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2016 Medicare Handbook

Chapter 4

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INTRODUCTION

The Medicare home health benefit is a crucial source of health care financing for Medicare beneficiaries who reside in their homes. 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 nonskilled services that allows a Medicare beneficiary to remain at home.

Relevant to home health care, the skilled services listed in the skilled nursing facility 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 including, but not limited to, injections, tube feedings, irrigation of an indwelling Foley catheter, changing a dressing on a wound, and suctioning a tracheotomy.

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 the Balanced Budget Act of 1997 (BBA '97),¹ 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.²

Even though 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,³ 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.

¹See The Balanced Budget Act of 1997 (BBA '97), Pub. L. No. 105-33 (Aug. 5, 1997), Title IV, Subtitle G, §§ 4601–4616 (Medicare Home Health Benefit), with significant home health care access limitations beginning in January 1998. *See § 4.05 of this Handbook.*

²Beginning in January 1998, there was an upswing in the denial, termination, and reduction of Medicare-covered home health care. Much of this was initially attributed to home health agency (HHA) fears, misunderstandings, and concerns about changes in payment and reimbursement methods established by the BBA '97.

³See BBA '97, Title IV, Subtitle G, §§ 4601–4616. *See § 4.05 of this Handbook.*

§ 4.02 COVERAGE

[A] Generally

The Medicare home health benefit is available under Parts A and B. The substantive coverage criteria are identical 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 (SNF) stay.⁴ Medicare provides for coverage of home health services under Parts A and B when the services are medically “reasonable and necessary,” and when⁵:

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;⁶ and
4. Such services are furnished by, or under arrangement with, a Medicare-certified home health agency (HHA).⁷

[B] Part A Coverage Criteria

In addition to the coverage criteria described above, BBA '97 added a prior-

⁴See 4.05 of this Handbook.

⁵42 U.S.C. § 1395f(a)(2)(C); 42 C.F.R. §§ 409.42 *et seq.*

⁶Effective for certifications made after January 1, 2010, the physician must have a face-to-face encounter with the patient before certification. See Patient Protection and Affordable Care Act of 2010 (PPACA) (also called the Affordable Care Act of 2010, or the ACA), Pub. L. No. 111-148, § 6407. This face-to-face requirement also extends to certifications for durable medical equipment. In addition, PPACA gives the Secretary of Health and Human Services (HHS) the authority to apply this face-to-face requirement to other services for which payment under the Medicare program is available based upon a finding that such a decision would reduce the risk of waste, fraud, or abuse. See PPACA, § 6407(c). Note, too, that § 6740(d) makes the face-to-face requirement as to home health care certifications applicable to the Medicaid program. See also <http://www.medicareadvocacy.org/home-health-face-to-face-physicianpractitioner-requirement-challenges/>, <http://www.cms.gov/HomeHealthPPS/Downloads/face-to-face-requirement-powerpoint.pdf>, and <http://www.cms.gov/center/hha.asp> (sites visited June 12, 2014). On June 5, 2014, the National Association for Home Care (NAHC) filed a lawsuit to challenge how the Centers for Medicare & Medicaid Services (CMS) has chosen to implement the face-to-face encounter certification requirement. NHAC claims that the CMS implementation approach inappropriately denies home health agency (HHA) payments on the basis of physician noncompliance and that the CMS implementation approach duplicates physician certification information that physicians have documented elsewhere. See <http://www.nahc.org/assets/1/7/NAHCVSEBELIUSComplaint060514.pdf> (cite visited July 21, 2014).

⁷42 U.S.C. § 1395x(m).

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.⁸ 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.⁹

[C] Home Health Spell of Illness Defined

The BBA '97 created and defined several new concepts applicable to the Medicare home health care benefit¹⁰:

1. *Post-institutional home health services.* Defined as home health services furnished to an individual¹¹:
 - 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:
 - Beginning with the first day* (not included in a previous home health spell of illness): on which such individual is furnished post-institutional home health services; and which occurs in a month for which the individual is entitled to benefits under Part A, and
 - Ending with the close of the first period of 60 consecutive days* thereafter on each of which the individual is neither an inpatient of a hospital or rural primary care hospital, nor an inpatient of a skilled nursing facility, nor provided home health services.
3. 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 SNF patient, nor provided home health services.
4. 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.
5. Individuals who *only* have Part A will receive all coverage under Part A, with or

⁸42 U.S.C. § 1395d.

⁹42 U.S.C. § 1395d.

¹⁰42 U.S.C. § 1395x.

¹¹42 U.S.C. § 1395x(tt)(1).

without a prior institutionalization. Individuals who *only* have Part B receive all coverage under Part B.

[D] 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.¹²

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.

The Medicare home health benefit is available under Parts A and B. The substantive coverage criteria are identical 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 (SNF) stay.⁴

§ 4.03 REQUIREMENTS FOR COVERAGE

[A] The Homebound Rule

The requirement that a patient is 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

¹²42 U.S.C. § 1395x(m)(1)–(4).

⁴ See § 4.05 of this Handbook.

disqualify an individual from being considered to be “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.¹³

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 often arises whether a patient in a wheelchair is homebound if he leaves home in a wheelchair on a regular basis.¹⁴ 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.

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.¹⁵ 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)

¹³See 42 U.S.C. §§ 1395f(a)(2)(C) (Part A), 1395n(a)(2)(A)(i) (Part B), and 1395n(a)(F) (further discussion of homebound criteria), as amended by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), Pub. L. No. 106-554 (Dec. 21, 2000).

¹⁴See 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 June 12, 2014).

¹⁵See MMA, § 703, 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 <http://www.cms.hhs.gov/ActiveProjectReports/> (site visited June 12, 2014).

Manual, Home Health Services chapter,¹⁶ 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;¹⁷ and
- A patient in the late stages of ALS or a neurodegenerative disability.

[B] Skilled Nursing Care on an Intermittent Basis, or Physical or Speech Therapy

[1] 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.¹⁸ 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 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.¹⁹

¹⁶See Medicare Benefit Policy (MBP) Manual, Centers for Medicare & Medicaid Services (CMS) Pub. 100-02, Ch. 7, *available at* <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c07.pdf> (site visited July 28, 2014).

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

¹⁸42 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, *available at* <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c07.pdf> (site visited July 28, 2014). 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 <http://www.cms.hhs.gov/manuals/> (site visited June 12, 2014).

¹⁹In 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 that 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).

[2] 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,²⁰ as defined in the regulations for SNFs.²¹ 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,²² and include numerous examples of skilled services, such as the management of wound care or the administration of intravenous medications.²³

[3] CMS Medicare Benefit Policy Manual, Home Health Services, Chapter 7

[a] 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 following²⁴:

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.²⁵
2. A beneficiary's diagnosis should never be the sole factor in deciding that a service the

²⁰MBP Manual, Ch. 7, § 40.1.2 (skilled nursing care), *available at* <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c07.pdf> (site visited July 28, 2014). *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.

²¹CMS 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) (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.

²²42 C.F.R. § 409.32(a) (SNF regulations).

²³42 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. *See also* the Center for Medicare Advocacy's online self-help packets and other materials for successful home health care advocacy at <http://www.medicareadvocacy.org/medicare-info/home-health-care/> (site visited June 12, 2014).

²⁴MBP Manual, Ch. 7, § 40.1.1, *available at* <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c07.pdf> (site visited July 28, 2014).

²⁵MBP Manual, Ch. 7, § 40.1.1(3), *available at* <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c07.pdf> (site visited July 28, 2014).

beneficiary needs is either skilled or non-skilled.²⁶

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.²⁷
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.²⁸
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.²⁹
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.³⁰
7. CMS, in final regulations, elaborated on the criteria for coverage of evaluation and management services when the evaluation and management of non-skilled services by a skilled nurse are considered to be a skilled service.³¹ The CMS elaboration can be seen as a tightening of the criteria. The language is as follows:

CMS provides that management and evaluation services in the home are reasonable and necessary skilled services when underlying conditions or complications are such that only a registered nurse can ensure that essential non-skilled care is achieving its purpose. To be considered a skilled service, the complexity of the necessary unskilled services that are a necessary part of the medical treatment must require the involvement of licensed nurses to promote the patient's recovery and medical safety in view of the overall condition. Where nursing visits are not needed to observe and assess the effects of the non-skilled services being provided to treat the illness or injury, skilled nursing care would not be considered reasonable and

²⁶MBP Manual, Ch. 7, § 40.1.1(4), *available at* <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c07.pdf> (site visited July 28, 2014).

²⁷MBP Manual, Ch. 7, § 40.1.1(4), *available at* <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c07.pdf> (site visited July 28, 2014).

²⁸MBP Manual, Ch. 7, § 40.1.2.1, *available at* <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c07.pdf> (site visited July 28, 2014).

²⁹MBP Manual, Ch. 7, § 40.1.2.2, *available at* <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c07.pdf> (site visited July 28, 2014).

³⁰MBP Manual, Ch. 7, § 40.1.1(2), *available at* <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c07.pdf> (site visited July 28, 2014).

³¹*See* 74 Fed. Reg. 58,133 (Nov. 10, 2009). The language of the final rule is included in 42 C.F.R. § 409.42(c)(1), effective January 1, 2010.

necessary, and the management and evaluation of the care plan would not be considered a skilled service. In some cases, the condition of the patient may cause a service that would originally be considered unskilled to be considered a skilled nursing service. This would occur when the patient's underlying condition or complication requires that only a registered nurse can ensure that essential non-skilled care is achieving its purpose. The registered nurse is ensuring that service is safely and effectively performed. However, a service is not considered a skilled nursing service merely because it is performed by or under the supervision of a licensed nurse. Where a service can be safely and effectively performed (or self-administered) by non-licensed staff without the direct supervision of a nurse, the service cannot be regarded as a skilled service even if a nurse actually provides the service. (ii) In the home health setting, skilled education services are no longer needed if it becomes apparent, after a reasonable period of time, that the patient, family, or caregiver could not or would not be trained. Further teaching and training would cease to be reasonable and necessary in this case, and would cease to be considered a skilled service. Notwithstanding that the teaching or training was unsuccessful, the services for teaching and training would be considered to be reasonable and necessary prior to the point that it became apparent that the teaching or training was unsuccessful, as long as such services were appropriate to the patient's illness, functional loss, or injury.

[b] 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.³² The decision in *Duggan v. Bowen* establishes that intermittent means “less than daily.”³³ 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.³⁴

Congress, in BBA '97, amended the Medicare statute for purposes of Section 1861(m) of the

³²*Duggan v. Bowen*, 691 F. Supp. 1487 (D.D.C. 1988). *See also* *Rizzi v. Shalala*, 1994 WL 686630 (D. Conn. 1994) (mooting the plaintiff's claim that the Secretary arbitrarily presumes that patients with a “chronic” or “stable” condition are ineligible for home health coverage. The court recognized that after *Duggan*, the HHA Manual was revised to clarify the standards that determine whether the skilled care requirement has been met).

³³*Duggan*, 691 F. Supp. 1487, 1511.

³⁴MBP Manual, Ch. 7, § 50.7, available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c07.pdf> (site visited July 28, 2014).

Social Security Act³⁵ 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).³⁶

In this amendment, Congress went on to define “intermittent” for purposes of Sections 1814(a)(2)(C)³⁷ and 1835(a)(2)(A)³⁸ 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).³⁹

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 MACs⁴⁰ for years to define the amount and frequency of home health nursing and aide services that are covered by Medicare.

[4] 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.⁴¹ 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.⁴² The issue of “improvement” and access to skilled therapy and nursing services is a

³⁵42 U.S.C. § 1395x(m).

³⁶42 U.S.C. § 1395x(m).

³⁷See 42 U.S.C. § 1395f(a) (conditions and limitations for payment).

³⁸See 42 U.S.C. § 1395n (payment of claims of providers of service).

³⁹42 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, *available at* <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c07.pdf> (site visited July 28, 2014).

⁴⁰Note that CMS has moved to the term “Medicare Administrative Contractor” (MAC) as descriptive of the entity that presently functions as what used to be called a carrier or fiscal intermediary.

⁴¹MBP Manual, Ch. 7, § 40.2.1.a, b, *available at* <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c07.pdf> (site visited July 28, 2014).

⁴²MBP Manual, Ch. 7, § 40.2.1.a, b, *available at* <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c07.pdf> (site visited July 28, 2014).

significant problem and is the subject of litigation in *Jimmo v Sebelius*.⁴³ CMS is taking the position that there has never been an “improvement standard” but, in forging a settlement with plaintiffs, has agreed to review and change language in its several manuals to make clear that improvement is not the standard for determining whether on-going skilled therapy and nursing services are necessary. The updated manuals and other CMS guidance are available as of January 2014.⁴⁴

Even as CMS says it has never had an “improvement standard,” 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 are necessary to prevent further deterioration or preserve current capabilities. This *includes* visits by the therapist to provide or supervise a maintenance program.⁴⁵

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;⁴⁶
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;⁴⁷
3. Gait training furnished a beneficiary whose ability to walk has been impaired by neurological, muscular, or skeletal abnormality;⁴⁸
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.⁴⁹

⁴³See CMS, “*Jimmo v. Sebelius* Settlement Agreement Fact Sheet,” available at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/Jimmo-FactSheet.pdf> (site visited July 28, 2014). See also *Jimmo v. Sebelius*, 2011 WL 5104355 (D. Vt. 2011).

⁴⁴See the *Jimmo* Fact Sheet, available at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/Jimmo-FactSheet.pdf> (site visited July 28, 2014) and *Jimmo*, 2011 WL 5104355. See also Center for Medicare Advocacy, “Improvement Standard and *Jimmo* News,” available at <http://www.medicareadvocacy.org/medicare-info/improvement-standard/> (site visited Aug. 12, 2014). Plaintiffs remain concerned that CMS’s implementation and education campaigns are inadequate.

⁴⁵42 C.F.R. § 409.44(c)(2)(iii); MBP Manual, Ch. 7, §§ 40.2.1.C, 40.2.2.E. Note that the parties in *Jimmo v. Sebelius*, 5:11-CV-17 (D. Vt. Jan. 18, 2011), have entered into a settlement agreement that affirms that improvement is an inappropriate standard in determining whether care for chronic conditions should be continued. See Center for Medicare Advocacy, “Improvement Standard and *Jimmo* News,” available at <http://www.medicareadvocacy.org/medicare-info/improvement-standard/> (site visited Aug. 12, 2014). Problems arise with implementation, particularly as many HHA providers are resistant to change and find the documentation requirements onerous. See Appendix 1-9. See Appendix 1-9.

⁴⁶MBP Manual, Ch. 7, § 40.2.2.A, available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c07.pdf> (site visited July 28, 2014).

⁴⁷MBP Manual, Ch. 7, § 40.2.2.B, available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c07.pdf> (site visited July 28, 2014).

⁴⁸MBP Manual, Ch. 7, § 40.2.2.C, available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c07.pdf> (site visited July 28, 2014).

⁴⁹MBP Manual, Ch. 7, § 40.2.2.D, available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c07.pdf> (site visited July 28, 2014).

[C] 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.⁵⁰

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.⁵¹ 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 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.⁵²

§ 4.04 CHRONIC, STABLE, AND MAINTENANCE-LEVEL PATIENTS

Medicare Administrative Contractors (MACs) (in transition from carriers and intermediaries) routinely deny home health coverage to patients deemed chronic, stable, or in need of care to “maintain” or “prevent deterioration”⁵³ of 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 MBP Manual makes it clear that Medicare coverage may be available in such cases and that

⁵⁰*Duggan*, 691 F. Supp. 1487, 1511.

⁵¹MBP Manual, Ch. 7, § 50.7, *available at* <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c07.pdf> (site visited July 28, 2014).

⁵²42 C.F.R. § 409.44(b)(3)(iii); MBP Manual, Ch. 7, § 40.1.1, *available at* <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c07.pdf> (site visited July 28, 2014). 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 recertifications permitted in a given fiscal year assuming a patient remains eligible for the Medicare home health benefit,” 65 Fed. Reg. 41,128, 41,140 (July 3, 2000). *See* § 4.05[D] of this Handbook.

⁵³42 C.F.R. § 409.32.

[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.⁵⁴

The MBP Manual also 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.⁵⁵

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.⁵⁶

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.⁵⁷

Furthermore, the United States District Court for the District of Connecticut ruled in *Fox v. Thompson (sub nom. Fox v. Bowen)*,⁵⁸ 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

⁵⁴MBP Manual, Ch. 7, § 40.1.1, available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c07.pdf> (site visited July 28, 2014).

⁵⁵MBP Manual, Ch. 7, § 40.1.2.2, available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c07.pdf> (site visited July 28, 2014).

⁵⁶42 C.F.R. § 409.44(b)(3)(iii).

⁵⁷42 C.F.R. § 409.32, incorporated into the home health regulations at 42 C.F.R. § 409.44(b).

⁵⁸656 F. Supp. 1236 (D. Conn. 1986).

coverage, even though the underlying medical condition will remain.⁵⁹

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 MAC, 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.

CMS issued new regulations on November 17, 2010, regarding coverage for home health services. The regulations clarify Medicare coverage for home health services, including physical therapy, occupational therapy, and speech-language pathology services.⁶⁰ The regulations became effective January 1, 2011.

Most importantly for people with long-term conditions, the regulations “clarify” that skilled care does include services that are intended to maintain a person's condition and that no “rules of thumb” should be used to deny care, including rules that require restoration potential.⁶¹ The regulations state:

“Rules of thumb” in the Medicare medical review process are prohibited....Any “rules of thumb” that would declare a claim not covered solely on the basis of elements, such as lack of restoration potential,...or degree of stability, is [sic] unacceptable without individual review of all pertinent facts.⁶²

To determine whether a service is skilled, and therefore coverable, the regulations direct decision-makers to review accepted standards of clinical practice and to consider whether a professional is needed for the service to be safe and effective for the particular beneficiary.⁶³

One of the most important aspects of the revised home health coverage regulations includes a more detailed explanation of when Medicare covers establishment or performance of therapy in

⁵⁹Smith v. Shalala, 855 F. Supp. 658 (D. Vt. 1994); Bergeron v. Shalala, 855 F. Supp. 665 (D. Vt. 1994). See also Prendergast v. Leavitt, No. 08-cv-1148 (D. Conn. Aug. 1, 2008), which held that it is inappropriate for a Managed Care plan to terminate services for a chronically ill patient who is not likely to improve but needs services to maintain or to slow the deterioration of her chronic condition. A similar case was filed in Vermont, Anderson v. Leavitt, No. 09-cv-16 (D. Vt., filed Jan. 16, 2009). The Center for Medicare Advocacy continues to pursue the revision and clarification of CMS policy. Across various disciplines, CMS continues to countenance the inappropriate termination of medically necessary services on the grounds that a patient is not improving. See Gill Deford, Margaret Murphy, & Judith Stein, *How the “Improvement Standard” Improperly Denies Coverage to Medicare Patients with Chronic Conditions*, Clearinghouse Review, Vol. 43, No. 9-10, Jan-Feb. 2010. Litigation is likely the next step in resolving this egregious problem. See also Jimmo, 5:11-CV-17. The parties have entered into a settlement agreement. See Center for Medicare Advocacy, “Improvement Standard and Jimmo News,” available at <http://www.medicareadvocacy.org/medicare-info/improvement-standard> (site visited June 12, 2014).

⁶⁰75 Fed. Reg. 70,461 (Nov. 17, 2010), amending 42 C.F.R. § 409.44(c) (effective Jan. 1, 2011).

⁶¹75 Fed. Reg. 70,395 (Nov. 17, 2010), 42 C.F.R. § 409.44(c)(2)(iii)(C).

⁶²75 Fed. Reg. 70,395 (Nov. 17, 2010).

⁶³42 C.F.R. § 409.44(c)(2)(i).

the context of a maintenance program. The regulation states:

The unique clinical condition of a patient may require the specialized skills of a qualified therapist to perform a safe and effective maintenance program required in connection with the patient's specific illness or injury. When the clinical condition of the patient is such that the complexity of the therapy services required to maintain function involve the use of complex and sophisticated therapy procedures...by the therapist...or the clinical condition of the patient is such that the complexity of the therapy services required to maintain function must be delivered by the therapist...to ensure the patient's safety and to provide an effective maintenance program, then those reasonable and necessary services shall be covered.⁶⁴

The Center for Medicare Advocacy, with Vermont Legal Aid and others, filed litigation in Vermont⁶⁵ against the Secretary of Health and Human Services (HHS) to assure the broadest possible application of the rule that improvement is not required to receive care for one's chronic condition. In *Jimmo*, following plaintiffs' successful efforts in defeating defendant's motion to dismiss, the parties entered into a settlement agreement in which the defendant agreed to revise its various manuals to clarify that the so-called improvement standard is inappropriate and that it has never been CMS's policy. Presently, the parties are in the final stages of reviewing defendant's manual changes and began an educational campaign in 2014 to educate providers, beneficiaries, and others about the correct standard applicable to the review of the need for ongoing therapies for chronic conditions.⁶⁶ This effort thus far has been only minimally successful. The parties are in discussion about additional educational efforts.

§ 4.05 PROSPECTIVE PAYMENT SYSTEM 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).⁶⁷ Final regulations to implement home health PPS were published in the *Federal Register* on July 3, 2000,⁶⁸ and CMS began paying HHAs under PPS on October 1, 2000.

⁶⁴42 C.F.R. § 409.44(c)(2)(iii)(C).

⁶⁵The Center for Medicare Advocacy and co-counsel from Vermont Legal Aid filed a class action lawsuit on January 18, 2011, against Kathleen Sebelius, the Secretary of HHS, aimed at terminating the application of the Medicare improvement standard (*Jimmo v. Sebelius*, 2011 WL 5104355 (D. Vt. 2011)). Opinion and Order in **Jimmo v. Sebelius**, denying in part and granting in part defendant's motion to dismiss for lack of subject matter jurisdiction and denying defendant's motion to dismiss for failure to state a claim, was entered on October 25, 2011. The opinion and order allow plaintiffs' case to move forward. *See also* Center for Medicare Advocacy, "Federal Judge Refuses to Dismiss Medicare Beneficiaries' Challenge to the Medicare 'Improvement Standard,'" *available at* <http://www.medicareadvocacy.org/federal-judge-refuses-to-dismiss-medicare-beneficiaries-challenge-to-the-medicare-improvement-standard-2/> (site visited June 12, 2014).

⁶⁶An extensive discussion of "improvement standard" concerns, including self-help materials and the CMS Fact Sheet on the *Jimmo* settlement can be found at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/Jimmo-FactSheet.pdf> (site visited June 12, 2014) and at <http://www.medicareadvocacy.org/medicare-info/improvement-standard/> (site visited June 12, 2014).

⁶⁷*See* 42 U.S.C. § 1395ff.

⁶⁸65 Fed. Reg. 41,128 (July 3, 2000).

[A] 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.⁶⁹ 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.⁷⁰

[B] 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.⁷¹ Information 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.⁷² 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.

⁶⁹42 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. For ongoing updates on home health PPS, see <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/index.html?redirect=/homehealthpps/> (site visited June 12, 2014).

⁷⁰42 C.F.R. §§ 409.100(a), 410.150(b)(19), 413.1(h). Note that most durable medical equipment (DME) is now subject to cost limitations associated with Medicare's competitive bidding program for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS). See CMS, "DMEPOS Competitive Bidding—Home," available at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSCompetitiveBid/index.html?redirect=/dmeuposcompetitivebid/> (site visited June 12, 2014). CMS continues to roll out the congressionally mandated DMEPOS competitive bidding program.

⁷¹64 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. See also 42 C.F.R. § 484 (effective June 21, 2006, requiring home health agencies to report electronically data from the Outcome and Assessment Information Set (OASIS) as a Condition of Participation). Updates on OASIS are available at <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/index.html?redirect=/homehealthqualityinits/> (site visited June 12, 2014).

⁷²42 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.

If a patient's care needs change substantially during the 60-day episode of care,⁷³ or if the patient's care plan is completed earlier than expected,⁷⁴ 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.⁷⁵ 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.⁷⁶

[C] The Claims Process

The claim submission process differs under PPS from the old fee-for-service process. PPS provides for split percentage payments.⁷⁷ 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.⁷⁸ 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.⁷⁹ Medicare will pay for home health services only if there is a signed doctor's certificate.⁸⁰ The current regulations state that a physician must have a face-to-face encounter with the patient seeking home health care either 90 days before or 30 days after the request for home health care services.⁸¹ The certification

⁷³A 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, 408.240 (outlier payments).

⁷⁴If a beneficiary changes agencies in the middle of a 60-day episode, or if a beneficiary is discharged after reaching his or 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).

⁷⁵An 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).

⁷⁶42 C.F.R. §§ 484.205(c), 484.230.

⁷⁷42 C.F.R. § 484.205(b)(1), (2).

⁷⁸42 C.F.R. § 484.205(b).

⁷⁹Although 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).

⁸⁰42 C.F.R. § 424.22. The requirement that there be a physician's certification has posed problems for beneficiaries accessing home health services. Doctors are frustrated with the requirements for certification and the complex process. It is often difficult to get physicians to dedicate time for this necessary certification. For more information, see Center for Medicare Advocacy, "Home Health Face to Face Physician/Practitioner Requirement Challenges," *available at* <http://www.medicareadvocacy.org/home-health-face-to-face-physicianpractitioner-requirement-challenges/> (site visited June 12, 2014).

⁸¹42 C.F.R. § 424.22(a)(1)(v).

must state why the patient requires home health care, including a statement that the patient is homebound and needs intermittent skilled nursing care.⁸² A physician's assistant, nurse practitioner, state licensed midwife, or clinical nurse specialist can complete the certification under the supervision of a physician.⁸³ If a visit with the doctor occurred 90 days before home health services started but was not related to the certification, the doctor must complete the certification within 30 days of the start of the services.⁸⁴ The face-to-face patient encounter may occur via telemedicine.⁸⁵

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.⁸⁶ The care plan must be signed and dated by the doctor before the claim for each episode is submitted for the final percentage PPS payment.⁸⁷

On June 5, 2014, the National Association for Home Care & Hospice, Inc. (NAHC) filed a law suit about the implementation of the face-to-face requirement.⁸⁸ Plaintiff NAHC represents the interests of various home health agencies around the country. The lawsuit alleges that the Defendant Secretary of Health and Human Services and the Administrator for CMS have, contrary to the Affordable Care Act (ACA), “added unauthorized physician documentation” requirements for physicians who must certify that Medicare beneficiaries receiving home health services have had a face-to-face encounter with a physician either 90 days before Medicare home health coverage begins or within 30 days of the start of Medicare-covered home health care. Plaintiff states that the defendants have “devised and administered [...] physician documentation requirements in a way that renders it nearly impossible to achieve compliance”; that the unauthorized requirements are incomprehensible to physicians, home health agencies, and patients. Additionally, the plaintiff alleges that the defendants’ unauthorized requirements state that a physician must give an in-depth explanation of why the patient is homebound, while ignoring the patient’s general health care record and the physician’s medical findings and conclusions that the patient is homebound and in need of Medicare-covered home health care. Plaintiff alleges that the defendants’ unauthorized requirements are baffling and create both major impediments for Medicare patients to access services and hurdles for Medicare-participating HHAs to receive payment. Plaintiff seeks to enjoin the defendants’ allegedly unlawful requirements for physician documentation and an order and judgment requiring the defendants to “promulgate and administer reasonable, consistent and comprehensible documentation requirements” with which physicians, beneficiaries, and home

⁸²42 C.F.R. § 424.22(a)(1)(v).

⁸³42 C.F.R. § 424.22(a)(1)(v).

⁸⁴42 C.F.R. § 424.22(a)(1)(v).

⁸⁵42 C.F.R. § 424.22(a)(1)(v)(C). For an extensive set of Q&As prepared by CMS on the face-to-face requirement, see <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/Downloads/QandAsFull-5-4-12.pdf> (site visited June 12, 2014).

⁸⁶42 C.F.R. § 409.43(c)(1).

⁸⁷42 C.F.R. § 409.43(c)(3).

⁸⁸*See* National Ass’n for Home Care & Hospice v. Sebelius, Civ. No. 1:14-cv-00950 (D.D.C. June 5, 2014). A copy of the complaint is available at <http://www.nahc.org/assets/1/7/NAHCVSEBELIUSComplaint060514.pdf> (site visited July 24, 2014).

health agencies can more easily comply.

[D] Issues Under PPS

Under PPS, HHAs are paid based on the medical and service needs (home health resource utilization groups, or HHRUGs) 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, although 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 2000.⁸⁹

§ 4.06 CLAIMS SUBMISSION, DETERMINATION, AND APPEAL

[A] 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.

[B] Medicare Home Health Claims Submission and Appeals Process

[1] 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.⁹⁰

[2] 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 405.⁹¹ 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

⁸⁹The PPS 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 Connecticut 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. Note that CMS is using the vehicle of a PPS rate announcement to introduce its proposed change to its observation and management regulations. The rates for 2014 are available at <http://www.gpo.gov/fdsys/pkg/FR-2013-12-02/pdf/2013-28457.pdf> (site visited June 12, 2014).

⁹⁰*See* § 7.04[G] of this Handbook. *See* the Center for Medicare Advocacy's home health "self help" packet for a compilation of materials, available at <http://medicareadvocacy.org/InfoByTopic/HomeHealth/HHSelfHelpPacket.03.2011.pdf> (site visited June 12, 2014).

⁹¹*See* 42 C.F.R. §§ 405.701 *et seq.*

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.⁹²

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.

[3] Initial Determinations and Redeterminations

As in the past, the claims process begins when the MAC 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 five 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.⁹³ 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

⁹²70 Fed. Reg. 11,420 (Mar. 8, 2005). *See* final regulations (non-expedited appeals) at <http://www.gpo.gov/fdsys/pkg/CFR-2011-title42-vol2/pdf/CFR-2011-title42-vol2-part405-subpartI.pdf> (site visited June 12, 2014), authorized by 42 U.S.C. §§ 1395ff, codified at 42 C.F.R. §§ 405.900 *et seq.* (Subpart I—Determinations, Redeterminations, Reconsiderations, and Appeals under Original Medicare process. *See also* Center for Medicare Advocacy, “CMS Issues Final Rules for Medicare Appeals,” available at http://medicareadvocacy.org/InfoByTopic/Reform/10_01.14.AppealsChanges.htm (site visited June 12, 2014), for a discussion of the changes. For the most part, the final regulations track the interim final regulations discussed in this chapter. In general, the regulations refer to “calendar” days unless otherwise specified.

⁹³Examples of CMS’s revised MSNs are available at http://www.cms.gov/apps/files/msn_changes.pdf;
<http://www.medicare.gov/pubs/pdf/SummaryNoticeA.pdf> (Part A);
<http://www.medicare.gov/pubs/pdf/SummaryNoticeB.pdf> (Part B); and
<http://www.medicare.gov/pubs/pdf/SummaryNoticeDME.pdf> (DME).

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.

[4] 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.

Since May 1, 2005, appeals of redeterminations by MACs, 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 five 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.⁹⁴

⁹⁴For a discussion of escalation and the appeals process, see CMS, “Third Level of Appeal: Hearing by an Administrative Law Judge,” *available at* <http://www.cms.gov/Medicare/Appeals-and-Grievances/OrgMedFFSAppeals/HearingsALJ.html> (site visited June 12, 2014).

[C] Summary of Expedited Appeals Process

Beneficiaries may seek expedited review of a home health service appeal.⁹⁵ 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 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.”⁹⁶ Home health services are treated as a termination of services for which a doctor's certificate of significant health risk must be provided.⁹⁷ A reduction in service is not considered a termination or discharge 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 whether 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

⁹⁵42 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* <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/Downloads/QandAsFull-5-4-12.pdf> (site visited June 12, 2014). Notice of expedited review is not given in benefit situations (1) when the termination of covered services is the result of a beneficiary's, not a provider's, decision 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 June 12, 2014).

⁹⁶42 U.S.C. § 1395ff(b)(1)(F).

⁹⁷42 C.F.R. § 405.1202(a).

to the reviewer in a timely manner.

If the QIO sustains the decision to terminate/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.

[D] 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 that must be approved by the patient's physician) and determine the home health resource utilization group (HHRUG) to which the patient will be assigned under PPS. If the agency believes coverage will be granted by the MAC (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 MAC at the end of the 60-day episode to receive the final PPS payment.⁹⁸ The claims are usually submitted at two-month intervals.⁹⁹

[E] Notice and Appeal Rights in Home Health Care

The Medicare statute requires HHAs, as a condition of participation, to protect and promote the following for each individual under its care¹⁰⁰:

- (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—
 - 1....(iv) any change in the charges or items described in clause (i), (ii), or (iii) [services not covered by Medicare]; and
- (3) The right to be fully informed in writing (in advance of coming under the care of the agency)

⁹⁸42 C.F.R. §§ 409.43, 424.33.

⁹⁹For a discussion of developing a Medicare Home Health Appeal, see Center for Medicare Advocacy, "An Introduction to Medicare Home Health Coverage and Appeals," *available at* http://www.medicareadvocacy.org/Projects/AdvocatesAlliance/IssueBriefs/09_08.10.HomeHealthCoverage.pdf (site visited June 12, 2014).

¹⁰⁰42 U.S.C. § 1395bbb(a)(1).

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.¹⁰¹ In addition, the Medicare Claims Processing (MCP) Manual requires HHAs to give their patients notice when the agencies deem services not covered.¹⁰² Note, however, that 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.¹⁰³ Expedited review is also available.¹⁰⁴

Unfortunately, these notice provisions are not monitored and enforced by CMS as extensively as needed, and consequently HHAs often fail to provide patients with notice of denials, reductions, or 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.¹⁰⁵ Effective March 1, 2001, HHAs are required to use a model notice whenever a triggering event defined by CMS occurs. Note that *Lutwin (Healey) v. Thompson* 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).¹⁰⁶

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 permitted only 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

¹⁰¹42 C.F.R. § 484.10(1), (2).

¹⁰²Medicare Claims Processing (MCP) Manual, CMS Pub. 100-04, Ch. 10, § 50, *available at* www.cms.hhs.gov/manuals/downloads/clm104c10.pdf (site visited June 12, 2014).

¹⁰³*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* <http://www.cms.gov/Medicare/Medicare-General-Information/BNI/Downloads/ABNdownloads2013.zip> (site visited June 12, 2014). *See also* **Appendix 4-7 of this Handbook**, 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).

¹⁰⁴The use of expedited review is discussed in **Appendix 4-7**, of this Handbook, Transmittal 1025.

¹⁰⁵Program Memorandum (PM) A-01-30 (Feb. 28, 2001), reissued as PM A-02-017 (Feb. 26, 2002); PM A-01-05 (Jan. 16, 2001), reissued as PM A-02-018 (Feb. 26, 2002); *Healey v. Thompson*, 186 F. Supp. 2d 105 (D. Conn. 2001).

¹⁰⁶*Lutwin (Healey)*, 361 F.3d. 146. 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. *See* **Appendix 4-7 of this Handbook**, including the discussion of “option box 2” in § 60-4. In addition, the issuance of an HHABN in this circumstance is voluntary. *See also* CMS, “FFS HHABN,” *available at* <http://www.cms.gov/Medicare/Medicare-General-Information/BNI/HHABN.html> (site visited July 21, 2014).

afford; and fourth, the appeal process is slow and cumbersome and decisions often come far too long after a crisis point.¹⁰⁷

[F] 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.¹⁰⁸ 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 MAC 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.¹⁰⁹ 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.¹¹⁰

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

¹⁰⁷For a discussion of developing and pursuing an appeal of a home health care denial, see Center for Medicare Advocacy, “An Introduction to Medicare Home Health Coverage and Appeals,” *available at* http://www.medicareadvocacy.org/Projects/AdvocatesAlliance/IssueBriefs/09_08.10.HomeHealthCoverage.pdf (site visited June 12, 2014).

¹⁰⁸See MCP Manual, Ch. 30, *available at* <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c30.pdf> (site visited July 21, 2014).

¹⁰⁹42 C.F.R. §§ 411.400–411.406.

¹¹⁰See The Intermediary Manual, CMS Pub. 13, Part 3—Claims Process, § 3439.3, *available at* <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1798A3.pdf> (site visited June 12, 2014). See **Appendix 4-1 of this Handbook**; see also **Appendix 4-7** for CMS's most recent treatment of “notice triggering” events. On February 14, 2012, Ch. 30, § 60 of the Medicare Claims Processing Manual on HHABN policy and issuance was revised. See Change Request (CR) 7323, which implements revised section instructions for the Home Health Beneficiary Notice of Non-coverage (HHABN), Form CMS-R-296, Ch. 30, § 60. Effective February 3, 2012, the revised section, as published in CR 7323, replaced the previous version (CR 5009) published Aug. 11, 2006, in the Medicare Claims Processing Manual. CMS has issued a revised HHABN that is mandatory for use on or after April 1, 2011. See the instruction sheets *available at* <http://www.cms.gov/Medicare/Medicare-General-Information/BNI/Downloads/ABNdownloads2013.zip> (site visited June 12, 2014).

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.

§ 4.07 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.

§ 4.08 HOW TO DEVELOP A WINNING APPEAL

[A] 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 MAC 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 MAC 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. Accordingly, it is the advocate's first duty to make sure that care is rendered.

Three ways to obtain an appealable initial determination are:

- a. 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.
 - b. 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.
 - c. 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.

[B] The Patient’s Plan of Care as an Advocacy Tool

[1] Plan-of-Care Requirements

A plan of care 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.¹¹¹ It must be signed and dated by a physician.¹¹²

¹¹¹42 C.F.R. §§ 409.43 *et seq.*

¹¹²*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).

[2] Physician Attestation Required

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.¹¹³ 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,¹¹⁴ including oral orders.¹¹⁵

[3] Plan of Care as 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 *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.

[4] 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.

[5] Termination of the Plan of Care

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.¹¹⁶ Medicare regulation and manual provisions anticipate at least a minimal process for recertification,¹¹⁷ to the extent that the physician is given an opportunity to review the plan of care, every 60 days, and sign a new care plan if services are needed.¹¹⁸

[6] Cycle for 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

¹¹³42 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.

¹¹⁴42 C.F.R. § 409.43(b).

¹¹⁵42 C.F.R. § 409.43(d).

¹¹⁶42 C.F.R. § 409.43(f).

¹¹⁷42 C.F.R. § 424.22(b) (recertification).

¹¹⁸42 C.F.R. § 424.22(b) (recertification).

physician.¹¹⁹ 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.

[C] Identifying Coverable Home Health Cases

The lists provided in the following sections can be used as a quick reference aid to help identify coverable home health claims.

[1] 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.

[2] 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. To the extent permitted in regulations, part-time or intermittent services of a home health aide.

[3] Additional Hints for Coverage

1. Medicare coverage should not be denied simply because the patient's condition is “chronic” or

¹¹⁹42 C.F.R. § 409.43(e). See the CMS website for its Notice Initiative for ongoing updates to notices in the home health arena, *available at* <http://www.cms.gov/Medicare/Medicare-General-Information/BNI/> (site visited June 12, 2014). If nursing, physical therapy, or speech therapy was needed originally but ends, continued occupational therapy will allow Medicare home health coverage to continue.

“stable.” “Restorative potential” is not necessary.

2. Resist arbitrary caps on coverage imposed by the MAC. For example, do not accept provider or MAC 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 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.