F.R. §409.44(c)(2)(iii); MBP Manual, Ch. 7, §§40.2.1.C, 40.2.2.E.
42 MBP Manual, Ch. 7, §40.2.2.A.
43 MBP Manual, Ch. 7, §40.2.2.B.
44 MBP Manual, Ch. 7, §40.2.2.C.
45 MBP Manual, Ch. 7, §40.2.2.D.
47 MBP Manual, Ch. 7, §50.7.
that care is "chronic" or staff shortages exist. It is, therefore, particularly important to note that
both the federal regulations and the CMS manual state that Medicare coverage is available even
if the patient's care is to last over a long period of time.48

**CHRONIC, STABLE, AND MAINTENANCE-LEVEL PATIENTS**

Fiscal intermediaries routinely deny home health coverage to patients deemed chronic, stable, in
need of care to "maintain" their conditions, or who otherwise are not getting better or worse at a
rapid pace. As a legal matter, however, Medicare coverage is available when individuals are
confined to home and need intermittent nursing care or physical or speech therapy even if the
patient is chronically ill and the care is needed over an extended period of time. The fiscal
intermediary's own manual makes it clear that Medicare coverage may be available in such cases
and that

[t]he determination of whether a beneficiary needs skilled nursing care should 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 extend over a long period of time. In
addition, skilled care may, dependent upon the unique condition of the beneficiary, continue to
be necessary for a beneficiary whose condition is stable.49

The MBP Manual makes clear that management and evaluation of a patient's plan of care will be
considered skilled nursing in certain circumstances:

Skilled nursing visits for management and evaluation of the patient's care plan are also
reasonable and necessary where underlying conditions or complications require that only a
registered nurse can ensure that essential non-skilled care is achieving its purpose. For skilled
nursing care to be reasonable and necessary for management and evaluation of the
beneficiary's plan of care, the complexity of the necessary unskilled services which are a
necessary part of the medical treatment must require the involvement of skilled nursing
personnel to promote the patient's recovery and medical safety in view of the beneficiary's
overall condition.50

The federal regulations reiterate this important concept:

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.51

As enunciated by these sections of the Medicare Act, federal regulations, and CMS guidelines,
individuals with chronic conditions can be entitled to Medicare coverage, even if the care they
need will continue for long periods of time. Restoration should not be the decisive factor in
determining entitlement to coverage.52

48 42 C.F.R. §409.44(b)(3)(iii); MBP Manual, Ch. 7, §40.1.1. In the preamble to the final home health
prospective payment regulations CMS stated, "In order to address the needs of longer stay patients we are not
limiting the number of 60-day episode re-certifications permitted in a given fiscal year assuming a patient remains
49 MBP Manual, Ch. 7, §40.1.1.
50 MBP Manual, Ch. 7, §40.1.2.2.
51 42 C.F.R. §409.44(b)(3)(iii).
52 42 C.F.R. §409.32, incorporated into the home health regulations at 42 C.F.R. §409.44(b).
Furthermore, the United States District Court for the District of Connecticut ruled in *Fox v. Thompson* (sub nom. *Fox v. Bowen*), a federal class action concerning Medicare coverage for skilled nursing facility care, that the Secretary of HHS shall not deny Medicare coverage on the basis of "arbitrary rules of thumb." Instead, as the court ruled in *Fox*, each claimant should receive an individualized assessment of his or her need for care based on the facts and circumstances of the claimant's particular case. A particular patient with multiple sclerosis, for example, may well be homebound, require intermittent skilled nursing and/or therapy, and qualify for Medicare coverage, even though the underlying medical condition will remain.

Unfortunately, HHAs are often convinced that Medicare coverage is unavailable for patients who will not recover and for those in need of maintenance physical therapy. In order to avoid the financial penalties associated with a claim submission that will be denied by the fiscal intermediary, many agencies deny coverage in these cases themselves and decline to submit a claim unless the patient insists. Since agencies usually rely upon the CMS manual, it is particularly important to note supportive sections of the manual, and to instruct the provider that the federal regulations are clear that coverage is available even if the patient is unlikely to improve and even when the care is needed to maintain his or her condition.

**PROSPECTIVE PAYMENT SYSTEM (PPS) FOR HOME HEALTH SERVICES**

BBA '97 added a requirement to the Medicare statute that all costs for Medicare home health services be reimbursed under a prospective payment system (PPS). Final regulations to implement home health PPS were published in the Federal Register on July 3, 2000, and CMS began paying HHAs under PPS on October 1, 2000.

**What Is PPS?**

PPS is a payment system. It does not change eligibility and coverage criteria for Medicare home health benefits. Under PPS, Medicare pays a fixed rate to HHAs for the services they provide a beneficiary during a 60-day episode of care. PPS covers all home health services and non-routine medical supplies including outpatient physical therapy. PPS does not cover the cost of durable medical equipment (DME) or certain osteoporosis drugs, which are reimbursed separately.

**Determining the Amount of Payment**

Effective July 19, 1999, an HHA must use the Outcome and Assessment Information Set (OASIS) to perform an assessment of each new patient before care is provided. Information

57 42 C.F.R. §§409.43(f), 424.22(b), 484.205(a). Before PPS, a home health plan of care had to be reviewed every 62 days.
58 42 C.F.R. §§409.100(a), 410.150(b)(19), 413.1(h).
59 64 Fed. Reg. 32,984 (June 18, 1999). OASIS is a group of data elements developed under a contract for CMS to assess each home health care patient and to measure patient outcomes.
from the new assessment helps determine the appropriate payment amount under PPS for each patient. First, CMS determines a national prospective 60-day episode payment rate. The rate is then adjusted by two factors: (1) a wage index appropriate for the area in which the beneficiary receives the services, and (2) a case-mix adjuster consisting of selected data elements from OASIS plus an additional data element measuring therapy services.60 The PPS rate varies, depending upon the patient's clinical condition, functional status, and service needs.

A patient is reassessed at the end of each 60-day episode of care to ensure proper payment. The reassessment also helps determine the proper payment amount for the next episode of care if more services are needed. If a patient's care needs change substantially during the 60-day episode of care,61 or if the patient's care plan is completed earlier than expected,62 CMS may change the amount of payment. CMS may also make an additional payment if the actual costs of providing services are much greater than anticipated.63 If the patient requires four or fewer home health visits, CMS makes a low-utilization payment adjustment (LUPA), and the agency is paid on a per visit amount that changes depending on the service provided.64

**The Claims Process**

The claim submission process differs under PPS from the old fee-for-service process. PPS provides for split percentage payments.65 At the beginning of an episode of care, the HHA submits to the Medicare contractor a request for anticipated payment (RAP) for the initial percentage payment. The initial payment is 60 percent of the total PPS amount for new patients and 50 percent for ongoing patients.66 At the end of the episode the agency submits a request for the residual final payment, and is paid the remaining amount.

The initial request for payment does not constitute a Medicare claim.67 Medicare will only pay for home health services if there is a signed doctor's certificate.68 Under PPS, the RAP may be submitted without a care plan signed by a doctor. The request for payment may be based on a signed doctor's referral prescribing detailed orders or on verbal doctor's orders that are recorded in the plan of care, that include a description of the patient's condition and services to be provided, that are attested to by the nurse or therapist responsible for the care, and that are included in a plan of care that is submitted to the doctor.69 The care plan must be signed and

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60 42 C.F.R. §§484.210, 484.215, 484.220, 484.250. The PPS rate is generally more for a beneficiary who needs at least eight hours, or ten visits, of therapy services.

61 A significant change in condition (SCIC) adjustment is made if a new OASIS adjustment shows the beneficiary has a significant change in condition not anticipated in the original plan of care and the doctor certifies the new plan of care. 42 C.F.R. §§484.205(e), 484.237.

62 If a beneficiary changes agencies in the middle of a 60-day episode, or if a beneficiary is discharged after reaching her goals and then returns to the same agency during the 60-day period, the agency will receive a partial episode payment (PEP) adjustment. The agency will be paid the prorated PPS amount based on the number of days services were provided during the 60-day episode. 42 C.F.R. §§484.205(d) (partial episode adjustment), 484.235 (methodology for calculating partial episode adjustment).

63 An agency may receive an outlier payment in addition to the PPS amount if the imputed cost of the 60-day episode exceeds 113 percent of the payment amount. 42 C.F.R. §484.205(f).

64 42 C.F.R. §§484.205(c), 484.230.

65 42 C.F.R. §484.205(b)(1), (2).

66 42 C.F.R. §484.205(b).

67 Although the initial request for payment is not a claim for Medicare purposes, it is a claim for enforcement purposes. 42 C.F.R. §409.43(c)(2).

68 42 C.F.R. §424.22.

69 42 C.F.R. §409.43(c)(1).
dated by the doctor before the claim for each episode is submitted for the final percentage PPS payment.\textsuperscript{70}

**Issues Under PPS**

Under PPS, HHAs are paid based on the medical and service needs of a particular beneficiary. Nevertheless, some beneficiaries who otherwise meet the eligibility criteria for Medicare home health benefits report problems in getting services or in getting the level of services prescribed by their doctors. Beneficiaries reporting problems include people with chronic conditions and those who use a large amount of non-routine medical supplies. Problems in getting services or supplies may arise where the agency does not believe the PPS rate adequately covers its costs. Thus, though PPS is ostensibly only a payment system, it may deter some HHAs from serving certain beneficiaries. Advocates should continue to watch PPS closely to ensure that PPS does not generate the same adverse consequences as generated by the interim payment system (IPS) in effect from 1998 through September 2000.\textsuperscript{71}

**CLAIMS SUBMISSION, DETERMINATION, AND APPEAL**

**Generally**

The home health claims submission process is complex and its reimbursement system seriously impedes the granting of appropriate coverage. The sections that follow describe the procedure in detail.

**Medicare Home Health Claims Submission and Appeals Process**

**Medicare Advantage**

In the event that the home health beneficiary has enrolled in a Medicare Advantage plan, then the beneficiary will be afforded the Medicare Advantage appeal rights.

**Appeals Arising Under Parts A and B of Medicare**

Rules regarding Medicare appeals were published in the *Federal Register* on March 8, 2005 and codified at Subpart G of Part 405.\textsuperscript{72} The rules establish a combined Part A and Part B appeals process. CMS’s regulations implement the changes to the appeals process for Medicare Part A and Part B claims and implement changes to the Administrative Law Judge (ALJ) hearing process for all Medicare claims, including managed care claims and prescription drug claims.\textsuperscript{73}

\textsuperscript{70} 42 C.F.R. §409.43(c)(3).

\textsuperscript{71} Its cap on reimbursement to HHAs caused HHAs to reduce care to patients and, in many instances, to terminate services or deny admission to patients because of their diagnosis or care needs. See, e.g., Winkler v. Interim Healthcare, Inc., 36 F. Supp. 2d 1026 (D. Tenn. 1999). This problem has taken on renewed urgency in several recent CT cases, particularly where services for a chronic care patient are needed on an ongoing basis. In these situations, but for the home health care services, the patient’s chronic condition would deteriorate.

\textsuperscript{72} See 42 C.F.R. §§405.701 et seq.

\textsuperscript{73} 70 Fed. Reg. 11,420 (Mar. 8, 2005).
Congress made additional changes to the appeals process in 2003, including authorizing the transfer of ALJs from the Social Security Administration (SSA) to the HHS, and negating some of the earlier time savings by extending the time in which contractors must complete their decisions.

**Initial Determinations and Redeterminations**

As in the past, the claims process begins when the Medicare administrative contractor (MAC) (in transition from carriers and intermediaries) issues an initial determination of a claim submitted by the home health provider or, occasionally, by the beneficiary. The regulations make clear that the initial determination, which will still be issued as the Medicare Summary Notice (MSN), goes only to the beneficiary, even when the contractor is aware that the beneficiary has an appointed representative. Someone who wants to appeal from the initial determination must submit a written, signed request for a redetermination within 120 days of the initial determination; the regulations assume the notice is received 5 days after the date of the notice. Requests for redeterminations must be filed with the office indicated on the MSN; beneficiaries can no longer file requests with Social Security offices.

The regulations also allow home health providers to request appeal of a denial of an initial determination. In such a case, the contractor must consolidate the appeals. The contractor has 60 days from receipt of the redetermination request to issue a decision. If more than one party files a request, the time period runs from the date the last request is received. If, for example, a beneficiary files a redetermination request on day 1, but the home health provider files on day 50, the 60-day time period for the contractor to act starts on day 50.

Unlike the MSN (now given quarterly when there is no payment due), the notice of the redetermination is sent to a beneficiary's appointed representative. The notice explains the facts, policies and, law relied upon in making the redetermination decision; the right to request a reconsideration and the process for doing so; and a statement of specific missing documents that must be submitted. The notice states that home health providers, but not beneficiaries (unless they are represented by a provider), must submit all of their evidence at the next level of review in order for the evidence to be considered at any further stage of the appeals process. In addition, contractors are not required to send redetermination notices to multiple beneficiaries in overpayment cases brought by home health providers if the beneficiary allegedly has no liability for the claim.

The regulations create a new reopening process to be used instead of the redetermination process to correct minor errors or omissions in initial determinations. This process responds to a new section of the Medicare law that allows home health providers to correct minor mistakes without going through the appeals process. Reopenings can also be used at subsequent levels of review.

**Reconsideration**

The 2000 law created a third level of review, the reconsideration. Reconsiderations will be conducted by a new group of Medicare contractors called Qualified Independent Contractors (QICs). Beneficiaries and other parties to the redetermination have 180 days to request a reconsideration determination by filing a request at the location indicated on the redetermination notice. Again, reconsiderations filed by beneficiaries and the home health provider will be consolidated, and the time for issuing a decision runs from receipt of the last-filed appeal.
Starting May 1, 2005, appeals of redeterminations by the fiscal intermediaries, concerning home health care, go through the QIC reconsideration.

The reconsideration level of review is a paper review; CMS states clearly in the preamble to the final regulations that QICs will not be conducting hearings. However, the QIC is to solicit the view of the beneficiary. As noted above, home health providers are required to submit all of the evidence they want considered in the claim to the QIC. Evidence not submitted may be excluded at subsequent levels of review.

The QIC is to complete its reconsideration within 60 days of the reconsideration request. Again, the time frame runs from the last request filed if more than one party seeks reconsideration; the QIC must so notify a party who filed an earlier request. The regulations do not indicate how QICs are to document receipt or how beneficiaries are to know when the 60-day period ends. Although the statute allows a party to the reconsideration to ask for an extension of not more than 14 days for the QIC to conclude the reconsideration, the regulations add 14 days to the reconsideration time frame each time that additional evidence is submitted.

If a QIC does not issue a timely decision, the statute allows a party to request that the appeal be escalated to the next level of review, the ALJ level. The regulations give the QIC 5 days to either issue a decision or acknowledge the escalation request and send it to the ALJ level of review. Under the regulations, an appeal escalated to the ALJ level will be completed within 180 days of receipt, rather than the statutorily mandated 90 days for ALJ decisions.

**Summary of Expedited Appeals Process**

Effective July 2005, beneficiaries may seek expedited review of a home health service appeal. The provider must give the beneficiary a general, standardized notice at least two days in advance of the proposed end of the service. If the service is fewer than two days, or if the time between services is more than two days, then notice must be given by the next-to-last service. The notice describes the service, the date coverage ends, the beneficiary's financial liability for continued services, and how to file an appeal.

A beneficiary must request expedited review, orally or in writing, by noon of the next calendar day after receiving notice. At that time, the beneficiary is given a more specific notice that includes a detailed explanation of why services are being terminated, a description of any

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42 C.F.R. §§405.1200-405.1204, implementing 42 U.S.C. §1395ff(b)(1)(F). See CMS's Question and Answer (Q&A) paper on Expedited Determinations (ED), available at<www.cms.hhs.gov/BNI/Downloads/Revised%20ED%20Qs%20and%20As%20Mar%2017.06.pdf> (site visited Apr. 30, 2008). Notice of expedited review is not given in benefit situations (1) when the termination of covered services is the result of a beneficiary, not a provider, deciding to end coverage; (2) when termination is for reasons other than medical necessity under Medicare coverage policy; and (3) when the beneficiary requires treatment at a higher level of care, such as transfer to an acute-care hospital. 42 C.F.R. §§405.1200—405.1204. See also CMS's generic expedited determination notice, "Notice of Medicare Provider Non-Coverage," Form Number CMS-10123, and the second or detailed notice, "Detailed Explanation of Non-Coverage." Form Number CMS-10124. See <www.cms.hhs.gov/BNI/06_FFSEDNotices.asp> (site visited Apr. 30, 2008).
applicable Medicare coverage rules and information on how to obtain them, and other facts specific to the beneficiary's case. The beneficiary is not financially liable for continued services until the later of two days after receiving the notice or the termination date specified on the notice.

Expedited review is available in cases involving a discharge from the provider of services, or a termination of services where "a physician certifies that failure to continue the provision of such services is likely to place the individual's health at risk." 75 Home health services are treated as a termination of services for which a doctor's certificate of significant health risk must be provided. 76 A reduction in service is not considered a termination or discharger for purposes of triggering expedited review.

Expedited review is conducted by the Quality Improvement Organization (QIO), which has 72 hours in which to make a decision. When the QIO receives the request for review, it must contact the provider, which then must supply the QIO with information supporting its determination by the close of the same business day. The QIO must solicit the views of the beneficiary and review the notice to determine if it meets CMS requirements. The beneficiary does not incur liability if the QIO decision is delayed because the provider did not get the necessary information to the reviewer in a timely manner.

If the QIO sustains the decision to termination/discharge services, the beneficiary may request expedited reconsideration, orally or in writing, by noon of the calendar day following initial notification. The reconsideration will be conducted by the QIC, which must issue a decision within 72 hours of the request. If the QIC does not comply with the time frame, the beneficiary may escalate the case to the ALJ level.

Beneficiaries retain the right to utilize the standard appeals process rather than the new expedited process in all situations. A QIO may review an appeal from a beneficiary when the request is not timely filed, but the QIO does not have to adhere to the otherwise applicable time frame for issuing a decision, and the limitation on liability does not apply.

Claims Development and Submission

When a beneficiary desires Medicare home health coverage, the beneficiary must contact an HHA certified by Medicare, present to the HHA a physician's order for care, and request Medicare-covered services. Typically, the agency will evaluate the patient and determine whether coverage will be available for the needed care (including developing the plan of care which must be approved by the patient's physician), and determine the home health resource group (HHRG) to which the patient will be assigned under PPS. If the agency believes coverage will be granted by the fiscal intermediary (the entity, usually an insurance company, acting as Medicare's agent), the agency will submit a RAP for the first part of its payment under PPS. The agency will deliver the services and then submit a claim for coverage to the fiscal intermediary at the end of the 60-day episode to receive the final PPS payment. 77 The claims are usually submitted at two-month intervals.

76 42 C.F.R. §405.1202(a).
77 42 C.F.R. §§409.43, 424.33.
NOTICE AND APPEAL RIGHTS

The Medicare statute requires HHAs, as a condition of participation, to protect and promote the following for each individual under its care:78

1. The right to be fully informed in advance about the care and treatment to be provided by the agency, to be fully informed in advance of any changes in the care or treatment to be provided by the agency that may affect the individual's well-being, and (except with respect to an individual adjudged incompetent) to participate in planning care and treatment or changes in care or treatment;

2. The right to be fully informed orally and in writing (in advance of coming under the care of the agency) of

3. ... any change in the charges or items described in clause (i), (ii), or (iii) [services not covered by Medicare]; and

4. The right to be fully informed in writing (in advance of coming under the care of the agency) of the individual's rights and obligations under this title.

Medicare regulations also require HHAs to give their patients written and oral notice called home health advanced beneficiary notice (HHABN) concerning when Medicare will pay for services initially as well as when there is a change in expectations of Medicare payment for services.79 In addition, the Medicare Claims Processing (MCP) Manual requires HHAs to give their patients notice when the agencies deem services not covered.80 Note, however, the Manual does not require agencies to notify such patients that they can demand that a claim be submitted to Medicare, but it does require the agencies to submit such claims if the patients learn on their own about the demand bill process.81 Expedited review is also available.82 Unfortunately, these notice provisions are not monitored and enforced by CMS, and consequently HHAs have failed to provide patients with notice of denials, reductions, or

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79 42 C.F.R. §484.10(1), (2).
81 Lutwin (Healey) v. Thompson, 361 F.3d 146 (2d Cir. 2004) requires notice to beneficiaries whenever home health care is denied, reduced, or terminated. For the latest developments, it is best to consult CMS's notice initiative page periodically. The key notion is that the beneficiary is provided the medical and factual basis for a termination of services and the steps to take in order to challenge such terminations. See <www.cms.hhs.gov/BNI> (site visited Apr. 30, 2008). Home Health Beneficiary Notice, Transmittal 1025 (Aug. 11, 2006). See also 69 Fed. Reg. 69,264 (Nov. 26, 2004), adding 42 C.F.R. §§405.1200—405.1204, to implement 42 U.S.C. §1395ff(b)(1)(F). See CMS's Question and Answer (Q&A) paper on Expedited Determinations (ED), available at <www.cms.hhs.gov/BNI/Downloads/Revised%20ED%20Qs%20and%20As%20Mar%2017.06.pdf> (site visited Apr. 30, 2008).
82 Transmittal 1025.
terminations of care. As a result, beneficiaries often lack information about appeal rights, including where to file, what to file, or how best to supplement one's record in support of a claim for coverage.83 Effective March 1, 2001, HHAs must use a model notice whenever a triggering event defined by CMS occurs. Note: Lutwin (Healey) requires notice in all situations where services are denied, reduced, or terminated. Issues involving CMS's monitoring and enforcement of the notice requirement are being resolved in large part through CMS Transmittal No. 1025 (Medicare Claims Processing).84

Although theoretically there is a procedure for appealing Medicare home health terminations and reductions, several characteristics of its design render it useless for most beneficiaries. First, appeal is only permitted with respect to services actually received; second, most HHAs will not provide services after a reduction or termination; third, agencies that agree to provide services only do so if the beneficiary pays for the services pending appeal, which most beneficiaries cannot afford; and fourth, the appeal process is slow and cumbersome and decisions often come far too long after a crisis point.

Liability Protections

The liability of the patient for the cost of care is waived until he or she is informed in writing, by issuance of the HHABN, that coverage is not available. Situations exist where PPS payment has been made for the full episode. Should additional coverage be granted, for example, additional home health aide hours, but care does not increase to outlier criteria, the HHA would not receive additional payment. But they cannot charge the beneficiary for the additional cost of care.

Whenever the HHA submits a claim to the Medicare contractor, it risks a financial penalty. If the intermediary determines that the services involved should not be covered, it issues an initial determination denying the claim. The HHA may not charge the patient for the cost of services delivered until the patient is informed in writing that Medicare coverage is denied.85 Thus, the agency is forced to absorb the cost of the care involved.

If the HHA believes that coverage will be denied by the contractor, or when the agency is unsure whether coverage will be granted, it will generally seek to avoid submitting a claim in order to escape any possible financial penalty. The agency may be found liable if it failed to issue a notice or issued a defective notice. Although the beneficiary has a right to insist that a claim be submitted even where the HHA believes coverage will be denied (called a "demand bill"), often the agency will seek to discourage the patient from requiring such a no-payment claim submission because, under some circumstances, the agency may be penalized if the contractor determines that a claim should have been deemed covered initially by the agency.86

84 Lutwin (Healey), 361 F.3d (2d Cir. 2004). Note, too, that if an HHA decides to stop providing service for a reason not related to Medicare coverage (e.g., for its own financial and business reasons), such a cessation of service is not subject to appeal. The issuance of an HHABN in this circumstance is voluntary.
In many cases, this system results in a complete loss of care as well as the loss of the right to appeal. When the agency is afraid to claim coverage from the contractor, the agency usually will not deliver home health services unless the patient agrees to pay for them. If the patient is unable to afford the expensive home health care involved, the care will not be delivered even though Medicare coverage should have been granted, and could have been won on appeal had the care been delivered and a claim submitted. (Remember, the contractor will not make an initial determination on a claim until after the services involved have been rendered.)

Inappropriate restrictions on Medicare coverage can result in the complete loss of home health care, or can mean that the patient will receive less care than he or she actually needs. Ultimately, the Medicare program may pay less home health coverage, but at the cost of increased disability, patient indigence, and unnecessary institutionalization.

THE ROLE OF ADVOCACY

Advocacy in the home health arena, as in other Medicare areas, is often the key to the individual's ability to "access" services. Good advocacy allows people to be heard. It focuses on the important questions of whether the circumstances of a particular individual have been given full consideration with respect to coverage and services.

Effective advocates can include Medicare beneficiaries themselves as well as lawyers, paralegals, family members, and friends acting on the beneficiary's behalf. Effectiveness is grounded in good information about the Medicare program and in a keen appreciation of, and insistence upon, the right to be heard when services are denied, reduced, or terminated.

Advocates should develop a working knowledge of the Medicare benefit, and a good and supportive relationship with health care providers. This will ensure a broad knowledge base for advocates about the law and the relevant medical facts that must be demonstrated in order to prove eligibility for coverage and services. At the same time, this activity on behalf of a beneficiary will often educate medical providers about the basic legal requirements for Medicare coverage. This synergy is essential to effective advocacy.

HOW TO DEVELOP AN APPEAL

Sequential Approach to Case Development

Advocacy can make a crucial difference to your client's chance of success on appeal. The following approach is suggested:

1. Ascertain whether the HHA involved is certified to participate in the Medicare program.
2. Determine whether your client is homebound and whether he or she requires intermittent skilled nursing services or physical or speech therapy.
3. Ascertain whether the care billed to the Medicare program qualifies as part-time or intermittent nursing, or aide services.
4. Ensure that the home health care your client needs is delivered. The fiscal intermediary will not issue an initial determination except where a claim for payment is submitted by a certified HHA for the cost of home health services already rendered. Unfortunately, unfair Medicare coverage denials often have an un-appealable prospective effect. The
agency decides that services will henceforth not be covered by the fiscal intermediary and declines to deliver the care unless payment is forthcoming. If the patient cannot pay for the care, the care will not be delivered, and a claim will not be submitted. The patient will not be able to challenge the unfair coverage denial. It’s an advocate's first responsibility to do all h/she can to ensure that care is rendered.

There are three ways to obtain an appealable Initial Determination:

- If your client has funds sufficient to cover the cost involved, or if other public or private funds are available, urge him or her to consider paying for the care and then to file an appeal for Medicare coverage. This approach is often fruitful where there is a strong medical basis for coverage.

- If your client is unable to afford the care involved, attempt to convince the HHA to "carry" the case. That is, try to persuade the agency to deliver the care without receiving payment in advance while the claim and appeals process proceed. Your client may be required to assume liability for the cost of services in writing should Medicare coverage be denied.

- Finally, you may be able to persuade the HHA to take a chance on the claim. Especially if you can demonstrate a successful record in appeals of similar cases, the HHA may be willing to deliver the care without assurance of payment in expectation that your appeal will prove successful.

5. Provide the HHA with copies of relevant, supporting language from the federal regulations and CMS manual.

6. Request in writing that the HHA submit a claim to Medicare for all the services ordered by the patient's physician that are coverable by Medicare.

7. Solicit the written opinion of the attending physician. For care already initiated by the agency, the attending physician will have been required to sign a certification and plan-of-treatment form. You should obtain a copy of this document for review and for submission with your appeal if it is helpful.

A more detailed letter from the physician emphasizing the patient's homebound status, the need for skilled care, and the medical necessity of both the skilled care and the home health aide is often helpful. A persuasive attending physician's letter often encourages the contractor to grant the claim at the initial determination level, thereby avoiding the need for further appeal. If an appeal to the reconsideration or ALJ hearing levels is necessary, a strong and detailed attending physician's letter will often be the key to coverage in most cases.

The Patient's Care Plan as an Advocacy Tool

Care Plan Requirements

A “plan of care,” often called a care plan, is a prerequisite for Medicare coverage for home health services. The plan of care must include physician's orders as well as drug treatments and frequency, and should explain the interrelationship of other medical/social services that the
particular patient might receive, including physical therapy, or speech therapy.\textsuperscript{87} It must be signed and dated by a physician.\textsuperscript{88}

**Physician Attestation Requirement**

The plan of care must be signed by the physician before the bill for services is submitted, and any changes in the plan must be signed and dated by the physician.\textsuperscript{89} Orders for "as needed" services or "PRN" services must be accompanied by a description of the medical signs and symptoms that would occasion such visits and a specific number of visits that can be made under that order before an additional physician's order would have to be obtained, \textsuperscript{90} including oral orders.\textsuperscript{91}

**Care Plan As An Advocacy Tool**

In some instances, HHAs, without consulting with attending physicians and obtaining their consent, are notifying patients at the end of a plan-of-care period that home health services will no longer be provided. Advocates should therefore pay particular attention to both the plan of care document \textit{and} the process of its development to ensure that the physician is responsible for the plan and supports its contents. This approach may be helpful in avoiding a termination of services initiated by the HHA. Such terminations are particularly prevalent when the patient needs costly care or care that will be required for a long period of time.

**Continuing Need for Care**

Advocates must demonstrate that the beneficiary continues to meet Medicare home health criteria, including the need for skilled care services. The plan of care should include as much detail as possible, supporting the need for the specific services to be continued.

**Termination of the Care Plan**

Federal regulations provide that a plan of care is considered terminated if the beneficiary does not receive at least one covered skilled nursing, physical therapy, speech-language pathology service, or occupational therapy visit in a 60-day period, unless the physician documents that the interval without such care is appropriate. \textsuperscript{92} Medicare regulation and manual provisions anticipate at least a minimal process for recertification, \textsuperscript{93} to the extent that the physician is given an

\textsuperscript{87} 42 C.F.R. §§409.43 \textit{et seq.}

\textsuperscript{88} See 42 C.F.R. §424.22(d) (the certifying physician may not have a significant ownership interest in the HHA as defined in §424.22(d)(2)-(4), a 5 percent or more ownership interest, or financial or contractual relationship).

\textsuperscript{89} 42 C.F.R. §409.33(c). Under PPS, a signed plan of care is submitted at the end of the 60-day episode of care, and not with the initial request for anticipated payment.

\textsuperscript{90} 42 C.F.R. §409.43(b).

\textsuperscript{91} 42 C.F.R. §409.43(d).

\textsuperscript{92} 42 C.F.R. §409.43(f).

\textsuperscript{93} 42 C.F.R. §424.22(b) (recertification).
opportunity to review the plan of care, every 60 days, and sign a new care plan if services are needed. 94

**Cycle for Care Plan Review**

The plan of care should be reviewed by the physician in consultation with the professional staff of the HHA at least every 60 days under PPS. Each such review is to be signed and dated by the physician. 95 As discussed above, termination of a plan of care is often a tricky issue, especially as HHAs seek to divest themselves of their heavy care patients. Again, be sure that the patient's attending physician is in charge of the plan of care, supports its contents, and approves of any discharge from home care.

**SUMMARY AND IMPORTANT PRACTICE TIPS**

**Coverage Criteria**

Home health claims are suitable for Medicare coverage, and appeal if they have been denied, if they meet the following criteria:

1. A physician has signed or will sign a plan of care.

2. The patient is or will be homebound. This criterion is met if leaving home requires a considerable and taxing effort which may be shown by the patient needing personal assistance, or the help of a wheelchair or crutches, etc. Occasional but infrequent "walks around the block" are allowable.

3. The patient needs or will need skilled nursing care on an intermittent basis (from as much as every day for recurring periods of 21 days—if there is a predictable end to the need for daily care—to as little as once every 60 days) or physical or speech therapy.

4. The care must be provided by, or under arrangements with, a Medicare certified provider.

**Coverable Home Health Services**

If the triggering conditions described above are met, the beneficiary is entitled to Medicare coverage for home health services. There is no coinsurance or deductible. Home health services include:

1. Part-time or intermittent nursing care provided by or under the supervision of a registered professional nurse;
2. Physical, occupational, or speech therapy;
3. Medical social services under the direction of a physician; and
4. Part-time or intermittent home health aide.

94 42 C.F.R. §424.22(b) (recertification).
95 42 C.F.R. §409.43(e). See the CMS Web site for its Notice Initiative for ongoing updates to notices in the home health arena, available at <www.cms.hhs.gov/BNI/> (site visited Apr. 30, 2008). If nursing, physical therapy, or speech therapy was needed originally but ends, continued occupational therapy will allow Medicare home health coverage to continue.
Advocacy Tips

1. Medicare coverage should not be denied simply because the patient's condition is “chronic" or "stable." "Restorative potential" is not necessary.

2. Resist arbitrary caps on coverage imposed by the intermediary. For example, do not accept provider or intermediary assertions that aide services in excess of one visit per day are not covered, or that daily nursing visits can never be covered.

3. There is no legal limit to the duration of the Medicare home health benefit. Medicare coverage is available for necessary home care even if it is to extend over a long period of time.

4. The doctor is the patient's most important ally. If it appears that Medicare coverage will be denied, ask the doctor to help demonstrate that the standards above are met. Home care services should not be ended or reduced unless this has been ordered by the doctor.

5. In order to be able to appeal a Medicare denial, the home health agency (HHA) must have filed a Medicare claim for the patient's care. Request in writing that the HHA file a Medicare claim even if the agency claims that Medicare will deny coverage.

CONCLUSION

Medicare’s home health benefit is an important means of providing necessary care to beneficiaries in the community. It can make the difference between an individual being able to remain at home rather than having to enter a nursing home. The Medicare home health benefit has no cost-sharing and coverage can continue as long as the threshold criteria are met. Knowledgeable advocacy in this field is thus tremendously important.