



—Toolkit —

Medicare Home Health Coverage And *Jimmo v. Sebelius*

1. Introduction

Medicare home health coverage can be an important resource for people with long-term and chronic conditions who need care at home. Contrary to common belief, Medicare home health coverage is not just a short-term, acute care benefit. In fact, under the law, Medicare beneficiaries who meet the threshold qualifying criteria are eligible for home health coverage so long as skilled care is reasonable and necessary. There are six threshold requirements for Medicare home health coverage:

- 1. The beneficiary must be homebound. (This requirement means it is difficult, or counter-indicated, for the individual to leave home alone, he/she does so infrequently, or for medical or certain other allowed purposes. The requirement does <u>not</u> mean that a beneficiary can never leave home);
- 2. The beneficiary must require skilled nursing care on an intermittent basis, physical therapy, speech language pathology services, or, in some instance, occupational therapy;
- 3. A physician must order the care to be provided by the home health agency, sign and certify a "Plan of Care;"
- 4. A physician, or a recognized non-physician health care professional, must have a face-to-face meeting with the beneficiary prior to certifying his/her need for home health care;
- 5. A document about the face-to-face meeting, signed by a physician, must be included in the home health care certification; and
- 6. The home health agency must be a Medicare-certified provider.

Unfortunately, home health agencies and Medicare Contractors continue to deny Medicare home health coverage, and/or access to care, even for patients who meet these coverage criteria. Too often beneficiaries are told Medicare will not cover skilled nursing or therapy services because they have "plateaued," or are "chronic," or "stable," or lack potential for improvement. These denials, based on an erroneous "Improvement Standard," violate the Court-approved settlement agreement in *Jimmo v. Sebelius*, No. 11-cv-17 (D. VT).

Jimmo is a nationwide class-action lawsuit brought on behalf of Medicare beneficiaries who received care in home health, skilled nursing facilities, and outpatient therapy settings and who were denied Medicare coverage on the basis that they were not improving or did not demonstrate

a potential for improvement. The U.S. District Court for the District of Vermont approved the Settlement between the plaintiffs and the Centers for Medicare & Medicaid Services (CMS) on January 24, 2013. Under the terms of the *Jimmo* Settlement, CMS was required to revise the Home Health and other relevant chapters of the Medicare Benefit Policy Manual, to eliminate any misleading suggestion that a beneficiary must show improvement to qualify for Medicare and to confirm that the need for skilled care is the determinative factor for coverage.

As a result of the *Jimmo* Settlement, Medicare policy now clearly states that coverage,

"... does not turn on the presence or absence of a beneficiary's potential for improvement, but rather on the beneficiary's need for skilled care. Skilled care may be necessary to improve a patient's condition, to maintain a patient's current condition, or to prevent or slow further deterioration of the patient's condition." (CMS Transmittal 179, Pub 100-02, 1/14/2014).

2. Unfair Medicare Denials Still Happen

Unfortunately, the Center still hears from Medicare beneficiaries and their families about Medicare home health denials based on some variation of the Improvement Standard. These stories often echo the story of Glenda Jimmo, the lead plaintiff in the "Improvement Standard" case. Ms. Jimmo was blind and her right leg had been amputated due to complications from diabetes, along with other conditions. She required a wheelchair, home health nursing, and aides to care for her multiple on-going medical conditions. However, Medicare denied coverage for her home care on the grounds that she would not improve.

Ms. Jimmo's story was just one example of tens of thousands. However, as a result of her lawsuit, the *Jimmo* Settlement should provide protection for <u>all</u> Medicare beneficiaries with long-term and debilitating conditions. The Settlement means that no Medicare beneficiary should be denied coverage for maintenance nursing or therapy provided by a **home health agency** (or by a skilled nursing facility, or outpatient therapy entity) when skilled personnel must provide or supervise the care in order for it to be safe and effective.

Medicare-covered skilled care includes care that improves <u>or</u> maintains <u>or</u> slows decline of a patient's condition. Medicare coverage decisions should hinge on the need for such skilled care, and in meeting the various specific level-of-care criteria (such as being homebound for home health coverage). Coverage should <u>not</u> be denied because an individual has an underlying condition that won't get better (such as MS, paralysis, ALS, diabetes, or Parkinson's disease).

3. Using This Toolkit

The Center for Medicare Advocacy provides this Toolkit to help Medicare beneficiaries, their families and advocates respond to unfair Medicare denials. The Toolkit includes self-help materials to advocate for home health care that has been denied by providers, Medicare Advantage plans, and/or traditional Medicare.

The Toolkit contains the following, to help obtain or restore Medicare when coverage is denied:

A. Official information About Jimmo and Medicare Home Health Coverage

- 1. An Important Message about the Jimmo Settlement from Medicare's website, CMS.gov
- 2. The Jimmo Settlement Agreement
- 3. Jimmo Fact Sheet from Medicare's website, CMS.gov
- 4. Medicare's Home Health Services Benefit Policy Manual Chapter 7
- 5. Medicare & Home Health Care from Medicare.gov
- 6. Frequently Asked Questions, from Medicare's website, CMS.gov
- 7. Medicare Appeals Booklet from Medicare.gov

B. Information from the Center for Medicare Advocacy

- 1. Medicare Home Health Coverage Booklet
- 2. Medicare Home Health Coverage Flowchart
- 3. Medicare Home Health Coverage is Not a Short-Term, Acute Care Benefit
- 4. Medicare Home Health Hot Topics
- 5. Frequently Asked Questions
- 6. Self-Help Packet for Home Health Appeals (Including for "Improvement Standard" Denials)
- 7. Sample Letters for Skilled Care Professionals to Support Medicare Coverage

8. Conclusion

Although challenging a Medicare denial may seem daunting, beneficiaries and their representatives <u>can</u> win appeals when equipped with the right information. The Center for Medicare Advocacy hopes this Toolkit provides that information, to help beneficiaries, families, and advocates fight for fair Medicare coverage.

As always, the Center for Medicare Advocacy will continue working to ensure that Medicare beneficiaries receive the Medicare coverage they qualify for under the law – and the care they need.

Let us know if we can provide further guidance.

Center for Medicare Advocacy February 2018



Important Message about the Jimmo Settlement (www.CMS.gov)



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Jimmo Settlement

Important Message About the Jimmo Settlement

The Centers for Medicare & Medicaid Services (CMS) reminds the Medicare community of the *Jimmo* Settlement Agreement (January 2013), which clarified that the Medicare program covers skilled nursing care and skilled therapy services under Medicare's skilled nursing facility, home health, and outpatient therapy benefits when a beneficiary needs skilled care in order to maintain function or to prevent or slow decline or deterioration (provided all other coverage criteria are met). Specifically, the *Jimmo* Settlement Agreement required manual revisions to restate a "maintenance coverage standard" for both skilled nursing and therapy services under these benefits:

Skilled nursing services would be covered where such skilled nursing services are necessary to maintain the patient's current condition or prevent or slow further deterioration so long as the beneficiary requires skilled care for the services to be safely and effectively provided.

Skilled therapy services are covered when an individualized assessment of the patient's clinical condition demonstrates that the specialized judgment, knowledge, and skills of a qualified therapist ("skilled care") are necessary for the performance of a safe and effective maintenance program. Such a maintenance program to maintain the patient's current condition or to prevent or slow further deterioration is covered so long as the beneficiary requires skilled care for the safe and effective performance of the program.

The *Jimmo* Settlement Agreement may reflect a change in practice for those providers, adjudicators, and contractors who may have erroneously believed that the Medicare program covers nursing and therapy services under these benefits only when a beneficiary is expected to improve. The *Jimmo* Settlement Agreement is consistent with the Medicare program's regulations governing maintenance nursing and therapy in skilled nursing facilities, home health services, and outpatient therapy (physical, occupational, and speech) and nursing and therapy in inpatient rehabilitation hospitals for beneficiaries who need the level of care that such hospitals provide.

Important Links

Additional Information

In essence, the *Jimmo* Settlement Agreement clarifies Medicare's longstanding policy that coverage of skilled nursing and skilled therapy services in the Skilled Nursing Facility (SNF), Home Health (HH), and Outpatient Therapy (OPT) settings does not turn on the presence or absence of a beneficiary's potential for improvement, but rather on the beneficiary's need for skilled care.

For ready reference, this CMS web page serves to provide access, in one location, to various public documents related to the *Jimmo* Settlement Agreement. Included in those public documents is an FAQ document for easy access. The *Jimmo* Settlement Agreement does not alter or supersede any other applicable coverage requirements beyond those involving the need for skilled care, such as Medicare's overall requirement that covered services must be reasonable and necessary to diagnose or treat the beneficiary's condition, or existing statutory limitations on the amount or duration of Medicare benefits.

Resources

Jimmo Settlement Agreement approved by the court on January 24, 2013 [PDF, 134KB]

<u>Jimmo v. Sebelius Settlement Agreement – Program Manual Clarifications (Fact Sheet) - Updated 2/3/2014 [PDF, 416KB]</u>

<u>Jimmo v. Sebelius Settlement Agreement (Fact Sheet) - 4/4/2013</u> [PDF, 88KB]

MLN Matters® Article <u>MM8458 [PDF, 107KB]</u>: Manual Updates to Clarify SNF, HH, and OPT Coverage Pursuant to Jimmo v. Sebelius Settlement Agreement

<u>CR 8458 [PDF, 549KB]</u>: Manual Updates to Clarify SNF, HH, and OPT Coverage Pursuant to Jimmo v. Sebelius Settlement Agreement

<u>CR 8644 [PDF, 43KB]</u>: Manual Updates to Clarify Skilled Nursing Facility Advanced Beneficiary Notice (SNF ABN) Requirements Pursuant to Jimmo v. Sebelius Settlement Agreement

MLN Connects® Call materials - December 2013

Medicare Benefit Policy Manual - Chapters 1, 7, 8, 15

Frequently Asked Questions

FAQs (August 2017)

Additional Questions

Providers and Suppliers: Contact your <u>Medicare Administrative</u>

Contractor

Beneficiaries: Please call 1-800-Medicare



A federal government website managed and paid for by the U.S. Centers for Medicare & Medicaid Services. 7500 Security Boulevard, Baltimore, MD 21244





Jimmo Settlement Agreement

(www.CMS.gov)

IN THE UNITED STATES DISTRICT COURT FOR THE DISTRICT OF VERMONT

GLENDA JIMMO, et al., on behalf of)	
themselves and all others similarly situated,)	
)	
Plaintiffs,)	
)	Civil Action No. 5:11-CV-17-CR
v.)	
)	
KATHLEEN SEBELIUS, Secretary of)	
Health and Human Services,)	
)	
Defendant.)	

SETTLEMENT AGREEMENT

I. INTRODUCTION

WHEREAS the parties desire to resolve amicably all the claims raised in this suit without admission of liability;

WHEREAS the parties have agreed upon mutually satisfactory terms for the complete resolution of this Federal Rule of Civil Procedure 23(b)(2) class action litigation;

NOW THEREFORE, the Plaintiffs and Defendant hereby consent to the entry of this Settlement Agreement with the following terms.

II. DEFINITIONS

1. "Approval Date" means the date upon which the Court approves this Settlement Agreement, after having determined that it is adequate, fair, reasonable, equitable, and just to the Class as a whole, after: (i) notice to the Class, (ii) an

opportunity for class members to submit timely objections to the Settlement Agreement, and (iii) a hearing on the fairness of the settlement.

- 2. "Class Counsel" or "Plaintiffs' Counsel" means the Center for Medicare Advocacy, Inc., Vermont Legal Aid, and Wilson Sonsini Goodrich & Rosati. "Plaintiffs' Lead Counsel" means the attorney Plaintiffs have authorized to be the main contact with Defendant's counsel.
- 3. The "Class" or "Class Members" means all Medicare beneficiaries as defined in Section XI.
 - 4. "CMS" refers to the Centers for Medicare & Medicaid Services.
- "Court" means the United States District Court for the District of
 Vermont.
- 6. "Defendant" or "the Secretary" means the Secretary of Health and Human Services, in his or her official capacity.
- 7. "Final, non-appealable denial" or "final and non-appealable" denial means a denial for which the applicable deadline, as described in federal regulations, for an appeal of a decision has expired.
- 8. "Named Plaintiffs" refers to the individuals and organizations who are named in the First Amended Complaint and have not been dismissed from this action by the Court as of the Approval Date.
- 9. "Improvement Standard" refers to a standard that Plaintiffs have alleged, but that Defendant denies, exists under which Medicare coverage of skilled services is denied on the basis that a Medicare beneficiary is not improving, without regard to an

individualized assessment of the beneficiary's medical condition and the reasonableness and necessity of the treatment, care or services in question.

- 10. "Parties" refers to Plaintiffs and to Defendant.
- 11. "Plaintiffs" refers to the Named Plaintiffs, acting on their own behalf and on behalf of all Class Members.
- 12. "State Medicaid agencies" refers to the agencies or their contractors within the fifty States and the District of Columbia that are responsible for administering medical assistance benefits under Title XIX of the Social Security Act.
- 13. "End of the Educational Campaign" means the date upon which the Educational Campaign described in Section IX.9 has been conducted and completed as agreed, as evidenced by Defendant's notification to Plaintiffs' Lead Counsel and certification in good faith that all terms of the Educational Campaign have been conducted and completed.
- 14. "HH" refers to "home health services" as addressed by § 1861(m) of the Social Security Act/ 42 U.S.C. § 1395x(m);
- 15. "SNF" refers to "skilled nursing facility" as addressed by § 1819(a) of the Social Security Act/ 42 U.S.C. § 1395i-3(a);
- 16. "OPT" refers to outpatient therapy services as follows: outpatient physical therapy services as addressed by § 1861(p) of the Social Security Act/ 42 U.S.C. § 1395x(p), outpatient occupational therapy services as addressed by § 1861(g) of the Social Security Act/ 42 U.S.C. § 1395x(g), and outpatient speech-language pathology services as addressed by § 1861(ll)(2) of the Social Security Act/ 42 U.S.C. § 1395x(ll)(2),

- 17. "IRF" refers to "inpatient rehabilitation facility" as addressed by 42 C.F.R. Part 412, Subpart P.
- 18. "CORF" refers to "comprehensive rehabilitation facility" as addressed by \$ 1861(cc) of the Social Security Act/ 42 U.S.C. \$ 1395x(cc)

III. ENTIRE AGREEMENT

The terms of this Settlement Agreement and any attachments thereto are the exclusive and full agreement of the Parties with respect to all claims for declaratory and injunctive relief and attorney's fees and costs as set forth in this Settlement Agreement and in the First Amended Complaint. No representations or inducements or promises to compromise this action or enter into this Settlement Agreement have been made, other than those recited or referenced in this Settlement Agreement.

IV. APPROVAL

- 1. This Settlement Agreement is expressly conditioned upon its approval by the Court.
- 2. The terms of this Settlement Agreement are fair, reasonable, and adequate. The entry of this Settlement Agreement is in the best interest of the Parties and the public.

V. FINAL JUDGMENT

If, after the fairness hearing, the Court approves this Settlement Agreement as fair, reasonable, and adequate, the Court shall direct the entry of Final Judgment (the "Final Judgment") dismissing this action with prejudice, pursuant to the terms of this Settlement Agreement and Fed. R. Civ. P. 41, except that the Court shall retain jurisdiction for the limited purposes described in Section VI of this Settlement

Agreement. The Final Judgment shall incorporate and be subject to the terms of the Settlement Agreement.

VI. CONTINUING JURISDICTION

- The Court has held, contrary to arguments made by Defendant, that it has subject matter jurisdiction over this matter. See Opinion and Order dated October 25, 2011 (Docket Entry No. 52).
- 2. If for any reason this Settlement Agreement (a) is not finalized by the parties, (b) is not approved by the Court following notice to class members and the fairness hearing, or (c) is in any way rendered null and void (in whole or in part),

 Defendant preserves all of her rights to argue (in this Court or on appeal) that the Court lacks subject matter jurisdiction over this matter.
- 3. Subject to the limitations and reservations set forth in the preceding paragraph, the Court will retain jurisdiction over this matter only for the limited purposes described in this paragraph for the following duration: (a) the Court will retain jurisdiction for a period not to exceed twenty-four (24) months following the End of the Educational Campaign if the Administrator of CMS issues a CMS Ruling communicating the clarified maintenance coverage standards for skilled nursing facility (SNF), home health (HH) and outpatient therapy (OPT) as set forth in Sections IX.6 and IX.7 of this Settlement Agreement within three (3) months after the effective date of the Manual Provisions; or (b) the Court will retain jurisdiction for a period not to exceed thirty-six (36) months following the End of the Educational Campaign if the Administrator of CMS does not issue such a CMS Ruling within three (3) months after the effective date of the Manual Provisions. Such limited jurisdiction shall be for the sole purposes of (a)

enforcing the provisions of the Settlement Agreement in the event that one of the Parties claims that there has been a breach of any of those provisions, (b) modifying the Settlement Agreement if jointly requested by the Parties pursuant to Section VII, (c) entering any other order authorized by the Settlement Agreement, and (d) deciding any fee petition filed by Plaintiffs, solely in the event that the parties are unable to agree on an amount of reasonable attorney's fees, as further described in Section X.

4. Notwithstanding the time frames for the Court's continuing jurisdiction discussed in the previous Section VI.3, the Court shall maintain jurisdiction to rule on a motion for enforcement of this Settlement Agreement, or for attorney's fees, filed prior to the end of the applicable time frame set out in Section VI.3. The Court will also have jurisdiction to rule on a motion for enforcement of this Settlement Agreement that was filed after the end of the applicable time frame in Section VI.3. if the Dispute Resolution process in Section VIII of this Settlement Agreement is initiated prior to the end of the time frame and if the Party files the motion for enforcement within 30 days of the other Party's written statement of disagreement with the relief requested by the moving Party.

VII. MODIFICATION

At any time while the Court retains jurisdiction over this matter as described in Section VI, Plaintiffs and Defendant may jointly agree to modify this Settlement Agreement. Any joint request for modification must be in writing, signed by both Class Counsel and Defendant's counsel, and is subject to approval by the Court.

VIII. DISPUTE RESOLUTION PROCEDURES

Either Party shall have the right to initiate steps to resolve any alleged noncompliance with any provision of the Settlement Agreement, subject to limitations and standards set forth in the Settlement Agreement.

- 1. If one party (the "Initiating Party") has good reason to believe that an issue of noncompliance exists, it will first give timely written notice to the other party (the "Responding Party"), including: (a) a reference to all specific provisions of the Settlement Agreement that are involved; (b) a statement of the issue; (c) a statement of the remedial action sought by the Initiating Party; and (d) a brief statement of the specific facts, circumstances, and any other arguments supporting the position of the Initiating Party; and (e) if there is a good faith basis for expedited resolution, the circumstances that make expedited resolution appropriate, and the proposed date for a reasonable expedited response. To be timely, such notice must be provided promptly. Notice that is not provided promptly because of a lack of diligence on the part of the Initiating Party shall not serve as a basis for the Court to exercise jurisdiction as described in Section VI.4 above.
- 2. Within thirty (30) calendar days after receiving such timely notice or within a reasonable time for an expedited resolution, the Responding Party shall respond in writing to the statement of facts and arguments set forth in the notice and shall provide its written position, including the facts and arguments upon which it relies in support of its position.
- 3. The Parties shall undertake good-faith negotiations, including meeting and conferring by telephone or in person and exchanging relevant documents and/or other information, to attempt to resolve the alleged noncompliance. The written notice set

forth in Section VIII.1 may be amended solely to include issue(s) related to the original notice that may arise during the meet-and-confer process described in this paragraph.

- 4. If the Initiating Party believes in good faith that efforts to resolve the matter have failed or if sixty (60) calendar days have elapsed from the Receiving Party's receipt of timely notice, the Initiating Party, after providing written notice to the Responding Party, may file a motion with the Court, with a supporting brief, requesting resolution of the alleged noncompliance, provided however that the relief sought by such motion shall be limited to the issue(s) of alleged noncompliance described in the written notice, as to which the Parties have met and conferred as described in Section VIII.3.
- 5. The Responding Party shall be provided with appropriate notice of any such motion and an opportunity to be heard on the motion, as provided under the Civil Local Rules of the District of Vermont and the Federal Rules of Civil Procedure.
- 6. The Initiating Party cannot seek contempt sanctions as a remedy for alleged noncompliance with the Settlement Agreement. If, however, the Initiating Party successfully argues to the Court that there has been a breach of the Agreement and obtains an order from the Court compelling the Responding Party to remedy the breach, and if the Responding Party subsequently violates that order, then the Initiating Party is free to seek contempt sanctions for that violation.

IX. INJUNCTIVE PROVISIONS

Manual Revisions

1. The agency will revise the relevant portions of Chapters 7, 8, and 15 of the Medicare Benefit Policy Manual (MBPM) to clarify the coverage standards for the skilled nursing facility (SNF), home health (HH), and outpatient therapy (OPT) benefits

when a patient has no restoration or improvement potential but when that patient needs skilled SNF, HH, or OPT services (SNF, HH, OPT "maintenance coverage standard"). The agency will also revise the relevant portions of Chapter 1, Section 110 of the MBPM to clarify the coverage standards for services performed in an inpatient rehabilitation facility (IRF).

- 2. The manual revisions to be made pursuant to this Settlement Agreement will clarify the SNF, HH, and OPT maintenance coverage standards and IRF coverage standard only as set forth below in Sections IX.6 through IX.8. Existing Medicare eligibility requirements for coverage remain in effect. Nothing in this Settlement Agreement modifies, contracts, or expands the existing eligibility requirements for receiving Medicare coverage, including such requirements found in:
 - a. Posthospital SNF Care, as set forth in 42 C.F.R. Part 409, SubpartsC and D, and related subregulatory guidance;
 - b. Home Health Services, as set forth in 42 C.F.R. Part 409, Subpart E, 42 C.F.R. Part 410, Subpart C, and related subregulatory guidance;
 - c. Outpatient Therapy Services, as set forth in 42 C.F.R. Part 410,Subpart B, and related subregulatory guidance; and
 - d. Inpatient Rehabilitation Facility services, as set forth in 42 C.F.R.
 Part 412, Subpart P, and related subregulatory guidance.
- 3. CMS will revise or eliminate any manual provisions in Chapters 7, 8, and 15 and Chapter 1, Section 110 of the MBPM that CMS determines are in conflict with the standards set forth below in Sections IX.6 through IX.8.

- 4. CMS will afford Plaintiffs' Counsel 21 days to review and provide a single set of written comments on the manual provisions revised or eliminated as part of settlement before the manual provisions are finalized and issued. CMS will take any recommendations from Plaintiffs' Counsel under advisement and will make a good faith effort to utilize Plaintiffs' Counsel's reasonable recommendations that are limited to the coverage standards as clarified in Sections IX.6 through IX.8 and that are consistent with those coverage standards as well as all other statutory and regulatory requirements. If plaintiffs request, CMS will also afford Plaintiffs' Counsel a second opportunity for review and comment on these manual revisions before the manual provisions are finalized and issued; Plaintiffs' Counsel will have 14 days to review any subsequent changes made and either provide a second set of written comments or communicate its comments at a meeting between counsel. CMS will take any recommendations from Plaintiffs' Counsel under advisement and will make a good faith effort to utilize Plaintiffs' Counsel's reasonable recommendations that are limited to the coverage standards as clarified in Sections IX.6 through IX.8 and that are consistent with those coverage standards as well as all other statutory and regulatory requirements. CMS shall retain final authority as to the ultimate content of the manual provisions.
- 5. In providing any set of recommendations described in paragraph 4 above, Plaintiffs agree to collect all recommendations into one consolidated document to be provided by Plaintiffs' Lead Counsel.

<u>Maintenance Coverage Standard for Therapy Services under the SNF, HH, and OPT Benefits</u>

6. Manual revisions will clarify that SNF, HH, and OPT coverage of therapy to perform a maintenance program does not turn on the presence or absence of a

beneficiary's potential for improvement from the therapy, but rather on the beneficiary's need for skilled care.

- a. The manual revisions will clarify that, under the SNF, HH, and OPT maintenance coverage standards, skilled therapy services are covered when an individualized assessment of the patient's clinical condition demonstrates that the specialized judgment, knowledge, and skills of a qualified therapist ("skilled care") are necessary for the performance of a safe and effective maintenance program. Such a maintenance program to maintain the patient's current condition or to prevent or slow further deterioration is covered so long as the beneficiary requires skilled care for the safe and effective performance of the program. When, however, the individualized assessment does not demonstrate such a necessity for skilled care, including when the performance of a maintenance program does not require the skills of a therapist because it could safely and effectively be accomplished by the patient or with the assistance of nontherapists, including unskilled caregivers, such maintenance services will not be covered under the SNF, HH, or OPT benefits.
- b. The manual revisions will further clarify that, under the standard set forth in the previous paragraph (Section IX.6.a.), skilled care is necessary for the performance of a safe and effective maintenance program only when (a) the particular patient's special medical complications require the skills of a qualified therapist to perform a therapy service that would otherwise be considered non-skilled; or (b) the

needed therapy procedures are of such complexity that the skills of a qualified therapist are required to perform the procedure.

- c. The manual revisions will further clarify that, to the extent provided by regulation, the establishment or design of a maintenance program by a qualified therapist, the instruction of the beneficiary or appropriate caregiver by a qualified therapist regarding a maintenance program, and the necessary periodic reevaluations by a qualified therapist of the beneficiary and maintenance program are covered to the degree that the specialized knowledge and judgment of a qualified therapist are required.
- d. The maintenance coverage standard for therapy as outlined in this section does not apply to therapy services provided in an inpatient rehabilitation facility (IRF) or a comprehensive outpatient rehabilitation facility (CORF).

<u>Maintenance Coverage Standard for Nursing Services under the SNF and HH</u> <u>Benefits</u>

- 7. Manual revisions will clarify that SNF and HH coverage of nursing care does not turn on the presence or absence of an individual's potential for improvement from the nursing care, but rather on the beneficiary's need for skilled care.
 - a. The manual revisions will clarify that, under the SNF and HH benefits, skilled nursing services are covered when an individualized assessment of the patient's clinical condition demonstrates that the specialized judgment, knowledge, and skills of a registered nurse or, when

provided by regulation, a licensed practical (vocational) nurse ("skilled care") are necessary. Skilled nursing services would be covered where such skilled nursing services are necessary to maintain the patient's current condition or prevent or slow further deterioration so long as the beneficiary requires skilled care for the services to be safely and effectively provided. When, however, the individualized assessment does not demonstrate such a necessity for skilled care, including when the services needed do not require skilled nursing care because they could safely and effectively be performed by the patient or unskilled caregivers, such services will not be covered under the SNF or HH benefits.

b. The manual revisions will further clarify that, under the standard set forth in the previous paragraph (Section IX.7.a.), skilled nursing care is necessary only when (a) the particular patient's special medical complications require the skills of a registered nurse or, when provided by regulation, a licensed practical nurse to perform a type of service that would otherwise be considered non-skilled; or (b) the needed services are of such complexity that the skills of a registered nurse or, when provided by regulation, a licensed practical nurse are required to furnish the services. To be considered a skilled service, the 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 as provided by regulation, including 42 C.F.R. 409.32.

c. The maintenance coverage standard for nursing services as outlined in this section does not apply to nursing services provided in an inpatient rehabilitation facility (IRF) or a comprehensive outpatient rehabilitation facility (CORF).

IRF Coverage Standard

8. Manual revisions will clarify that an IRF claim could never be denied for the following reasons: (1) because a patient could not be expected to achieve complete independence in the domain of self-care or (2) because a patient could not be expected to return to his or her prior level of functioning.

Educational Campaign

- 9. CMS will engage in a nationwide educational campaign, as set forth in the following Sections IX.10 through IX.14, which will use written materials and interactive forums with providers and contractors, to communicate the SNF, home health, and OPT maintenance coverage standards and the IRF coverage standards as set forth in Sections IX.6 through IX.8.
- 10. The educational campaign will be directed to include the following contractors, adjudicators, and providers and suppliers (collectively "recipients") through the following written educational materials ("written educational materials"):
 - a. Medicare Administrative Contractors (MACs, Part A/B contractors): Program Transmittal and MLN Matters article

- b. Medicare Advantage (MA) Organizations (Part C contractors):
 Health Plan Management System (HPMS) memorandum and MLN
 Matters article
- c. Part A/B Qualified Independent Contractors (QICs): MLN Matters article
- d. Part C QIC/Independent Review Entity (IRE): MLN Matters article
- e. Quality Improvement Organizations (QIOs, formerly PROs):

 Transmittal of Policy Systems (TOPS) memorandum and MLN Matters

 article
- f. Recovery Audit Contractors (RACs): Program Transmittal and MLN Matters article
- g. Administrative Law Judges (ALJs): MLN Matters article will be distributed to the Chief Administrative Law Judge for dissemination to the ALJs.
- h. Medicare Appeals Council: MLN Matters article will be distributed to the Chair of the Departmental Appeals Board for dissemination to the Administrative Appeals Judges.
- Providers and suppliers: MLN Matters article to be distributed by the MACs, MA contractors, and CMS via listservs to subscribed providers.
- j. Subscribers to CMS listservs: MLN Matters article

- k. 1-800 MEDICARE Scripts: CMS will revise relevant 1-800
 MEDICARE customer service scripts as necessary to ensure consistency with the revised manual provisions
- 11. CMS will include an accompanying message with the distribution of the MLN Matters article stating that the article was prepared and is being distributed as a result of this Settlement Agreement.
- 12. CMS will afford Plaintiffs' Counsel 21 days to review and provide a single set of written comments on the written educational materials created as part of settlement before the materials are finalized and issued. CMS will take any recommendations from Plaintiffs' Counsel under advisement and will make a good faith effort to utilize Plaintiffs' Counsel's reasonable recommendations that are limited to the coverage standards as clarified in Sections IX.6 through IX.8 and that are consistent with those coverage standards as well as all other statutory and regulatory requirements. If Plaintiffs request, CMS will also afford Plaintiffs' Counsel a second opportunity for review and comment on these written educational materials before they are finalized and disseminated: Plaintiffs' Counsel will have 14 days to review any subsequent changes made and either provide a second set of written comments or communicate its comments at a meeting between counsel. CMS will take any recommendations from Plaintiffs' Counsel under advisement and will make a good faith effort to utilize Plaintiffs' Counsel's reasonable recommendations that are limited to the coverage standards as clarified in Sections IX.6 through IX.8 and that are consistent with those coverage standards as well as all other statutory and regulatory requirements. CMS shall retain final authority as to the ultimate content of the written educational materials. CMS,

through counsel, agrees to tell Plaintiffs' Counsel (through Plaintiffs' Lead Counsel) when the written educational materials have been distributed.

- 13. In providing any set of recommendations described in paragraph 12 above, Plaintiffs agree to collect all recommendations into one consolidated document to be provided by Plaintiffs' Lead Counsel.
 - 14. Other educational initiatives:
 - a. National Call for providers & suppliers: CMS will conduct a National Call for providers and suppliers for the sole purpose of communicating the policy clarifications reflected by the manual revisions agreed to as part of this Settlement Agreement as detailed in Sections IX.6 through IX.8. An audio and written transcript of the call will be made available on the CMS website, www.CMS.gov, for those providers and suppliers unable to attend the call.
 - b. National Call for contractors & adjudicators: CMS will conduct a National Call for contractors, ALJs, medical reviewers, and agency staff to communicate the policy clarifications reflected by the manual revisions agreed to as part of this Settlement Agreement as detailed in Sections IX.6 through IX.8. Following this National Call, CMS will provide all contractors and adjudicators invited to the call a summary of the call, consisting of a copy of the PowerPoint slides presented and the summary prepared by CMS of the questions posed and answers provided during this National Call.

c. For both National Calls, CMS will prepare a deck of PowerPoint slides to assist in communicating the policy clarifications reflected by the manual revisions. Before these slides are finalized, CMS will afford Plaintiffs' Counsel at least 7 days to review and provide a single set of written comments on the slides. CMS will take any recommendations from Plaintiffs' Counsel under advisement and will make a good faith effort to utilize in the final presentation Plaintiffs' Counsel's reasonable recommendations that are limited to the coverage standards as clarified in Sections IX.6 through IX.8 and that are consistent with those coverage standards as well as all other statutory and regulatory requirements. CMS shall retain final authority as to the ultimate content of these PowerPoint slides. In providing any set of recommendations described in this paragraph, Plaintiffs agree to collect all recommendations into one consolidated document to be provided by Plaintiffs' Lead Counsel.

d. Open Door Forum (ODF):

Following the issuance of the manual revisions made pursuant to this Settlement Agreement, CMS will include an announcement of the manual revisions and a reference to the above-described National Call for providers and suppliers as agenda items for a Home Health, Hospice, and Durable Medical Equipment ODF, a Hospital ODF, a Physicians, Nurses and Allied Health Professionals ODF, and a Skilled Nursing Facilities/Long-Term Care ODF. Following the issuance of the manual revisions, CMS

will also include an announcement of the manual revisions as an agenda item for a Medicare Beneficiary ombudsman ODF.

- e. CMS will post the Program Transmittal and MLN Matters article on CMS's website, www.CMS.gov. CMS will inform Plaintiffs' Lead Counsel when the Program Transmittal is issued.
- advance of the National Calls and Open Door Forums described above in Section IX.14 to be held to carry out the educational campaign provided in the settlement agreement. Plaintiffs and Plaintiffs' Counsel will be permitted to attend the Open Door Forums and the National Call for providers and suppliers described above in Section IX.14. Following the National Call for contractors and adjudicators described above in Section IX.14.b, CMS, through counsel, will provide to Plaintiffs' Counsel (1) a certification that this National Call occurred; (2) a certification that guidance was given consistent with the PowerPoint slides described in Section IX.14.c and the manual revisions revised as part of this Settlement Agreement as set forth in Sections IX.6 through IX.8; (3) a certification that any questions from contractors or adjudicators were answered consistent with those manual revisions; and (4) a summary prepared by CMS of the questions posed and answers provided during this National Call.
- 16. CMS agrees to finalize and issue the revised manual provisions and to carry out the educational campaign provided by the settlement agreement within one year of the Approval Date.

Accountability Measures

Claims Review

- 17. CMS will engage in the following measures:
 - a. Sampling of QIC Decisions: CMS will develop protocols for reviewing a random sample of SNF, HH, and OPT coverage decisions by the QICs (for claims under Parts A, B, and C) under the SNF, HH, and OPT maintenance coverage standards set forth above in Sections IX.6 through IX.7 to determine overall trends and any problems in the application of these maintenance coverage standards. CMS will make a reasonable effort to draw the random sample of QIC decisions to reflect claims initially decided by a representative cross-section of contractors and MA Organizations. Plaintiffs' Counsel may provide suggestions to CMS as to how to identify appropriate claims for sampling, e.g., through target diagnosis codes.
 - b. CMS will provide updates to Plaintiffs' Counsel regarding the results of this random sampling during the bi-annual meetings referenced below in Section IX.17.f, beginning with the first meeting following completion of the educational campaign (which will be the second of the five bi-annual meetings). CMS's obligation to conduct sampling of QIC decisions as described above in Section IX.17.a pursuant to this Settlement Agreement terminates with the results reported at the fifth and final of the bi-annual meetings.
 - c. For any QIC decision from the random sample in which CMS finds reason to believe an error was made in applying the correct SNF, HH, and OPT maintenance coverage standards as set forth in Sections

IX.6 and IX.7, CMS will contact the QIC to determine whether an error was made. For those decisions in which an error by the QIC is confirmed, CMS will direct, or request if the agency does not have authority to direct, the QIC to correct its error.

- d. If the random sampling indicates that a particular Medicare contractor or MA organization is not applying the correct SNF, HH, and OPT maintenance coverage standards as set forth in Sections IX.6 and IX.7, CMS will address this issue directly with that entity. The manner in which CMS addresses the issue will be within its discretion.
- e. Review of Individual Claims Determinations: To address any individual beneficiary claims determinations that Plaintiffs believe were not decided in accordance with the SNF, HH, and OPT maintenance coverage standards as set forth above in Sections IX.6 and IX.7, CMS will agree to review and address individual claims determinations as follows:
 - During the bi-annual meetings referenced below in
 Section IX.17.f, Plaintiffs will present CMS (through
 Plaintiffs' Lead Counsel) individual claims determinations
 it believes were not decided in accordance with the SNF,
 HH, and OPT maintenance coverage standards as set forth
 in Sections IX.6 and IX.7. The total number of such
 individual claims determinations Plaintiffs' Counsel
 presents over the course of all bi-annual meetings is not to
 exceed 100.

- 2. CMS will direct, or request if the agency does not have authority to direct, the pertinent Medicare contractors or MA Organizations to review and evaluate these claims and related documentation. If the review of such claims indicates that a particular Medicare contractor or MA organization is not applying the correct SNF, HH, and OPT maintenance coverage standard as set forth in Sections IX.6 and IX.7, CMS will address this issue directly with that entity. The manner in which CMS addresses the issue will be within its discretion. Workload permitting, CMS will provide updates to Plaintiffs' Lead Counsel regarding the action taken on these cases during the subsequent bi-annual meeting referenced below in Section IX.17.f, provided that CMS receives proper authorization from the beneficiary.
- f. Bi-Annual Meetings: CMS will meet with Plaintiffs' Counsel on a biannual basis to discuss the results of the sampling of claims data and the
 agency's review of the individual claims determinations as discussed
 above in Sections IX.17.a-b and IX.17.e. The meetings can also be used
 to bring any issues related to the settlement to the agency's attention.

 The first of these meetings will take place following the issuance of the
 revised manual provisions and prior to the completion of the educational

campaign, and meetings will continue on a bi-annual basis thereafter for a total of five (5) meetings.

18. The Parties recognize that Defendant's obligations are met under the Settlement Agreement once it has complied with the terms of this Settlement Agreement, and that Defendant is not guaranteeing to Plaintiffs that certain results will be achieved once the steps set forth in this Settlement Agreement have been implemented.

X. ATTORNEY'S FEES

Defendant agrees to pay reasonable and appropriate attorney's fees, costs, and expenses related to work performed by Plaintiffs' Counsel in the litigation and settlement of this matter up until the Approval Date, subject to appropriate documentation and exercise of business judgment by Plaintiffs and Plaintiffs' Counsel, pursuant to the Equal Access to Justice Act. For work performed by Plaintiffs' Counsel after the Approval Date, Defendant agrees to pay reasonable and appropriate attorney's fees, costs, and expenses only for the post-Approval Date work specified in this Settlement Agreement, to be capped at \$300,000, subject to appropriate documentation and exercise of business judgment by Plaintiffs and their attorneys and pursuant to the Equal Access to Justice Act. However, if Plaintiffs initiate proceedings to enforce this Settlement Agreement, as described above, and if the Court finds that Defendant has not complied with the Settlement Agreement, Plaintiffs reserve the right to seek the payment of additional fees, costs, and expenses in connection with that enforcement proceeding that will not be subject to the above cap. Plaintiffs' Lead Counsel may submit request(s) for post-Approval fees to Defendant's Counsel for periods no less than 12 months in length, except for the last period if one or more earlier periods has been for more than 12 months. In the event that the parties are unable to agree upon the amount of fees, Plaintiffs may retain the right to file a fee petition with the Court. Notwithstanding their agreement to limit any post-Approval attorney's fees, costs, and expenses to the above fee cap, Plaintiffs and Plaintiffs' Counsel object to the principle of a fee cap and reserve their right to object to such a cap in future cases.

XI. CLASS CERTIFICATION AND RELIEF

Class Definition

- 1. Defendant will stipulate to the certification of a class pursuant to Federal Rule of Civil Procedure 23(b)(2) consisting of all Medicare beneficiaries who:
 - a. received skilled nursing or therapy services in a skilled nursing facility, home health setting, or outpatient setting; and
 - b. received a denial of Medicare coverage (in part or in full) for those services described in the previous paragraph based on a lack of improvement potential in violation of the SNF, HH, or OPT maintenance coverage standards as defined above in section Sections IX.6 and IX.7 and that denial became final and non-appealable on or after January 18, 2011; and
 - c. seek Medicare coverage on his or her own behalf; the definition of class members specifically excludes providers or suppliers of Medicare services or a Medicaid State Agency.

Re-Review Relief for Certain Members of the Class

- 2. Certain members of the class are eligible for re-review of the claim denials described above in Section XI.1.b, if the following requirements are met:
 - a. The services described above in Section XI.1.a that are the subject of the denial described above in Section XI.1.b must not have been covered or paid for by any third-party payer or insurer or Medicare, except in the case of an individual Medicare beneficiary whose services were paid for by Medicaid and who paid for the service or is personally or financially liable or subject to recovery for the services; and
 - b. There must not have been a basis for the denial of the claim for Medicare coverage that was separate and independent from the alleged failure to apply the SNF, HH, or OPT maintenance coverage standards as defined above in Sections IX.6 and IX.7. A separate and independent basis for denial would include the failure to satisfy any procedural requirement, any Medicare eligibility requirement, or any threshold requirement for coverage, but a conclusory determination that services were not "reasonable and necessary," were not "medically necessary," or that coverage is denied using other conclusory, non-specific language, that may be based on a failure to apply the SNF, HH, or OPT maintenance coverage standards as defined in Sections IX.6 and IX.7 above would not be such a separate and independent basis for denial.
- 3. Claim denials described in Section XI.1.b that become final and non-appealable after the End of the Educational Campaign are not eligible for re-review under this Section (XI).

- 4. Claims of class members other than of the Named Plaintiffs that are currently the subject of any lawsuit pending in an Article III United States Court or have been the subject of a final, non-appealable judgment by such courts are not eligible for rereview under this Section (XI).
- 5. Only class members on their own behalf may receive re-review of claims under this section. No provider or supplier of Medicare services or Medicaid State

 Agency is permitted to receive re-review under this section on behalf of or by assignment from a class member.
- 6. Class members who are eligible for re-review of claim denials will be partitioned into two groups.
 - a. Group 1 consists of all class members who received a final, non-appealable denial of Medicare coverage (in part or in full) where that denial became final and non-appealable after January 18, 2011 and up to and including the Approval Date.
 - b. Group 2 consists of all class members who received a final, non-appealable denial of Medicare coverage (in part or in full) from the day after the Approval Date through and including the End of the Educational Campaign.
- 7. Group 1 class members seeking re-review relief as set forth in this

 Section (XI) will be required to identify themselves and their final, non-appealable

 denials to CMS no later than six (6) months after the End of the Educational Campaign.

 Group 2 class members seeking re-review relief as set forth in this Section (XI) will be

required to identify themselves and their final, non-appealable denials to CMS no later than twelve (12) months after the End of the Educational Campaign.

- 8. For each Group 1 or 2 class member who identifies himself or herself to CMS within the specified timeframe for re-review as set forth in the previous paragraph, the agency will direct, or request if the agency does not have the authority to direct, the contractor or adjudicator who last denied the class member's claim for Medicare coverage to re-review the claim under the clarified maintenance coverage standards set forth above in Sections IX.6 and IX.7, subject to the exceptions described above in Sections XI.4 and XI.5.
- 9. When results of the re-review process confirm that the claim was denied in error and that the care should have been covered by Medicare, the agency will reimburse for that care, or, if the agency does not have the authority to reimburse, request reimbursement for the class member for that care, subject to applicable Medicare reimbursement limits.
- 10. Within 10 days of Approval of this Settlement Agreement, Defendant will inform Plaintiffs' Lead Counsel of the process, including to whom class members should identify themselves (pursuant to Section XI.7 through XI.8), by which class members should identify themselves in order to obtain re-review.
- 11. Within 30 days after the End of the Educational Campaign, Plaintiffs' Lead Counsel shall provide Defendant with the final claim denial that Ms. Jimmo received that is at issue in this lawsuit. Defendant shall promptly process Ms. Jimmo's claim under the re-review process as set forth in Section XI.2 through XI.10. Defendant

shall make a good faith effort to issue a final decision on Ms. Jimmo's claim, if appropriate, as soon as practicable.

XII. COMPLIANCE WITH LEGAL AUTHORITY

The parties recognize that Defendant is required to comply with applicable statutes and regulations, including any future revisions to the statutes and regulations that govern Medicare coverage, and that nothing in this Settlement Agreement shall prohibit Defendant from modifying its policies and procedures to comply with any relevant statutory or regulatory changes, even if such modifications are made during the period of the Court's continuing jurisdiction under this Settlement Agreement, or from otherwise changing Defendant's regulations in a manner consistent with the Administrative Procedure Act. If Plaintiffs' Counsel believes that any such modifications to Defendant's policies and procedures, such as the Medicare Benefits Policy Manual, are not authorized by any statutory or regulatory changes, and that any such modifications would constitute a breach of any of the provisions of this Settlement Agreement, they reserve the right to initiate the Dispute Resolution process in Section VIII.

XIII. RELEASE

1. In consideration for the promises of Defendant as set forth in this

Settlement Agreement, the Named Plaintiffs and all Class Members, and their heirs,
administrators, successors, or assigns (together, the "Releasors"), hereby release and
forever discharge Defendant and the United States Department of Health and Human

Services (HHS), along with Defendant's and HHS's administrators, successors, officers,
employees, and agents (together, the "Releasees") from any and all claims and causes of
action that have been asserted or could have been asserted in this action by reason of, or

with respect to, Plaintiffs' allegations that Defendant has illegally applied, or has failed to properly prevent the application of, an Improvement Standard under which Medicare coverage of skilled services is denied on the basis that a Medicare beneficiary is not improving, without regard to an individualized assessment of the beneficiary's medical condition and the reasonableness and necessity of the treatment, care or services in question.

- 2. The above release shall not affect the right of any Class Member to seek any and all individual relief that is otherwise available in satisfaction of an individual claim against Defendant for Medicare benefits that is not based upon the allegations set forth in Section XIII.1 above.
- 3. The above release also shall not affect Plaintiffs' or any Class Member's right, if any, to bring a separate lawsuit challenging any new policy or procedure that is adopted by Defendant after the end of the Court's jurisdiction over this Settlement Agreement, as described in Section VI. Plaintiffs and Class Members will have no right to claim that such a change in policies or procedures violates the Settlement Agreement, but do not waive any right to claim that the new policy or procedure violates the Social Security Act, Defendant's regulations, or any other provision of law.

XIV. NO ADMISSION OF LIABILITY

Neither this Settlement Agreement nor any order approving this Settlement

Agreement is or shall be construed as an admission by Defendant of the truth of any of
the allegations set forth in the First Amended Complaint or the validity of the claims

asserted in the First Amended Complaint, or of Defendant's liability for any of those claims.

The undersigned representatives of the parties certify that they are fully authorized to consent to the Court's entry of the terms and conditions of this Settlement Agreement.

Dated: October 16, 2012

/s/ Judith Stein (by permission)

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Dated: October 16, 2012

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Counsel for Defendant



Jimmo Fact Sheet

(www.CMS.gov)



Jimmo v. Sebelius Settlement Agreement Program Manual Clarifications Fact Sheet



Overview:

As explained in the previously-issued *Jimmo v. Sebelius* Settlement Agreement Fact Sheet (available online at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/Jimmo-FactSheet.pdf), the Centers for Medicare & Medicaid Services (CMS) is issuing revised portions of the relevant program manuals used by Medicare contractors. Specifically, in accordance with the settlement agreement, the manual revisions clarify that coverage of skilled nursing and skilled therapy services in the skilled nursing facility (SNF), home health (HH), and outpatient therapy (OPT) settings "...does not turn on the presence or absence of a beneficiary's potential for improvement, but rather on the beneficiary's need for skilled care." Skilled care may be necessary to improve a patient's current condition, to maintain the patient's current condition, or to prevent or slow further deterioration of the patient's condition.

The Settlement Agreement:

The settlement agreement itself includes language specifying that "Nothing in this Settlement Agreement modifies, contracts, or expands the existing eligibility requirements for receiving Medicare coverage."

Rather, the intent is to clarify Medicare's longstanding policy that when skilled services are required in order to provide care that is reasonable and necessary to prevent or slow further deterioration, coverage cannot be denied based on the absence of potential for improvement or restoration. As such, the manual revisions contained in Change Request (CR) 8458 do not represent an *expansion* of coverage, but rather, provide clarifications that are intended to help ensure that claims are adjudicated accurately and appropriately in accordance with the *existing* Medicare policy. Similarly, these revisions do not alter or supersede any other applicable coverage requirements beyond those involving the need for skilled care, such as Medicare's overall requirement that covered services must to be reasonable and necessary to diagnose or treat the beneficiary's condition. The following are some significant aspects of the manual clarifications:

• No "Improvement Standard" is to be applied in determining Medicare coverage for maintenance claims in which skilled care is required.

There are situations in which the patient's potential for improvement would

be a reasonable criterion to consider, such as when the goal of treatment is to restore function. We note that this would always be the goal of treatment in the inpatient rehabilitation facility (IRF) setting, where skilled therapy must be reasonably expected to improve the patient's functional capacity or adaptation to impairments in order to be covered. However, Medicare has long recognized that there may be situations in the SNF, home health, and outpatient therapy settings where, even though no improvement is expected, skilled nursing and/or therapy services to prevent or slow a decline in condition are necessary because of the particular patient's special medical complications or the complexity of the needed services.

- The manual revisions clarify that a beneficiary's lack of restoration potential cannot, in itself, serve as the basis for denying coverage in this context, without regard to an individualized assessment of the beneficiary's medical condition and the reasonableness and necessity of the treatment, care, or services in question. Conversely, such coverage would not be available in a situation where the beneficiary's maintenance care needs can be addressed safely and effectively through the use of *nonskilled* personnel.
- Medicare has never supported the imposition of an "Improvement Standard" rule-of-thumb in determining whether skilled care is required to prevent or slow deterioration in a patient's condition. Thus, such coverage depends not on the beneficiary's restoration potential, but on whether skilled care is required, along with the underlying reasonableness and necessity of the services themselves. The manual revisions serve to reflect and articulate this basic principle more clearly. Therefore, denial notices for claims involving maintenance care in the SNF, HH, and OPT settings should contain an accurate summary of the reason for the determination, which should always be based on whether the beneficiary has a need for skilled care rather than on a lack of improvement.

Appropriate Documentation:

Portions of the revised manual provisions now include additional information on the role of appropriate documentation in facilitating accurate coverage determinations for claims involving skilled care. While the presence of appropriate documentation is not, in and of itself, an element of the definition of a "skilled" service, such documentation serves as the *means* by which a provider would be able to establish and a Medicare contractor would be able to confirm that skilled care is, in fact, needed and received in a given case. Thus, even though the

terms of the settlement agreement do not include an explicit reference to documentation requirements as such, we have nevertheless decided to use this opportunity to introduce additional guidance in this area, both generally and as it relates to particular clinical scenarios.

We note that this material on documentation does not serve to require the presence of any particular phraseology or verbal formulation as a prerequisite for coverage (although it does identify certain vague phrases like "patient tolerated treatment well," "continue with POC," and "patient remains stable" as being *insufficiently explanatory* to establish coverage). Rather, as indicated previously, coverage determinations must consider the *entirety* of the clinical evidence in the file, and our enhanced guidance on documentation is intended simply to assist providers in their efforts to identify and include the kind of clinical information that can most effectively serve to support a finding that skilled care is needed and received—which, in turn, will help to ensure more accurate and appropriate claims adjudication.

Care must be taken to assure that documentation justifies the necessity of the skilled services provided. Justification for treatment would include, for example, objective evidence or a clinically supportable statement of expectation that:

- In the case of rehabilitative therapy, the patient's condition has the potential to improve or is improving in response to therapy; maximum improvement is yet to be attained; and, there is an expectation that the anticipated improvement is attainable in a reasonable and generally predictable period of time.
- In the case of maintenance therapy, the skills of a therapist are necessary to maintain, prevent, or slow further deterioration of the patient's functional status, and the services cannot be safely and effectively carried out by the beneficiary personally, or with the assistance of non-therapists, including unskilled caregivers.

Forthcoming Activities:

As discussed in the previously-issued *Jimmo v. Sebelius* Settlement Agreement Fact Sheet, CMS is planning to conduct additional educational outreach and claims review activities in the near future pursuant to the settlement agreement.



Medicare's Home Health Services Benefit Policy Manual

(www.CMS.gov)

Medicare Benefit Policy Manual Chapter 7 - Home Health Services

20.1.2 - Determination of Coverage

(Rev. 179, Issued: 01-14-14, Effective: 01-07-14, Implementation: 01-07-14) A3-3113.1.B, HHA-203.1.B

The intermediary's decision on whether care is reasonable and necessary is based on information reflected in the home health plan of care, the OASIS as required by 42 CFR 484.55 or a medical record of the individual patient. Medicare does not deny coverage solely on the basis of the reviewer's general inferences about patients with similar diagnoses or on data related to utilization generally, but bases it upon objective clinical evidence regarding the patient's individual need for care. Coverage of skilled nursing care or therapy to perform a maintenance program does not turn on the presence or absence of a patient's potential for improvement from the nursing care or therapy, but rather on the patient's need for skilled care. Skilled care may be necessary to improve a patient's current condition, to maintain the patient's current condition, to prevent or slow further deterioration of the patient's condition.

30.1.2 - Patient's Place of Residence

(Rev. 179, Issued: 01-14-14, Effective: 01-07-14, Implementation: 01-07-14) A3-3117.1.B, HHA-204.1.B

A patient's residence is wherever he or she makes his or her home. This may be his or her own dwelling, an apartment, a relative's home, a home for the aged, or some other type of institution. However, an institution may not be considered a patient's residence if the institution meets the requirements of §§1861(e)(1) or 1819(a)(1) of the Act. Included in this group are hospitals and skilled nursing facilities, as well as most nursing facilities under Medicaid. (See the Medicare State Operations Manual, §2166.)

Thus, if a patient is in an institution or distinct part of an institution identified above, the patient is not entitled to have payment made for home health services under either Part A or Part B since such an institution may not be considered their residence. When a patient remains in a participating SNF following their discharge from active care, the facility may not be considered their residence for purposes of home health coverage.

A patient may have more than one home and the Medicare rules do not prohibit a patient from having one or more places of residence. A patient, under a Medicare home health plan of care, who resides in more than one place of residence during an episode of Medicare covered home health services will not disqualify the patient's homebound status for purposes of eligibility. For example, a person may reside in a principal home and also a second vacation home, mobile home, or the home of a caretaker relative. The fact that the patient resides in more than one home and, as a result, must transit from one to the other, is not in itself, an indication that the patient is not homebound. The requirements of homebound must be met at each location (e.g., considerable taxing effort etc.).

A. Assisted Living Facilities, Group Homes, and Personal Care Homes

An individual may be "confined to the home" for purposes of Medicare coverage of home health services if he or she resides in an institution that is not primarily engaged in providing to inpatients:

- Diagnostic and therapeutic services for medical diagnosis;
- Treatment:
- Care of *injured*, disabled or sick persons;
- Rehabilitation services or *other skilled services needed to maintain a patient's current condition or to prevent or slow further deterioration; or*
- Skilled nursing care or related services for patients who require medical or nursing care.

If it is determined that the assisted living facility (also called personal care homes, group homes, etc.) in which the individuals reside are not primarily engaged in providing the above services, then Medicare will cover reasonable and necessary home health care furnished to these individuals.

If it is determined that the services furnished by the home health agency are duplicative of services furnished by an assisted living facility (also called personal care homes, group homes, etc.) when provision of such care is required of the facility under State licensure requirements, claims for such services should be denied under §1862(a)(1)(A) of the Act. Section 1862(a)(1)(A) excludes services that are not necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member from Medicare coverage. Services to people who already have access to appropriate care from a willing caregiver would not be considered reasonable and necessary to the treatment of the individual's illness or injury.

Medicare coverage would not be an optional substitute for the services that a facility is required to provide by law to its patients or where the services are included in the base contract of the facility. An individual's choice to reside in such a facility is also a choice to accept the services it holds itself out as offering to its patients.

B. Day Care Centers and Patient's Place of Residence

The current statutory definition of homebound or confined does not imply that Medicare coverage has been expanded to include adult day care services.

The law does not permit an HHA to furnish a Medicare covered billable visit to a patient under a home health plan of care outside his or her home, except in those limited circumstances where the patient needs to use medical equipment that is too cumbersome to bring to the home. Section 1861(m) of the Act stipulates that home health services provided to a patient be provided to the patient on a visiting basis in a place of residence

used as the individual's home. A licensed/certified day care center does not meet the definition of a place of residence.

C. State Licensure/Certification of Day Care Facilities

Section 1861(m) of the Act, an adult day care center must be either licensed or certified by the State or accredited by a private accrediting body. State licensure or certification as an adult day care facility must be based on State interpretations of its process. For example, several States do not license adult day care facilities as a whole, but do certify some entities as Medicaid certified centers for purposes of providing adult day care under the Medicaid home and community based waiver program. It is the responsibility of the State to determine the necessary criteria for "State certification" in such a situation. A State could determine that Medicaid certification is an acceptable standard and consider its Medicaid certified adult day care facilities to be "State certified." On the other hand, a State could determine Medicaid certification to be insufficient and require other conditions to be met before the adult day care facility is considered "State certified".

D. Determination of the Therapeutic, Medical or Psychosocial Treatment of the Patient at the Day Care Facility

It is not the obligation of the HHA to determine whether the adult day care facility is providing psychosocial treatment, but only to assure that the adult day care center is licensed/certified by the State or accrediting body. The intent of the law, in extending the homebound exception status to attendance at such adult day care facilities, recognizes that they ordinarily furnish psychosocial services.

40.1 - Skilled Nursing Care

(Rev. 179, Issued: 01-14-14, Effective: 01-07-14, Implementation: 01-07-14) A3-3118.1, HHA-205.1

To be covered as skilled nursing services, the services must require the skills of a registered nurse, or a licensed practical (vocational) nurse under the supervision of a registered nurse, must be reasonable and necessary to the treatment of the patient's illness or injury as discussed in §40.1.1, below, and must be intermittent as discussed in §40.1.3. Coverage of skilled nursing care does not turn on the presence or absence of a patient's potential for improvement from the nursing care, but rather on the patient's need for skilled care.

40.1.1 - General Principles Governing Reasonable and Necessary Skilled Nursing Care

(Rev. 179, Issued: 01-14-14, Effective: 01-07-14, Implementation: 01-07-14) A3-3118.1, HHA-205.1

If all other eligibility and coverage requirements under the home health benefit are met, skilled nursing services are covered when an individualized assessment of the patient's clinical condition demonstrates that the specialized judgment, knowledge, and skills of a

registered nurse or, when provided by regulation, a licensed practical (vocational) nurse ("skilled care") are necessary. Skilled nursing services are covered where such skilled nursing services are necessary to maintain the patient's current condition or prevent or slow further deterioration so long as the beneficiary requires skilled care for the services to be safely and effectively provided. When, however, the individualized assessment does not demonstrate such a necessity for skilled care, including when the services needed do not require skilled nursing care because they could safely and effectively be performed by the patient or unskilled caregivers, such services will not be covered under the home health benefit.

Skilled nursing care is necessary only when (a) the particular patient's special medical complications require the skills of a registered nurse or, when provided by regulation, a licensed practical nurse to perform a type of service that would otherwise be considered non-skilled; or (b) the needed services are of such complexity that the skills of a registered nurse or, when provided by regulation, a licensed practical nurse are required to furnish the services. To be considered a skilled service, the 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 as provided by regulation, including 42 C.F.R. 409.32.

Some services may be classified as a skilled nursing service on the basis of complexity alone (e.g., intravenous and intramuscular injections or insertion of catheters) and, if reasonable and necessary to the treatment of the patient's illness or injury, would be covered on that basis. If a service can be safely and effectively performed (or self-administered) by an unskilled person, without the direct supervision of a nurse, the service cannot be regarded as a skilled nursing service although a nurse actually provides the service. However, in some cases, the condition of the patient may cause a service that would ordinarily be considered unskilled to be considered a skilled nursing service. This would occur when the patient's condition is such that the service can be safely and effectively provided only by a nurse. A service is not considered a skilled nursing service merely because it is performed by or under the supervision of a nurse. The unavailability of a competent person to provide a non-skilled service, regardless of the importance of the service to the patient, does not make it a skilled service when a nurse provides the service.

A service that, by its nature, requires the skills of a 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.

The skilled nursing service must be reasonable and necessary to the diagnosis and treatment of the patient's illness or injury within the context of the patient's unique medical condition. To be considered reasonable and necessary for the diagnosis or treatment of the patient's illness or injury, the services must be consistent with the nature and severity of the illness or injury, the patient's particular medical needs, and accepted standards of medical and nursing practice. The determination of whether the services are reasonable and necessary should be made in consideration that a physician has

determined that the services ordered are reasonable and necessary. The services must, therefore, be viewed from the perspective of the condition of the patient when the services were ordered and what was, at that time, reasonably expected to be appropriate treatment for the illness or injury throughout the certification period.

A patient's overall medical condition, without regard to whether the illness or injury is acute, chronic, terminal, or expected to extend over a long period of time, should be considered in deciding whether skilled services are needed. A patient's diagnosis should never be the sole factor in deciding that a service the patient needs is either skilled or not skilled. Skilled care may, depending on the unique condition of the patient, continue to be necessary for patients whose condition is stable.

As is outlined in home health regulations, as part of the home health agency (HHA) Conditions of Participation (CoPs), the clinical record of the patient must contain progress and clinical notes. Additionally, in Pub. 100-04, Medicare Claims Processing Manual, Chapter 10; "Home Health Agency Billing", instructions specify that for each claim, HHAs are required to report all services provided to the beneficiary during each episode, which includes reporting each visit in line-item detail. As such, it is expected that the home health records for every visit will reflect the need for the skilled medical care provided. These clinical notes are also expected to provide important communication among all members of the home care team regarding the development, course and outcomes of the skilled observations, assessments, treatment and training performed. Taken as a whole then, the clinical notes are expected to tell the story of the patient's achievement towards his/her goals as outlined in the Plan of Care. In this way, the notes will serve to demonstrate why a skilled service is needed.

Therefore the home health clinical notes must document as appropriate:

- the history and physical exam pertinent to the day's visit, (including the response or changes in behavior to previously administered skilled services) and the skilled services applied on the current visit, and
- the patient/caregiver's response to the skilled services provided, and
- the plan for the next visit based on the rationale of prior results,
- a detailed rationale that explains the need for the skilled service in light of the patient's overall medical condition and experiences,
- the complexity of the service to be performed, and
- any other pertinent characteristics of the beneficiary or home

Clinical notes should be written so that they adequately describe the reaction of a patient to his/her skilled care. Clinical notes should also provide a clear picture of the treatment, as well as "next steps" to be taken. Vague or subjective descriptions of the

patient's care should not be used. For example terminology such as the following would not adequately describe the need for skilled care:

- Patient tolerated treatment well
- Caregiver instructed in medication management
- Continue with POC

Objective measurements of physical outcomes of treatment should be provided and/or a clear description of the changed behaviors due to education programs should be recorded in order that all concerned can follow the results of the applied services.

EXAMPLE 1:

The presence of a plaster cast on an extremity generally does not indicate a need for skilled nursing care. However, the patient with a preexisting peripheral vascular or circulatory condition might need skilled nursing care to observe for complications, monitor medication administration for pain control, and teach proper skin care to preserve skin integrity and prevent breakdown. The documentation must support the severity of the circulatory condition that requires skilled care. The clinical notes for each home health visit should document the patient's skin and circulatory examination as well as the patient and/or caregiver application of the educational principles taught since the last visit. The plan for the next visit should describe the skilled services continuing to be required.

EXAMPLE 2:

The condition of a patient, who has irritable bowel syndrome or is recovering from rectal surgery, may be such that he or she can be given an enema safely and effectively only by a nurse. If the enema were necessary to treat the illness or injury, then the visit would be covered as a skilled nursing visit. The documentation must support the skilled need for the enema, and the plan for future visits based on this information.

EXAMPLE 3:

Giving a bath does not ordinarily require the skills of a nurse and, therefore, would not be covered as a skilled nursing service unless the patient's condition is such that the bath could be given safely and effectively only by a nurse (as discussed in §30.1 above).

EXAMPLE 4:

A patient with a well-established colostomy absent complications may require assistance changing the colostomy bag because they cannot do it themselves and there is no one else to change the bag. Notwithstanding the need for the routine colostomy care, *changing* the *colostomy bag* does not become a skilled nursing service when the nurse provides it.

EXAMPLE 5:

A patient was discharged from the hospital with an open draining wound that requires irrigation, packing, and dressing twice each day. The HHA has taught the family to perform the dressing changes. The HHA continues to see the patient for the wound care that is needed during the time that the family is not available and willing to provide the dressing changes. The wound care continues to be skilled nursing care, notwithstanding that the family provides it part of the time, and may be covered as long as the patient requires it.

EXAMPLE 6:

A physician has ordered skilled nursing visits for a patient with a hairline fracture of the hip. *The home health record must document the reason skilled services are required and why the* nursing visits *are* reasonable and necessary for treatment of the patient's hip injury.

EXAMPLE 7:

A physician has ordered skilled nursing visits for teaching of self-administration and self-management of the medication regimen for a patient, *newly diagnosed*, with diabetes mellitus *in* the *home health plan of care*. *Each visit's documentation must describe the patient's progress in this activity*.

EXAMPLE 8:

Following a cerebrovascular accident (CVA), a patient has an in-dwelling Foley catheter because of urinary incontinence, and is expected to require the catheter for a long and indefinite period. The medical condition of the patient must be described and documented to support the need for nursing skilled services in the home health plan of care. Periodic visits to change the catheter as needed, treat the symptoms of catheter malfunction, and teach proper catheter care would be covered as long as they are reasonable and necessary, although the patient is stable, even if there is an expectation that the care will be needed for a long and indefinite period. However, at every home health visit, the patient's current medical condition must be described and there must be documentation to support the need for continued skilled nursing services.

EXAMPLE 9:

A patient with advanced multiple sclerosis undergoing an exacerbation of the illness needs skilled teaching of medications, measures to overcome urinary retention, and the establishment of a program designed to minimize the adverse impact of the exacerbation. The clinical notes for each home health visit must describe why skilled nursing services were required. The skilled nursing care received by the patient would be covered despite the chronic nature of the illness.

EXAMPLE 10:

A patient with malignant melanoma is terminally ill, and requires skilled observation, assessment, teaching, and treatment. The patient has not elected coverage under Medicare's hospice benefit. *The documentation should describe the goal of the skilled nursing intervention, and at each visit the services provided should support that goal.* The skilled nursing care that the patient requires would be covered, notwithstanding that the condition is terminal, because the *documentation and description must support that the needed* services *required* the skills of a nurse.

40.1.2.1 - Observation and Assessment of the Patient's Condition When Only the Specialized Skills of a Medical Professional Can Determine Patient's Status

(Rev. 179, Issued: 01-14-14, Effective: 01-07-14, Implementation: 01-07-14)

Observation and assessment of the patient's condition by a nurse are reasonable and necessary skilled services where there is a reasonable potential for change in a patient's condition that requires skilled nursing personnel to identify and evaluate the patient's need for possible modification of treatment or initiation of additional medical procedures until the patient's *clinical condition and/or* treatment regimen *has* stabilized. Where a patient was admitted to home health care for skilled observation because there was a reasonable potential of a complication or further acute episode, but did not develop a further acute episode or complication, the skilled observation services are still covered for 3 weeks or so long as there remains a reasonable potential for such a complication or further acute episode.

Information from the patient's home health record must document the rationale that demonstrates that there is a reasonable potential for a future complication or acute episode and, therefore, may justify the need for continued skilled observation and assessment beyond the 3-week period. Such signs and symptoms as abnormal/fluctuating vital signs, weight changes, edema, symptoms of drug toxicity, abnormal/fluctuating lab values, and respiratory changes on auscultation may justify skilled observation and assessment. Where these signs and symptoms are such that there is a reasonable potential that skilled observation and assessment by a licensed nurse will result in changes to the treatment of the patient, then the services would be covered. However, observation and assessment by a nurse is not reasonable and necessary for the treatment of the illness or injury where fluctuating signs and symptoms are part of a longstanding pattern of the patient's condition which has not previously required a change in the prescribed treatment.

EXAMPLE 1:

A patient with atherosclerotic heart disease with congestive heart failure requires observation by skilled nursing personnel for signs of decompensation or adverse effects resulting from *newly* prescribed medication. Skilled observation is needed to determine whether the *new* drug regimen should be modified or whether other therapeutic measures

should be considered until the patient's *clinical condition and/or* treatment regimen *has* stabilized. *The clinical notes for each home health visit should reflect the deliberations* and their outcome.

EXAMPLE 2:

A patient has undergone peripheral vascular disease treatment including a revascularization procedure (bypass). The incision area is showing signs of potential infection, (e.g., heat, redness, swelling, drainage) and the patient has elevated body temperature. *For each home health visit, the clinical notes must demonstrate that the skilled* observation and monitoring is required.

EXAMPLE 3:

A patient was hospitalized following a heart attack. *Following* treatment *he was* discharged home. Because it is not known whether *increasing* exertion will exacerbate the heart disease, skilled observation is reasonable and necessary as mobilization is initiated *in the patient's home*. *The patient's necessity for skilled observation must be documented at each home health visit* until the patient's *clinical condition and/or* treatment regimen *has* stabilized.

EXAMPLE 4:

A frail 85-year old man was hospitalized for pneumonia. The infection was resolved, but the patient, who had previously maintained adequate nutrition, will not eat or eats poorly. The patient is discharged to the HHA for monitoring of fluid and nutrient intake and assessment of the need for tube feeding. Observation and monitoring by skilled nurses of the patient's oral intake, output and hydration status is required to determine what further treatment or other intervention is needed. The patient's necessity for skilled observation and treatment must be documented at each home health visit, until the patient's clinical condition and/or treatment regimen has stabilized.

EXAMPLE 5:

A patient with glaucoma and a cardiac condition has a cataract extraction. Because of the interaction between the eye drops for the glaucoma and cataracts and the beta-blocker for the cardiac condition, the patient is at risk for serious cardiac arrhythmia. Skilled observation and monitoring of the drug actions is reasonable and necessary until the patient's condition is stabilized. The patient's necessity for skilled observation must be documented at each home health visit, until the clinical condition and/or patient's treatment regimen has stabilized.

EXAMPLE 6:

A patient with hypertension suffered dizziness and weakness. The physician found that the blood pressure was too low and discontinued the hypertension medication. Skilled

observation and monitoring of the patient's blood pressure and medication regimen is required until the blood pressure remains stable and in a safe range. *The patient's necessity for skilled observation must be documented at each home health visit, until the patient's clinical condition and/or treatment regimen has stabilized.*

EXAMPLE 7:

A patient has chronic non-healing skin ulcers, Diabetes Mellitus Type I, and spinal muscular atrophy. In the past, the patient's wounds have deteriorated, requiring the patient to be hospitalized. Previously, a skilled nurse has trained the patient's wife to perform wound care. The treating physician orders a new episode of skilled care, at a frequency of one visit every 2 weeks to perform observation and assessment of the patient's skin ulcers to make certain that they are not worsening. This order is reasonable and necessary because, although the unskilled family caregiver has learned to care for the wounds, the skilled nurse can use observation and assessment to determine if the condition is worsening.

40.1.2.2 - Management and Evaluation of a Patient Care Plan (*Rev. 179, Issued: 01-14-14, Effective: 01-07-14, Implementation: 01-07-14*) A3-3118.1.B.2, HHA-205.1.B.2

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 *unskilled* care is achieving its purpose. For skilled nursing care to be reasonable and necessary for management and evaluation of the patient's plan of care, the complexity of the necessary unskilled services that 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 patient's overall condition.

EXAMPLE 1:

An aged patient with a history of diabetes mellitus and angina pectoris is recovering from an open reduction of the neck of the femur. He requires, among other services, careful skin care, appropriate oral medications, a diabetic diet, a therapeutic exercise program to preserve muscle tone and body condition, and observation to notice signs of deterioration in his condition or complications resulting from his restricted, but increasing mobility. Although a properly instructed person could perform any of the required services, that person would not have the capability to understand the relationship among the services and their effect on each other. Since the combination of the patient's condition, age, and immobility create a high potential for serious complications, such an understanding is essential to ensure the patient's recovery and safety. The management of this plan of care requires skilled nursing personnel until *nursing visits are not needed to observe and assess the effects of the non-skilled services being provided to treat the illness or injury until the patient recovers. 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 necessary, and the management and evaluation of the care plan would not be considered a skilled service.

EXAMPLE 2:

An aged patient with a history of mild dementia is recovering from pneumonia which has been treated at home. The patient has had an increase in disorientation, has residual chest congestion, decreased appetite, and has remained in bed, immobile, throughout the episode with pneumonia. While the residual chest congestion and recovery from pneumonia alone would not represent a high risk factor, the patient's immobility and increase in confusion could create a high probability of a relapse. In this situation, skilled oversight of the *unskilled* services would be reasonable and necessary pending the elimination of the chest congestion and resolution of the persistent disorientation to ensure the patient's medical safety. For this determination to be made, the home health documentation must describe the complexity of the unskilled services that are a necessary part of the medical treatment and which require the involvement of a registered nurse in order to ensure that essential unskilled care is achieving its purpose. Where visits by a licensed nurse are not needed to observe and assess the effects of the *unskilled* services being provided to treat the illness or injury, skilled nursing care would not be considered reasonable and necessary to treat the illness or injury.

EXAMPLE 3:

A physician orders one skilled nursing visit every 2 weeks and three home health aide visits each week for bathing and washing hair for a patient whose recovery from a CVA has left him with residual weakness on the left side. The cardiovascular condition is stable and the patient has reached the maximum restoration potential. There are no underlying conditions that would necessitate the skilled supervision of a licensed nurse in assisting with bathing or hair washing. The skilled nursing visits are not necessary to manage and supervise the home health aide services and would not be covered.

40.1.2.3 - Teaching and Training Activities (Rev. 179, Issued: 01-14-14, Effective: 01-07-14, Implementation: 01-07-14) A3-3118.1.B.3, HHA-205.1.B.3

Teaching and training activities that require skilled nursing personnel to teach a patient, the patient's family, or caregivers how to manage the treatment regimen would constitute skilled nursing services. Where the teaching or training is reasonable and necessary to the treatment of the illness or injury, skilled nursing visits for teaching would be covered. The test of whether a nursing service is skilled relates to the skill required to teach and not to the nature of what is being taught. Therefore, where skilled nursing services are necessary to teach an unskilled service, the teaching may be covered. Skilled nursing visits for teaching and training activities are reasonable and necessary where the teaching or training is appropriate to the patient's functional loss, illness, or injury.

Where it becomes apparent after a reasonable period of time that the patient, family, or caregiver will not or is not able to be trained, then further teaching and training would cease to be reasonable and necessary. *The reason why the training was unsuccessful should be documented in the record.* 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.

In determining the reasonable and necessary number of teaching and training visits, consideration must be given to whether the teaching and training provided constitutes reinforcement of teaching provided previously in an institutional setting or in the home or whether it represents initial instruction. Where the teaching represents initial instruction, the complexity of the activity to be taught and the unique abilities of the patient are to be considered. Where the teaching constitutes reinforcement, an analysis of the patient's retained knowledge and anticipated learning progress is necessary to determine the appropriate number of visits. Skills taught in a controlled institutional setting often need to be reinforced when the patient returns home. Where the patient needs reinforcement of the institutional teaching, additional teaching visits in the home are covered.

Re-teaching or retraining for an appropriate period may be considered reasonable and necessary where there is a change in the procedure or the patient's condition that requires re-teaching, or where the patient, family, or caregiver is not properly carrying out the task. The medical record should document the reason that the re-teaching or retraining is required and the patient/caregiver response to the education.

EXAMPLE 1:

A physician has ordered skilled nursing care for teaching a diabetic who has recently become insulin dependent. The physician has ordered teaching of self-injection and management of insulin, signs, and symptoms of insulin shock, and actions to take in emergencies. The *education is* reasonable and necessary to the treatment of the illness or injury, *and the teaching services and the patient/caregiver responses must be documented*.

EXAMPLE 2:

A physician has ordered skilled nursing care to teach a patient to follow a new medication regimen in which there is a significant probability of adverse drug reactions due to the nature of the drug and the patient's condition, *to recognize* signs and symptoms of adverse reactions to new medications, and *to follow the* necessary dietary restrictions. After it becomes apparent that the patient remains unable to take the medications properly, cannot demonstrate awareness of potential adverse reactions, and is not following the necessary dietary restrictions, skilled nursing care for further teaching would not be reasonable and necessary, since the patient has demonstrated an inability to

be taught. The documentation must thoroughly describe all efforts that have been made to educate the patient/caregiver, and their responses. The health record should also describe the reason for the failure of the educational attempts.

EXAMPLE 3:

A physician has ordered skilled nursing visits to teach self-administration of insulin to a patient who has been self-injecting insulin for 10 years and there is no change in the patient's physical or mental status that would require re-teaching. The skilled nursing visits would not be considered reasonable and necessary since the patient has a longstanding history of being able to perform the service.

EXAMPLE 4:

A physician has ordered skilled nursing visits to teach self-administration of insulin to a patient who has been self-injecting insulin for 10 years because the patient has recently lost the use of the dominant hand and must be retrained to use the other hand. Skilled nursing visits to re-teach self-administration of the insulin would be reasonable and necessary. The patient's response to teaching must be documented at each home health visit, until the patient has learned how to self-administer.

EXAMPLE 5:

A patient recovering from pneumonia is being sent home requiring I.V. infusion of antibiotics four times per day. The patient's spouse has been shown how to administer the drug during the hospitalization and has been told the signs and symptoms of infection. The physician has ordered home health services for a nurse to teach the administration of the drug and the signs and symptoms requiring immediate medical attention.

EXAMPLE 6:

A spouse who has been taught to perform a dressing change for a post-surgical patient may need to be re-taught wound care if the spouse demonstrates improper performance of wound care. The medical record should document the reason that the re-teaching or retraining is required and the patient/caregiver response to the education.

NOTE: There is no requirement that the patient, family or other caregiver be taught to provide a service if they cannot or choose not to provide the care.

Teaching and training activities that require the skills of a licensed nurse include, but **are not limited to**, the following:

1. Teaching the self-administration of injectable medications, or a complex range of medications;

- 2. Teaching a newly diagnosed diabetic or caregiver all aspects of diabetes management, including how to prepare and to administer insulin injections, to prepare and follow a diabetic diet, to observe foot-care precautions, and to observe for and understand signs of hyperglycemia and hypoglycemia;
- 3. Teaching self-administration of medical gases;
- 4. Teaching wound care where the complexity of the wound, the overall condition of the patient or the ability of the caregiver makes teaching necessary;
- 5. Teaching care for a recent ostomy or where reinforcement of ostomy care is needed;
- 6. Teaching self-catheterization;
- 7. Teaching self-administration of gastrostomy or enteral feedings;
- 8. Teaching care for and maintenance of peripheral and central venous lines and administration of intravenous medications through such lines;
- 9. Teaching bowel or bladder training when bowel or bladder dysfunction exists;
- Teaching how to perform the activities of daily living when the patient or caregiver must use special techniques and adaptive devices due to a loss of function;
- 11. Teaching transfer techniques, e.g., from bed to chair, that are needed for safe transfer;
- 12. Teaching proper body alignment and positioning, and timing techniques of a bed-bound patient;
- 13. Teaching ambulation with prescribed assistive devices (such as crutches, walker, cane, etc.) that are needed due to a recent functional loss;
- 14. Teaching prosthesis care and gait training;
- 15. Teaching the use and care of braces, splints and orthotics and associated skin care;
- 16. Teaching the preparation and maintenance of a therapeutic diet; and
- 17. Teaching proper administration of oral medication, including signs of sideeffects and avoidance of interaction with other medications and food.

18. Teaching the proper care and application of any special dressings or skin treatments, (for example, dressings or treatments needed by patients with severe or widespread fungal infections, active and severe psoriasis or eczema, or due to skin deterioration due to radiation treatments)

40.1.2.7 - Catheters

(Rev. 179, Issued: 01-14-14, Effective: 01-07-14, Implementation: 01-07-14) A3-3118.1.B.7, HHA-205.1.B.7

Insertion and sterile irrigation and replacement of catheters, care of a suprapubic catheter, and in selected patients, urethral catheters, are considered to be skilled nursing services. Where the catheter is necessitated by a permanent or temporary loss of bladder control, skilled nursing services that are provided at a frequency appropriate to the type of catheter in use would be considered reasonable and necessary. Absent complications, Foley catheters generally require skilled care once approximately every 30 days and silicone catheters generally require skilled care once every 60-90 days and this frequency of service would be considered reasonable and necessary. However, where there are complications that require more frequent skilled care related to the catheter, such care would, with adequate documentation, be covered.

EXAMPLE: A patient who has a Foley catheter due to loss of bladder control because of multiple sclerosis has a history of frequent plugging of the catheter and urinary tract infections. The physician has ordered skilled nursing visits once per month to change the catheter, and has left a "PRN" order for up to three additional visits per month for skilled observation and evaluation and/or catheter changes if the patient or caregiver reports signs and symptoms of a urinary tract infection or a plugged catheter. During the certification period, the patient's family contacts the HHA because the patient has an elevated temperature, abdominal pain, and scant urine output. The nurse visits the patient and determines that the catheter is plugged and there are symptoms of a urinary tract infection. The nurse changes the catheter and contacts the physician to report findings and discuss treatment. The skilled nursing visit to change the catheter and to evaluate the patient would be reasonable and necessary to the treatment of the illness or injury. *The need for the skilled services must be documented*.

40.1.2.8 - Wound Care

(Rev. 179, Issued: 01-14-14, Effective: 01-07-14, Implementation: 01-07-14) A3-3118.1.B.8, HHA-205.1.B.8

Care of wounds, (including, but not limited to, ulcers, burns, pressure sores, open surgical sites, fistulas, tube sites, and tumor erosion sites) when the skills of a licensed nurse are needed to provide safely and effectively the services necessary to treat the illness or injury, is considered to be a skilled nursing service. For skilled nursing care to be reasonable and necessary to treat a wound, the size, depth, nature of drainage (color, odor, consistency, and quantity), and condition and appearance of the skin surrounding the wound must be documented in the clinical findings so that an assessment of the need for skilled nursing care can be made. Coverage or denial of skilled nursing visits for

wound care may not be based solely on the stage classification of the wound, but rather must be based on all of the documented clinical findings. Moreover, the plan of care must contain the specific instructions for the treatment of the wound. Where the physician has ordered appropriate active treatment (e.g., sterile or complex dressings, administration of prescription medications, etc.) of wounds with the following characteristics, the skills of a licensed nurse are usually reasonable and necessary:

- Open wounds which are draining purulent or colored exudate or have a foul odor present or for which the patient is receiving antibiotic therapy;
- Wounds with a drain or T-tube with requires shortening or movement of such drains;
- Wounds which require irrigation or instillation of a sterile cleansing or medicated solution into several layers of tissue and skin and/or packing with sterile gauze;
- Recently debrided ulcers;
- Pressure sores (decubitus ulcers) with the following characteristics:
 - There is partial tissue loss with signs of infection such as foul odor or purulent drainage; or
 - There is full thickness tissue loss that involves exposure of fat or invasion of other tissue such as muscle or bone.

NOTE: Wounds or ulcers that show redness, edema, and induration, at times with epidermal blistering or desquamation do not ordinarily require skilled nursing care.

- Wounds with exposed internal vessels or a mass that may have a proclivity for hemorrhage when a dressing is changed (e.g., post radical neck surgery, cancer of the vulva);
- Open wounds or widespread skin complications following radiation therapy, or which result from immune deficiencies or vascular insufficiencies;
- Post-operative wounds where there are complications such as infection or allergic reaction or where there is an underlying disease that has a reasonable potential to adversely affect healing (e.g., diabetes);
- Third degree burns, and second degree burns where the size of the burn or presence of complications causes skilled nursing care to be needed;
- Skin conditions that require application of nitrogen mustard or other chemotherapeutic medication that present a significant risk to the patient;

• Other open or complex wounds that require treatment that can only be provided safely and effectively by a licensed nurse.

EXAMPLE 1:

A patient has a second-degree burn with full thickness skin damage on the back. The wound is cleansed, followed by an application of Sulfamylon. While the wound requires skilled monitoring for signs and symptoms of infection or complications, the dressing change requires skilled nursing services. The home health record at each visit must document the need for the skilled nursing services.

EXAMPLE 2:

A patient experiences a decubitus ulcer where the full thickness tissue loss extends through the dermis to involve subcutaneous tissue. The wound involves necrotic tissue with a physician's order to apply a covering of a debriding ointment following vigorous irrigation. The wound is then packed loosely with wet to dry dressings or continuous moist dressing and covered with dry sterile gauze. Skilled nursing care is necessary for proper treatment. The home health record at each visit must document the need for the skilled nursing services.

NOTE: This section relates to the direct, hands on skilled nursing care provided to patients with wounds, including any necessary dressing changes on those wounds. While a wound might not require this skilled nursing care, the wound may still require skilled monitoring for signs and symptoms of infection or complication (See §40.1.2.1) or skilled teaching of wound care to the patient or the patient's family. (See §40.1.2.3.)

40.1.2.9 - Ostomy Care

(Rev. 179, Issued: 01-14-14, Effective: 01-07-14, Implementation: 01-07-14) A3-3118.1.B.9, HHA-205.1.B.9

Ostomy care during the post-operative period and in the presence of associated complications where the need for skilled nursing care is clearly documented is a skilled nursing service. Teaching ostomy care remains skilled nursing care regardless of the presence of complications. *The teaching services and the patient/caregiver responses must be documented.*

40.1.2.13 - Venipuncture

(Rev. 179, Issued: 01-14-14, Effective: 01-07-14, Implementation: 01-07-14) A3-3118.1.B.13, HHA-205.1.B.13

Effective February 5, 1998, venipuncture for the purposes of obtaining a blood sample can no longer be the sole reason for Medicare home health eligibility. However, if a beneficiary qualifies for home health eligibility based on a skilled need other than solely venipuncture (e.g., eligibility based on the skilled nursing service of wound care and

meets all other Medicare home health eligibility criteria), medically reasonable and necessary venipuncture coverage may continue during the 60-day episode under a home health plan of care.

Sections 1814(a)(2)(C) and 1835(a)(2)(A) of the Act specifically exclude venipuncture, as a basis for qualifying for Medicare home health services if this is the sole skilled service the beneficiary requires. However, the Medicare home health benefit will continue to pay for a blood draw if the beneficiary has a need for another qualified skilled service and meets all home health eligibility criteria. This specific requirement applies to home health services furnished on or after February 5, 1998.

For venipuncture to be reasonable and necessary:

- 1. The physician order for the venipuncture for a laboratory test should be associated with a specific symptom or diagnosis, or the documentation should clarify the need for the test when it is not diagnosis/illness specific. In addition, the treatment must be recognized (in the Physician's Desk Reference, or other authoritative source) as being reasonable and necessary to the treatment of the illness or injury for venipuncture and monitoring the treatment must also be reasonable and necessary.
- 2. The frequency of testing should be consistent with accepted standards of medical practice for continued monitoring of a diagnosis, medical problem, or treatment regimen. Even where the laboratory results are consistently stable, periodic venipuncture may be reasonable and necessary because of the nature of the treatment.
- 3. The home health record must document the rationale for the blood draw as well as the results.

Examples of reasonable and necessary venipuncture for stabilized patients include, but are not limited to those described below.

- a. Captopril may cause side effects such as leukopenia and agranulocytosis and it is standard medical practice to monitor the white blood cell count and differential count on a routine basis (every 3 months) when the results are stable and the patient is asymptomatic.
- b. In monitoring phenytoin (e.g., Dilantin) administration, the difference between a therapeutic and a toxic level of phenytoin in the blood is very slight and it is therefore appropriate to monitor the level on a routine basis (every 3 months) when the results are stable and the patient is asymptomatic.
- c. Venipuncture for fasting blood sugar (FBS)

- An unstable insulin dependent or noninsulin dependent diabetic would require FBS more frequently than once per month if ordered by the physician.
- Where there is a new diagnosis or where there has been a recent exacerbation, but the patient is not unstable, monitoring once per month would be reasonable and necessary.
- A stable insulin or noninsulin dependent diabetic would require monitoring every 2-3 months.

d. Venipuncture for prothrombin

- Where the documentation shows that the dosage is being adjusted, monitoring would be reasonable and necessary as ordered by the physician.
- Where the results are stable within the therapeutic ranges, monthly monitoring would be reasonable and necessary.
- Where the results *remain* within nontherapeutic ranges, there must be *specific* documentation of *the* factors *that* indicate why continued monitoring is reasonable and necessary.

EXAMPLE: A patient with coronary artery disease was hospitalized with atrial fibrillation and subsequently discharged to the HHA with orders for anticoagulation therapy *as well as other skilled nursing care. If indicated*, monthly venipuncture to report prothrombin (protime) levels to the physician *would be reasonable and necessary even though* the patient's prothrombin time tests indicate essential stability. *The home health record must document the rationale for the blood draw as well as the results*.

40.1.2.14 - Student Nurse Visits

(Rev. 179, Issued: 01-14-14, Effective: 01-07-14, Implementation: 01-07-14) A3-3118.1.B.14, HHA-205.1.B.14

Visits made by a student nurse may be covered as skilled nursing care when the HHA participates in training programs that utilize student nurses enrolled in a school of nursing to perform skilled nursing services in a home setting. To be covered, the services must be reasonable and necessary skilled nursing care and must be performed under the general supervision of a registered or licensed nurse. The supervising nurse need not accompany the student nurse on each visit. *All documentation requirements must be fulfilled by student nurses*.

40.1.2.15 - Psychiatric Evaluation, Therapy, and Teaching (*Rev. 179, Issued: 01-14-14, Effective: 01-07-14, Implementation: 01-07-14*) A3-3118.1.B.15, HHA-205.1.B.15

The evaluation, psychotherapy, and teaching needed by a patient suffering from a diagnosed psychiatric disorder that requires active treatment by a psychiatrically trained nurse and the costs of the psychiatric nurse's services may be covered as a skilled nursing service. Psychiatrically trained nurses are nurses who have special training and/or experience beyond the standard curriculum required for a registered nurse. The services of the psychiatric nurse are to be provided under a plan of care established and reviewed by a physician.

Because the law precludes agencies that primarily provide care and treatment of mental diseases from participating as HHAs, psychiatric nursing must be furnished by an agency that does not primarily provide care and treatment of mental diseases. If a substantial number of an HHA's patients attend partial hospitalization programs or receive outpatient mental health services, the intermediary will verify whether the patients meet the eligibility requirements specified in §30 and whether the HHA is primarily engaged in care and treatment of mental disease.

Services of a psychiatric nurse would not be considered reasonable and necessary to assess or monitor use of psychoactive drugs that are being used for nonpsychiatric diagnoses or to monitor the condition of a patient with a known psychiatric illness who is on treatment but is considered stable. A person on treatment would be considered stable if their symptoms were absent or minimal or if symptoms were present but were relatively stable and did not create a significant disruption in the patient's normal living situation.

EXAMPLE 1:

A patient is homebound for medical conditions, but has a psychiatric condition for which he has been receiving medication. The patient's psychiatric condition has not required a change in medication or hospitalization for over 2 years. During a visit by the nurse, the patient's spouse indicates that the patient is awake and pacing most of the night and has begun ruminating about perceived failures in life. The nurse observes that the patient does not exhibit an appropriate level of hygiene and is dressed inappropriately for the season. The nurse comments to the patient about her observations and tries to solicit information about the patient's general medical condition and mental status. The nurse advises the physician about the patient's general medical condition and the new symptoms and changes in the patient's behavior. The physician orders the nurse to check blood levels of medication used to treat the patient's medical and psychiatric conditions. The physician then orders the psychiatric nursing service to evaluate the patient's mental health and communicate with the physician about whether additional intervention to deal with the patient's symptoms and behaviors is warranted. *The home health record at each visit should document the need for the psychiatric skilled nursing services and treatment.*

The home health record must also reflect the patient/caregiver response to any interventions provided.

EXAMPLE 2:

A patient is homebound after discharge following hip replacement surgery and is receiving skilled therapy services for range of motion exercise and gait training. In the past, the patient had been diagnosed with clinical depression and was successfully stabilized on medication. There has been no change in her symptoms. The fact that the patient is taking an antidepressant does not indicate a need for psychiatric nursing services.

EXAMPLE 3:

A patient was discharged after 2 weeks in a psychiatric hospital with a new diagnosis of major depression. The patient remains withdrawn; in bed most of the day, and refusing to leave home. The patient has a depressed affect and continues to have thoughts of suicide, but is not considered to be suicidal. Psychiatric *skilled* nursing *services are* necessary for supportive interventions until antidepressant blood levels are reached and the suicidal thoughts are diminished further, to monitor suicide ideation, ensure medication compliance and patient safety, perform suicidal assessment, and teach crisis management and symptom management to family members. *The home health record at each visit should document the need for the psychiatric skilled nursing services and treatment. The home health record must also reflect the patient/caregiver response to any interventions provided.*

40.2 - Skilled Therapy Services

(Rev. 179, Issued: 01-14-14, Effective: 01-07-14, Implementation: 01-07-14) A3-3118.2, HHA-205.2

To be covered as skilled therapy, the services must require the skills of a qualified therapist and must be reasonable and necessary for the treatment of the patient's illness or injury as discussed below. Coverage does not turn on the presence or absence of an individual's potential for improvement, but rather on the beneficiary's need for skilled care.

40.2.1 - General Principles Governing Reasonable and Necessary Physical Therapy, Speech-Language Pathology Services, and Occupational Therapy

(Rev. 179, Issued: 01-14-14, Effective: 01-07-14, Implementation: 01-07-14)

The service of a physical therapist, speech-language pathologist, 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 general supervision of a skilled therapist. To be covered, *assuming all other eligibility and coverage criteria have been met*, the skilled services must also be reasonable and necessary to the treatment of the

patient's illness or injury or to the restoration or maintenance of function affected by the patient's illness or injury. It is necessary to determine whether individual therapy services are skilled and whether, in view of the patient's overall condition, skilled management of the services provided is needed.

The development, implementation, management, and evaluation of a patient care plan based on the physician's orders constitute skilled therapy services when, because of the patient's *clinical* condition, those activities require the *specialized* skills, *knowledge*, *and judgment* of a qualified therapist to ensure the effectiveness of the treatment goals and ensure medical safety. Where the *specialized* skills, *knowledge*, *and judgment* of a therapist are needed to manage and periodically reevaluate the appropriateness of a maintenance program, such services would be covered, even if the skills of a therapist were not needed to carry out the activities performed as part of the maintenance program.

While a patient's particular medical condition is a valid factor in deciding if skilled therapy services are needed, a patient's diagnosis or prognosis should never be the sole factor in deciding that a service is or is not skilled. The key issue is whether the skills of a therapist are needed to treat the illness or injury, or whether the services can be carried out by *unskilled* personnel.

A service that is ordinarily considered *unskilled* could be considered a skilled therapy service in cases *where* there is clear documentation that, because of special medical complications, skilled rehabilitation personnel are required to perform the service. However, the importance of a particular service to a patient or the frequency with which it must be performed does not, by itself, make *an unskilled* service into a skilled service.

Assuming all other eligibility and coverage criteria have been met, the skilled therapy services must be reasonable and necessary to the treatment of the patient's illness or injury within the context of the patient's unique medical condition. To be considered reasonable and necessary for the treatment of the illness or injury:

- a. The services must be consistent with the nature and severity of the illness or injury, the patient's particular medical needs, including the requirement that the amount, frequency, and duration of the services must be reasonable; and
- b. The services must be considered, under accepted standards of medical practice, to be specific, safe, and effective treatment for the patient's condition, meeting the standards noted below. *The home health record must specify the purpose of the skilled service provided*.

1. Assessment, Measurement and Documentation of Therapy Effectiveness

To ensure therapy services are effective, at defined points during a course of treatment, for each therapy discipline for which services are provided, a qualified therapist (instead of an assistant) must perform the ordered therapy service. During this visit, the therapist must assess the patient using a method which

allows for objective measurement of function and successive comparison of measurements. The therapist must document the measurement results in the clinical record. Specifically:

i. <u>Initial Therapy Assessment</u>

- For each therapy discipline for which services are provided, a qualified therapist (instead of an assistant) must assess the patient's function using a method which objectively measures activities of daily living such as, but not limited to, eating, swallowing, bathing, dressing, toileting, walking, climbing stairs, using assistive devices, and mental and cognitive factors. The measurement results must be documented in the clinical record.
- Where more than one discipline of therapy is being provided, a qualified
 therapist from each of the disciplines must functionally assess the patient.
 The therapist must document the measurement results which correspond to
 the therapist's discipline and care plan goals in the clinical record.

ii. Reassessment at least every 30 days (performed in conjunction with an ordered therapy service)

- At least once every 30 days, for each therapy discipline for which services are provided, a qualified therapist (instead of an assistant) must provide the ordered therapy service, functionally reassess the patient, and compare the resultant measurement to prior assessment measurements. The therapist must document in the clinical record the measurement results along with the therapist's determination of the effectiveness of therapy, or lack thereof. The 30-day clock begins with the first therapy service (of that discipline) and the clock resets with each therapist's visit/assessment/measurement/documentation (of that discipline).
- Where more than one discipline of therapy is being provided, at least once every 30 days, a qualified therapist from each of the disciplines must provide the ordered therapy service, functionally reassess the patient, and compare the resultant measurement to prior assessment measurements. The therapist must document in the clinical record the measurement results along with the therapist's determination of the effectiveness of therapy, or lack thereof. In multi-discipline therapy cases, the qualified therapist would reassess functional items (and measure and document) those which correspond to the therapist's discipline and care plan goals. In cases where more than one discipline of therapy is being provided, the 30-day clock begins with the first therapy service (of that discipline) and the clock resets with each therapist's visit/assessment/measurement/documentation (of that discipline).

iii. Reassessment prior to the 14th and 20th therapy visit

- If a patient's course of therapy treatment reaches 13 therapy visits, for each therapy discipline for which services are provided, a qualified therapist (instead of an assistant) must provide the ordered 13th therapy service, functionally reassess the patient, and compare the resultant measurement to prior measurements. The therapist must document in the clinical record the measurement results along with the therapist's determination of the effectiveness of therapy, or lack thereof.
 - Similarly, if a patient's course of therapy treatment reaches 19 therapy visits, a qualified therapist (instead of an assistant) must provide the ordered 19th therapy service, functionally reassess, measure and document the effectiveness of therapy, or lack thereof.
 - When the patient resides in a rural area or when documented circumstances outside the control of the therapist prevent the qualified therapist's visit at exactly the 13th visit, the qualified therapist's visit can occur after the 10th therapy visit but no later than the 13th visit. Similarly, in rural areas or if documented exceptional circumstances exist, the qualified therapist's visit can occur after the 16th therapy visit but no later than the 19th therapy visit.
 - Where more than one discipline of therapy is being provided, a qualified therapist from each of the disciplines must provide the ordered therapy service and functionally reassess, measure, and document the effectiveness of therapy or lack thereof close to but no later than the 13th and 19th therapy visit. The 13th and 19th therapy visit timepoints relate to the sum total of therapy visits from all therapy disciplines. In multi-discipline therapy cases, the qualified therapist would reassess functional items and measure those which correspond to the therapist's discipline and care plan goals.
 - Therapy services provided after the 13th and 19th visit (sum total of therapy visits from all therapy disciplines), are not covered until:
 - The qualified therapist(s) completes the assessment/measurement/documentation requirements.
 - O The qualified therapist(s) determines if the goals of the plan of care have been achieved or if the plan of care may require updating. If needed, changes to therapy goals or an updated plan of care is sent to the physician for signature or discharge.
 - o If the measurement results do not reveal progress toward therapy goals and/or do not indicate that therapy is effective, but therapy continues, the qualified therapist(s) must document why the

physician and therapist have determined therapy should be continued.

- c. Services involving activities for the general welfare of any patient, e.g., general exercises to promote overall fitness or flexibility and activities to provide diversion or general motivation do not constitute skilled therapy. *Unskilled* individuals without the supervision of a therapist can perform those services.
- d. Assuming all other eligibility and coverage requirements have been met, in order for therapy services to be covered, one of the following three conditions must be met:
 - 1. The skills of a qualified therapist are needed to restore patient function:
 - To meet this coverage condition, therapy services must be provided with the expectation, based on the assessment made by the physician of the patient's restorative potential that the condition of the patient will improve materially in a reasonable and generally predictable period of time.
 Improvement is evidenced by objective successive measurements.
 - Therapy is not considered reasonable and necessary under this condition if the patient's expected restorative potential would be insignificant in relation to the extent and duration of therapy services required to reach such potential.
 - Therapy is not required to effect improvement or restoration of function where a patient suffers a transient or easily reversible loss of function (such as temporary weakness following surgery) which could reasonably be expected to improve spontaneously as the patient gradually resumes normal activities. Therapy in such cases is not considered reasonable and necessary to treat the patient's illness or injury, under this condition. However, if the criteria for maintenance therapy described in (3) below is met, therapy could be covered under that condition.
 - 2. The patient's *clinical* condition requires *the specialized skills, knowledge, and judgment of* a qualified therapist to establish *or design* a maintenance program, *related to the patient's illness or injury, in order to ensure the safety of the patient and the effectiveness of the program, to the extent provided by regulation,*
 - For patients receiving rehabilitative/restorative therapy services, if the specialized skills, knowledge, and judgment of a qualified therapist are required to develop a maintenance program, the expectation is that the development of that maintenance program would occur during the last visit(s) for rehabilitative/restorative treatment. The goals of a maintenance program would be to maintain the patient's current functional status or to prevent or slow further deterioration.

- *Necessary periodic* reevaluations *by a qualified therapist* of the beneficiary and maintenance program *are* covered if the specialized skills, *knowledge, and judgment* of a qualified therapist *are required*.
- Where a maintenance program is not established until after the rehabilitative/restorative therapy program has been completed, or where there was no rehabilitative/restorative therapy program, and the specialized skills, knowledge, and judgment of a qualified therapist are required to develop a maintenance program, such services would be considered reasonable and necessary for the treatment of the patient's condition in order to ensure the effectiveness of the treatment goals and ensure medical safety. When the development of a maintenance program could not be accomplished during the last visits(s) of rehabilitative/restorative treatment, the therapist must document why the maintenance program could not be developed during those last rehabilitative/restorative treatment visit(s).
- When designing or establishing a maintenance program, the qualified therapist must teach the patient or the patient's family or caregiver's necessary techniques, exercises or precautions as necessary to treat the illness or injury. The instruction of the beneficiary or appropriate caregiver by a qualified therapist regarding a maintenance program is covered if the specialized skills, knowledge, and judgment of a qualified therapist are required. However, visits made by skilled therapists to a patient's home solely to train other HHA staff (e.g., home health aides) are not billable as visits since the HHA is responsible for ensuring that its staff is properly trained to perform any service it furnishes. The cost of a skilled therapist's visit for the purpose of training HHA staff is an administrative cost to the agency.
- 3. The skills of a qualified therapist (*not an assistant*) are needed to perform maintenance therapy:

Coverage of therapy services to perform a maintenance program is not determined solely on the presence or absence of a beneficiary's potential for improvement from the therapy, but rather on the beneficiary's need for skilled care. Assuming all other eligibility and coverage requirements are met, skilled therapy services are covered when an individualized assessment of the patient's clinical condition demonstrates that the specialized judgment, knowledge, and skills of a qualified therapist ("skilled care") are necessary for the performance of a safe and effective maintenance program. Such a maintenance program to maintain the patient's current condition or to prevent or slow further deterioration is covered so long as the beneficiary requires skilled care for the safe and effective performance of the program. When, however, the individualized

assessment does not demonstrate such a necessity for skilled care, including when the performance of a maintenance program does not require the skills of a therapist because it could safely and effectively be accomplished by the patient or with the assistance of non-therapists, including unskilled caregivers, such maintenance services will not be covered.

Further, under the standard set forth in the previous paragraph, skilled care is necessary for the performance of a safe and effective maintenance program only when (a) the particular patient's special medical complications require the skills of a qualified therapist to perform a therapy service that would otherwise be considered non-skilled; or (b) the needed therapy procedures are of such complexity that the skills of a qualified therapist are required to perform the procedure.

e. The amount, frequency, and duration of the services must be reasonable.

As is outlined in home health regulations, as part of the home health agency (HHA) Conditions of Participation (CoPs), the clinical record of the patient must contain progress and clinical notes. Additionally, in Pub. 100-04, Medicare Claims Processing Manual, Chapter 10; "Home Health Agency Billing", instructions specify that for each claim, HHAs are required to report all services provided to the beneficiary during each episode, this includes reporting each visit in line-item detail. As such, it is expected that the home health records for every visit will reflect the need for the skilled medical care provided. These clinical notes are also expected to provide important communication among all members of the home care team regarding the development, course and outcomes of the skilled observations, assessments, treatment and training performed. Taken as a whole then, the clinical notes are expected to tell the story of the patient's achievement towards his/her goals as outlined in the Plan of Care. In this way, the notes will serve to demonstrate why a skilled service is needed.

Therefore the home health clinical notes must document as appropriate:

- the history and physical exam pertinent to the day's visit, (including the response or changes in behavior to previously administered skilled services) and
- the skilled services applied on the current visit, and
- the patient/caregiver's immediate response to the skilled services provided, and
- the plan for the next visit based on the rationale of prior results.

Clinical notes should be written such that they adequately describe the reaction of a patient to his/her skilled care. Clinical notes should also provide a clear picture of the treatment, as well as "next steps" to be taken. Vague or subjective descriptions of the patient's care should not be used. For example terminology such as the following would not adequately describe the need for skilled care:

- Patient tolerated treatment well
- Caregiver instructed in medication management
- Continue with POC

Objective measurements of physical outcomes of treatment should be provided and/or a clear description of the changed behaviors due to education programs should be recorded in order that all concerned can follow the results of the applied services.

When the skilled service is being provided to either maintain the patient's condition or prevent or slow further deterioration, the clinical notes must also describe:

- A detailed rationale that explains the need for the skilled service in light of the patient's overall medical condition and experiences,
- the complexity of the service to be performed, and
- any other pertinent characteristics of the beneficiary or home.

40.2.2 - Application of the Principles to Physical Therapy Services (Rev. 179, Issued: 01-14-14, Effective: 01-07-14, Implementation: 01-07-14)

The following discussion of skilled physical therapy services applies the principles in <u>§40.2.1</u> to specific physical therapy services about which questions are most frequently raised.

A. Assessment

Assuming all other eligibility and coverage requirements have been met, the skills of a physical therapist to assess and periodically reassess a patient's rehabilitation needs and potential or to develop and/or implement a physical therapy program are covered when they are reasonable and necessary because of the patient's condition. Skilled rehabilitation services concurrent with the management of a patient's care plan include objective tests and measurements such as, but not limited to, range of motion, strength, balance, coordination, endurance, or functional ability.

As described in section 40.2.1(b), at defined points during a course of therapy, the qualified physical therapist (instead of an assistant) must perform the ordered therapy service visit, assess the patient's function using a method which allows for objective measurement of function and comparison of successive measurements, and document the results of the assessments, corresponding measurements, and effectiveness of the therapy

in the patient's clinical record. Refer to §40.2.1(b) for specific timing and documentation requirements associated with these requirements.

B. Therapeutic Exercises

Therapeutic exercises, which require the skills of a qualified physical therapist to ensure the safety of the beneficiary and the effectiveness of the treatment constitute skilled physical therapy, when the criteria in §40.2.1(d) above are met.

C. Gait Training

Gait evaluation and training furnished to a patient whose ability to walk has been impaired by neurological, muscular or skeletal abnormality require the skills of a qualified physical therapist and constitute skilled physical therapy and are considered reasonable and necessary if they can be expected to materially improve *or maintain* the patient's ability to walk *or prevent or slow further deterioration of the patient's ability to walk*. Gait evaluation and training which is furnished to a patient whose ability to walk has been impaired by a condition other than a neurological, muscular, or skeletal abnormality would nevertheless be covered where physical therapy is reasonable and necessary to restore *or maintain* function *or to prevent or slow further deterioration*. Refer to §40.2.1(d)(1) for the reasonable and necessary coverage criteria associated with restoring patient function.

EXAMPLE 1:

A physician has ordered gait evaluation and training for a patient whose gait has been materially impaired by scar tissue resulting from burns. Physical therapy services to evaluate the beneficiary's gait, establish a gait training program, and provide the skilled services necessary to implement the program would be covered. *The patient's response to therapy must be documented. At appropriate intervals (see above), the qualified therapist must assess the patient with objective measurements of function.*

EXAMPLE 2:

A patient who has had a total hip replacement is ambulatory but demonstrates weakness and is unable to climb stairs safely. Physical therapy would be reasonable and necessary to teach the patient to climb and descend stairs safely. Once the patient has reached the goal of climbing and descending stairs safely, additional therapy services are no longer required, and thus would not be covered.

EXAMPLE 3:

A patient who has received gait training has reached their maximum restoration potential, and the physical therapist is teaching the patient and family how to safely perform the activities that are a part of the maintenance program. The visits by the physical therapist to demonstrate and teach the activities (which by themselves do not require the skills of a

therapist) would be covered since they are needed to establish the program (refer to §40.2.1(d)(2)). The patient's and caregiver's understanding and implementation of the maintenance program must be documented. After the establishment of the maintenance program, any further visits would need to document why the skilled services of a physical therapist are still required.

D. Range of Motion

Only a qualified physical therapist may perform range of motion tests and, therefore, such tests are skilled physical therapy.

Range of motion exercises constitute skilled physical therapy only if they are part of an active treatment for a specific disease state, illness, or injury that has resulted in a loss or restriction of mobility (as evidenced by physical therapy notes showing the degree of motion lost and the degree to be restored). *Unskilled* individuals may provide range of motion exercises unrelated to the restoration of a specific loss of function often safely and effectively. Passive exercises to maintain range of motion in paralyzed extremities that can be carried out by *unskilled* persons do not constitute skilled physical therapy.

However, if the criteria in §40.2.1(d)(3) are met, where there is clear documentation that, because of special medical complications (e.g., susceptible to pathological bone fractures), the skills of a therapist are needed to provide services which ordinarily do not need the skills of a therapist, and then the services would be covered.

E. Maintenance Therapy

Where services that are required to maintain the patient's current function or to prevent or slow further deterioration are of such complexity and sophistication that the skills of a qualified therapist are required to perform the procedure safely and effectively, the services would be covered physical therapy services. Further, where the particular patient's special medical complications require the skills of a qualified therapist to perform a therapy service safely and effectively that would otherwise be considered unskilled, such services would be covered physical therapy services. Refer to \$40.2.1(d)(3).

EXAMPLE 4:

Where there is an unhealed, unstable fracture that requires regular exercise to maintain function until the fracture heals, the skills of a physical therapist would be needed to ensure that the fractured extremity is maintained in proper position and alignment during maintenance range of motion exercises.

EXAMPLE 5:

A Parkinson's patient or a patient with rheumatoid arthritis who has not been under a restorative physical therapy program may require the services of a physical therapist to

determine what type of exercises are required to maintain the patient's present level of function *or to prevent or slow further deterioration*. The initial evaluation of the patient's needs, the designing of a maintenance program appropriate to *the patient's* capacity and tolerance and *to* the treatment objectives of the physician, the instruction of the patient, family or caregivers to carry out the program safely and effectively, and such reevaluations as may be required by the patient's condition, would constitute skilled physical therapy. *Each component of this process must be documented in the home health record*.

While a patient is under a restorative physical therapy program, the physical therapist should regularly reevaluate the patient's condition and adjust any exercise program the patient is expected to carry out alone or with the aid of supportive personnel to maintain the function being restored. Consequently, by the time it is determined that no further restoration is possible (i.e., by the end of the last restorative session) the physical therapist will already have designed the maintenance program required and instructed the patient or caregivers in carrying out the program.

F. Ultrasound, Shortwave, and Microwave Diathermy Treatments

These treatments must always be performed by or under the supervision of a qualified physical therapist and are skilled therapy.

G. Hot Packs, Infra-Red Treatments, Paraffin Baths and Whirlpool Baths

Heat treatments and baths of this type ordinarily do not require the skills of a qualified physical therapist. However, the skills, knowledge, and judgment of a qualified physical therapist might be required in the giving of such treatments or baths in a particular case, e.g., where the patient's condition is complicated by circulatory deficiency, areas of desensitization, open wounds, fractures, or other complications. *There must be clear documentation in the home health record, of the special medical complications that describe the need for the skilled services provided by the therapist.*

H. Wound Care Provided Within Scope of State Practice Acts

If wound care falls within the auspice of a physical therapist's State Practice Act, then the physical therapist may provide the specific type of wound care services defined in the State Practice Act. However, such visits in this specific situation would be a covered therapy service when there is documentation in the home health record that the skills of a therapist are required to perform the service. The patient's response to therapy must be documented.

40.2.3 - Application of the General Principles to Speech-Language Pathology Services

(Rev. 179, Issued: 01-14-14, Effective: 01-07-14, Implementation: 01-07-14)

The following discussion of skilled speech-language pathology services applies the principles to specific speech-language pathology services about which questions are most frequently raised. Coverage of speech-language pathology services is not determined solely on the presence or absence of a beneficiary's potential for improvement from the therapy, but rather on the beneficiary's need for skilled care. Assuming all other eligibility and coverage requirements have been met, skilled speech-language pathology services are covered when the individualized assessment of the patient's clinical condition demonstrates that the specialized judgment, knowledge, and skills of a qualified speech-language pathologist are necessary.

As described in §40.2.1(b), at defined points during a course of therapy, the qualified speech-language pathologist must perform the ordered therapy service visit, assess the patient's function using a method which allows for objective measurement of function and comparison of successive measurements, and document the results of the assessments, corresponding measurements, and effectiveness of therapy in the patient's clinical record. Refer to §40.2.1(b) for specific timing and documentation requirements associated with these requirements.

- 1. The skills of a speech-language pathologist are required for the assessment of a patient's rehabilitation needs (including the causal factors and the severity of the speech and language disorders), and rehabilitation potential. Reevaluation would be considered reasonable and necessary only if the patient exhibited:
 - A change in functional speech or motivation;
 - Clearing of confusion; or
 - The remission of some other medical condition that previously contraindicated speech-language pathology services.

Where a patient is undergoing restorative speech-language pathology services, routine reevaluations are considered to be a part of the therapy and cannot be billed as a separate visit.

- 2. The services of a speech-language pathologist would be covered if they are needed as a result of an illness or injury and are directed towards specific speech/voice production.
- 3. Speech-language pathology would be covered where *a skilled* service can only be provided by a speech-language pathologist and where it is reasonably expected that the *skilled* service will improve, *maintain*, *or prevent or slow further deterioration in* the patient's ability to carry out *communication or feeding* activities.
- 4. The services of a speech-language pathologist to establish a hierarchy of speech-voice-language communication tasks and cueing that directs a patient toward speech-

language communication goals in the plan of care would be covered speech-language pathology.

- 5. The services of a speech-language pathologist to train the patient, family, or other caregivers to augment the speech-language communication, treatment, to establish an effective maintenance program, or carry out a safe and effective maintenance program when the particular patient's special medical complications require the skills of a qualified therapist (not an assistant) to perform a therapy service that would otherwise be considered unskilled or the needed therapy procedures are of such complexity that the skills of a qualified therapist are required to perform the procedures, would be covered speech-language pathology services.
- 6. The services of a speech-language pathologist to assist patients with aphasia in rehabilitation of speech and language skills are covered when needed by a patient.
- 7. The services of a speech-language pathologist to assist patients with voice disorders to develop proper control of the vocal and respiratory systems for correct voice production are covered when needed by a patient.

40.2.4 - Application of the General Principles to Occupational Therapy (Rev. 179, Issued: 01-14-14, Effective: 01-07-14, Implementation: 01-07-14) A3-3118.2.D, HHA-205.2.D

The following discussion of skilled occupational therapy services applies the principles to specific occupational therapy services about which questions are most frequently raised. Coverage of occupational therapy services is not determined solely on the presence or absence of a beneficiary's potential for improvement from the therapy, but rather on the beneficiary's need for skilled care. Assuming all other eligibility and coverage requirements have been met, skilled occupational therapy services are covered when the individualized assessment of the patient's clinical condition demonstrates that the specialized judgment, knowledge, and skills of a qualified occupational therapist are necessary.

40.2.4.1 - Assessment

(Rev. 179, Issued: 01-14-14, Effective: 01-07-14, Implementation: 01-07-14)

Assuming all other eligibility and coverage requirements are met, the skills of an occupational therapist to assess and reassess a patient's rehabilitation needs and potential or to develop and/or implement an occupational therapy program are covered when they are reasonable and necessary because of the patient's condition.

As described in §40.2.1(b), at defined points during a course of therapy, the qualified occupational therapist (instead of an assistant) must perform the ordered therapy service visit, assess the *patient's* function using a method which allows for objective measurement of function and comparison of successive measurements, and document the results of the assessments, corresponding measurements, and effectiveness of therapy in

the patient's clinical record. Refer to §40.2.1(b) for specific timing and documentation requirements associated with these requirements.

40.2.4.3 - Illustration of Covered Services

(Rev. 179, Issued: 01-14-14, Effective: 01-07-14, Implementation: 01-07-14) A3-3118.2.D.3, HHA-205.2.D.3

EXAMPLE 1:

A physician orders occupational therapy for a patient who is recovering from a fractured hip and who needs to be taught compensatory and safety techniques with regard to lower extremity dressing, hygiene, toileting, and bathing. The occupational therapist will establish goals for the patient's rehabilitation (to be approved by the physician), and will undertake teaching techniques necessary for the patient to reach the goals. Occupational therapy services would be covered at a duration and intensity appropriate to the severity of the impairment and the patient's response to treatment. Such visits would be considered covered when the skills of a therapist are required to perform the services. The patient's needs in response to therapy must be documented.

EXAMPLE 2:

A physician has ordered occupational therapy for a patient who is recovering from a CVA. The patient has decreased range of motion, strength, and sensation in both the upper and lower extremities on the right side. In addition, the patient has perceptual and cognitive deficits resulting from the CVA. The patient's condition has resulted in decreased function in activities of daily living (specifically bathing, dressing, grooming, hygiene, and toileting). The loss of function requires assistive devices to enable the patient to compensate for the loss of function and maximize safety and independence. The patient also needs equipment such as himi-slings to prevent shoulder subluxation and a hand splint to prevent joint contracture and deformity in the right hand. The services of an occupational therapist would be necessary to:

- Assess the patient's needs;
- Develop goals (to be approved by the physician);
- Manufacture or adapt the needed equipment to the patient's use;
- Teach compensatory techniques;
- Strengthen the patient as necessary to permit use of compensatory techniques; and
- Provide activities that are directed towards meeting the goals governing increased perceptual and cognitive function.

Occupational therapy services would be covered at a duration and intensity appropriate to the severity of the impairment and the patient's response to treatment. Such visits would be considered covered therapy services when the skills of a therapist are required to perform the services. The patient's needs, course of therapy and response to therapy must be documented.



Medicare & Home Health Care

(www.Medicare.gov)

CENTERS for MEDICARE & MEDICAID SERVICES



Medicare & Home Health Care

This official government booklet tells you:

- Who's eligible
- What services are covered
- How to find and compare home health agencies
- Your Medicare rights



Paid for by the Department of Health & Human Services.

The information in this booklet describes the Medicare Program at the time this booklet was printed. Visit Medicare.gov, or call 1-800-MEDICARE (1-800-633-4227) to get the most current information. TTY users can call 1-877-486-2048.

"Medicare & Home Health Care" isn't a legal document. Official Medicare Program legal guidance is contained in the relevant statutes, regulations, and rulings.

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Home health care

Many health care treatments that were once offered only in a hospital or a doctor's office can now be done in your home. Home health care is usually less expensive, more convenient, and can be just as effective as care you get in a hospital or skilled nursing facility. In general, the goal of home health care is to provide treatment for an illness or injury. Where possible, home health care helps you get better, regain your independence, and become as self-sufficient as possible. Home health care may also help you maintain your current condition or level of function, or to slow decline.

Medicare pays for you to get health care services in your home if you meet certain eligibility criteria and if the services are considered reasonable and necessary for the treatment of your illness or injury.

This booklet describes the home health care services that Medicare covers, and how to get those benefits through Medicare. If you get your Medicare benefits through a Medicare health plan (not Original Medicare) check your plan's membership materials, and contact the plan for details about how the plan provides your Medicare-covered home health benefits.

Section 1: Medicare Coverage of Home Health Care

Who's eligible?

If you have Medicare, you can use your home health benefits if:

- 1. You're under the care of a doctor, and you're getting services under a plan of care established and reviewed regularly by a doctor.
- 2. You need, and a doctor certifies that you need, one or more of these:
 - Intermittent skilled nursing care (other than drawing blood)
 - Physical therapy
 - Speech-language pathology services
 - Continued occupational therapy
 See pages 8–9 for more details on these services.
- 3. The home health agency caring for you is approved by Medicare (Medicare certified).
- 4. You're homebound, and a doctor certifies that you're homebound. To be homebound means:
 - You have trouble leaving your home without help (like using a cane, wheelchair, walker, or crutches; special transportation; or help from another person) because of an illness or injury, or leaving your home isn't recommended because of your condition.
 - You're normally unable to leave your home, but if you do it requires a major effort.

You may leave home for medical treatment or short, infrequent absences for non-medical reasons, like an occasional trip to the barber, a walk around the block or a drive, or attendance at a family reunion, funeral, graduation,

Words in red are defined on pages 27–28.

- or other infrequent or unique event. You can still get home health care if you attend adult day care or religious services.
- 5. As part of your certification of eligibility, a doctor, or certain health care professionals who work with a doctor (like a nurse practitioner), must document that they've had a face-to-face encounter with you (like an appointment with your primary care doctor) within required timeframes and that the encounter was related to the reason you need home health care.

If you only need skilled nursing care, but you need more than "intermittent" skilled nursing care, you don't qualify for home health services. To determine if you're eligible for home health care based on a medically predictable recurring need for skilled nursing, Medicare defines "intermittent" as skilled nursing care that's needed or given either:

- Fewer than 7 days each week.
- Daily for less than 8 hours each day for up to 21 days. Medicare may extend the three week limit in exceptional circumstances if your doctor can predict when your need for daily skilled nursing care will end.

If you're expected to need full-time skilled nursing care over an extended period of time, you wouldn't usually qualify for home health benefits.



How Medicare pays for home health care

Medicare pays your Medicare-certified home health agency one payment for the covered services you get during a 60-day period. This 60-day period is called an "episode of care." The payment is based on your condition and care needs.

Getting treatment from a home health agency that's Medicare certified can reduce your out-of-pocket costs. A Medicare certified home health agency agrees to:

- Be paid by Medicare
- Accept only the amount Medicare approves for their services

Medicare's home health benefit only pays for services provided by the home health agency. Other medical services, like visits to your doctor or equipment, are generally still covered by your other Medicare benefits.

Look in your "Medicare & You" handbook for information on how these services are covered under Medicare. To view or print this booklet, visit Medicare.gov/publications. You can also call 1-800-MEDICARE (1-800-633-4227) if you have questions about your Medicare benefits. TTY users can call 1-877-486-2048.

What's covered?

If you're eligible for Medicare-covered home health care (see page 5), Medicare covers these services if they're reasonable and necessary for the treatment of your illness or injury. Skilled nursing and therapy services are covered when a personalized assessment of your clinical condition shows that the specialized judgment, knowledge, and skills of a nurse or therapist are necessary for the services to be safely and effectively provided.

• Skilled nursing care: Medicare covers skilled nursing care when the services you need require the skills of a nurse, are reasonable and necessary for the treatment of your illness or injury, and are given on a part-time or intermittent basis (visits solely for the purpose of getting your blood drawn aren't covered by Medicare). "Part-time or intermittent" means you may be able to get home health aide and skilled nursing services (combined) any number of days per week as long as the services are provided:

- Fewer than 8 hours each day
- 28 or fewer hours each week (or up to 35 hours a week in some limited situations)

A registered nurse (RN) or a licensed practical nurse (LPN) can provide skilled nursing services. If you get services from an LPN, your care will be supervised by an RN. Home health nurses provide direct care and teach you and your caregivers about your care. They also manage, observe, and evaluate your care. Examples of skilled nursing care include: giving IV drugs, certain injections, or tube feedings; changing dressings; and teaching about prescription drugs or diabetes care. Any service that could be done safely and effectively by a non-medical person (or by yourself) without the supervision of a nurse <code>isn't</code> skilled nursing care.

- Physical therapy, occupational therapy, and speech-language pathology services: Your therapy services are considered reasonable and necessary in the home setting if:
 - 1. They're a specific, safe, and effective treatment for your condition
 - 2. They're complex such that your condition requires services that can only be safely and effectively performed by, or under the supervision of, qualified therapists
 - 3. Your condition requires one of these:
 - Therapy that's reasonable and necessary to restore or improve functions affected by your illness or injury
 - A skilled therapist to safely and effectively establish a program and/or perform therapy under a maintenance program to help you maintain your current condition or to prevent your condition from getting worse
 - 4. The amount, frequency, and duration of the services are reasonable
- **Home health aide services:** Medicare will pay for part-time or intermittent home health aide services (like personal care), if needed to maintain your health or treat your illness or injury. Medicare

doesn't cover home health aide services unless you're also getting skilled care. Skilled care includes:

- Skilled nursing care
- Physical therapy
- Speech-language pathology services
- Continuing occupational therapy, if you no longer need any of the above

"Part-time or intermittent" means you may be able to get home health aide and skilled nursing services (combined) any number of days per week, as long as the services are provided:

- Fewer than 8 hours each day
- 28 or fewer hours each week (or up to 35 hours a week in some limited situations)
- Medical social services: Medicare covers these services when a doctor orders them to help you with social and emotional concerns that may interfere with your treatment or how quickly you recover. This might include counseling or help finding resources in your community. However, Medicare doesn't cover medical social services unless you're also getting skilled care as mentioned above.
- **Medical supplies:** Medicare covers supplies like wound dressings, when your doctor orders them as part of your care.

Medicare pays separately for durable medical equipment. The equipment must meet certain criteria and be ordered by a doctor. Medicare usually pays 80% of the Medicare-approved amount for certain pieces of medical equipment, like a wheelchair or walker. If your home health agency doesn't supply durable medical equipment directly, the home health agency staff will usually arrange for a home equipment supplier to bring the items you need to your home.

Note: Before your home health care begins, the home health agency should tell you how much of your bill Medicare will pay. The agency should also tell you if any items or services they give you aren't covered by Medicare, and how much you'll have to pay for them. This should be explained by both talking with you and in writing.

The home health agency is responsible for meeting **all** of your medical, nursing, rehabilitative, social, and discharge planning needs, as noted in your home health plan of care. See page 19 for more information. Home health agencies are required to perform a comprehensive assessment of each of your care needs when you're admitted to the home health agency, and communicate those needs to the doctor responsible for the plan of care. After that, home health agencies are required to routinely assess your needs.

What isn't covered?

Here are some examples of what Medicare doesn't pay for:

- 24-hour-a-day care at home
- Meals delivered to your home
- Homemaker services, like shopping, cleaning, and laundry
- Custodial or personal care like bathing, dressing, and using the bathroom when this is the only care you need

Talk to your doctor or the home health agency if you have questions about whether certain services are covered. You can also call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

Note: If you have a Medigap (Medicare Supplement Insurance) policy or other health coverage, be sure to tell your doctor or other health care provider so your bills get paid correctly.

What you pay

You may be billed for these:

- Services and supplies that are never paid for by Medicare, like routine foot care.
- Services and supplies that are usually paid for by Medicare but won't be paid for in this instance, when you've agreed to pay for them. The home health agency must give you a notice called the "Advance Beneficiary Notice of Noncoverage" (ABN) in these situations. See the next page.

 20% of the Medicare-approved amount for Medicare-covered medical equipment, like wheelchairs, walkers, and oxygen equipment.

"Advance Beneficiary Notice of Noncoverage" (ABN)

The home health agency must give you a written notice called an "Advance Beneficiary Notice of Noncoverage" (ABN) before giving you a home health service or supply that Medicare probably won't pay for because of any of these:

- The care isn't medically reasonable and necessary.
- The care is only nonskilled, personal care, like help with bathing or dressing.
- You aren't homebound.
- You don't need skilled care on an intermittent basis.

When you get an ABN because Medicare isn't expected to pay for a medical service or supply, the notice should describe the service and/or supply, and explain why Medicare probably won't pay. The ABN gives clear directions for getting an official decision from Medicare about payment for home health services and supplies and for filing an appeal if Medicare won't pay.

In general, to get an official decision on payment, you should do these:

- Keep getting the home health services and/or supplies if you think you need them. The home health agency must tell you how much they'll cost. Talk to your doctor and family about this decision.
- Understand you may have to pay the home health agency for these services and/or supplies.
- Ask the home health agency to send your claim to Medicare so that Medicare will make a decision about payment. You have the right to have the home health agency bill Medicare for your care.

If Original Medicare pays for your care, you'll get back all of your payments, except for any applicable coinsurance or deductibles, including any coinsurance payments you made for durable medical equipment.

The home health agency must also give you the ABN or a "Home Health Change of Care Notice" (HHCCN) when they reduce or stop providing home health services or supplies:

- For business-related reasons
- Because your doctor has changed or hasn't renewed your orders

If a home health agency reduces or stops providing certain services or supplies, you may have the option to keep getting them. The ABN or HHCCN will explain what service or supply is going to be reduced or stopped and give you instructions on what you can do if you want to keep getting the service or supply.

Your right to a fast appeal



When all of your covered home health services are ending, you may have the right to a fast appeal if you think these services are ending too soon. During a fast appeal, an independent reviewer called a Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO) looks at your case and decides if you need your home health services to continue.

Your home health agency will give you a written notice called the "Notice of Medicare Non-Coverage" (NOMNC) at least 2 days before all covered services end. If you don't get this notice, ask for it. Read the notice carefully. It contains important information about the termination of services, including:

- The date all your covered services will end
- How to ask for a fast appeal
- Your right to get a detailed notice about why your services are ending
- Any other information required by Medicare

If you ask for a fast appeal, the BFCC-QIO will ask why you think coverage of your home health services should continue. The BFCC-QIO will also look at your medical information and talk to your doctor. The BFCC-QIO will notify you of its decision as soon as possible, generally no later than 3 days after the effective date of the NOMNC.

If the BFCC-QIO decides your home health services should continue, Medicare may continue to cover your home health care services, except for any applicable coinsurance or deductibles.

If the BFCC-QIO decides that your coverage should end, you'll have to pay for any services you got after the date on the NOMNC that says your covered services should end. Your home health agency must give you an ABN with an estimate of how much these services will cost.

You may stop getting services on or before the date given on the NOMNC and avoid paying for any further services. If you don't ask for a fast appeal and want to continue getting services after the date listed on the NOMNC, your home health agency must give you an ABN to let you know what you must pay.



Section 1: Medicare Coverage of Home Health Care

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For more information on your right to a fast appeal and other Medicare appeal rights, look at your "Medicare & You" handbook or visit Medicare.gov/appeals. You can also call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

Section 2: Choosing a Home Health Agency

Finding a Medicare-certified home health agency

If your doctor decides you need home health care, you may choose an agency from the participating Medicare-certified home health agencies that serve your area. Home health agencies are certified to make sure they meet certain federal health and safety requirements. Your choice should be honored by your doctor, hospital discharge planner, or other referring agency. You have a say in which agency you use, but your choices may be limited by agency availability, or by your insurance coverage. If you have a Medicare Advantage Plan (like an HMO or PPO) or other Medicare health plan, it may require that you get home health services from agencies they contract with. Call your plan for more information.

Comparing home health agencies

Visit Medicare.gov/homehealthcompare to compare home health agencies in your area. You can compare home health agencies by the types of services they offer and the quality of care they provide. Home Health Compare shows this information about home health agencies:

- Name, address, and phone number
- Services offered, like nursing care, physical therapy, occupational therapy, speech-language pathology services, medical/social services, and home health aide services
- Initial date of Medicare certification
- Type of ownership (for profit, government, non-profit)
- Information about the quality of care they give (quality measures)

Words in red are defined on pages 27–28.

Comparing quality

Some home health agencies do a better job of caring for their patients than others. Home health agencies give quality care when they give their patients care and treatment known to get the best results for each patient's condition. In some cases, the home health agency will help improve the patient's condition. In other situations, it will help maintain a patient's condition or slow their decline.

Visit Medicare.gov/homehealthcompare to see how well home health agencies in your area care for their patients. You can compare agencies based on various measures of quality and against state and national averages.

See below for an example of some of the information you'll find on Home Health Compare. In this example, the score for each measure means the percentage of patients the home health agency was able to help regain or maintain their health during their episode of care.

Quality measures	Percentage for XYZ home care agency	State average	National average		
Higher percentages are better					
Percentage of patients who get better at walking or moving around	71%	76%	82%		
Percentage of patients who have less pain when moving around	59%	80%	76%		
How often the home health team taught patients (or their family caregivers) about their drugs	99%	97%	97%		
Lower percentages are better					
How often home health patients had to be admitted to the hospital	20%	16%	17%		

Home Health Agency Checklist

Use this checklist when choosing a home health agency.

Name of the home health agency:

Question	Yes	No	Comments
1. Medicare certified?			
2. Medicaid certified (if you have both Medicare and Medicaid)?			
3. Offers the specific health care services I need, like skilled nursing services or physical therapy?			
4. Meets my special needs, like language or cultural preferences?			
5. Offers the personal care services I need, like help bathing, dressing, and using the bathroom?			
6. Offers the support services I need, or can help me arrange for additional services, like a meal delivery service, that I may need? (NOTE: These types of services aren't generally covered by Medicare).			
7. Has staff that can give the type and hours of care my doctor ordered and start when I need them?			
8. Is recommended by my hospital discharge planner, doctor, or social worker?			
9. Has staff available at night and on weekends for emergencies?			
10. Explained what my insurance will cover and what I must pay out-of-pocket?			
11. Has letters from satisfied patients, family members, and doctors that testify to the home health agency providing good care?			

Special rules for home health care

In general, most Medicare-certified home health agencies will accept all people with Medicare. An agency isn't required to accept you if it can't meet your medical needs. An agency shouldn't refuse to take you because of your condition, unless the agency would also refuse to take other people with the same condition.

Medicare will only pay for you to get care from one home health agency at a time. You may decide to end your relationship with one agency and choose another at any time. Contact your doctor to get a referral to a new agency. You should tell both the agency you're leaving and the new agency you choose that you're changing home health agencies.

Find out more about home health agencies

Your State Survey Agency, the agency that inspects and certifies home health agencies for Medicare, also has information about home health agencies. Ask them for the state survey report on the home health agency of interest to you. Visit Medicare.gov/contacts to get your State Survey Agency's phone number. You can also call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

In some cases, your local long-term care ombudsman may have information on the home health agencies in your area. Visit ltcombudsman.org, visit eldercare.gov, or call the eldercare locator at 1-800-677-1116.

To find out more about home health agencies, you can do either of these:

- Ask your doctor, hospital discharge planner, or social worker.
 Or, ask friends or family about their home health care experiences.
- Use a senior community referral service, or other community agencies that help you with your health care.

Section 3: Getting Home Health Care

Usually, once your doctor refers you for home health services, staff from the home health agency will come to your home to talk to you about your needs and ask you some questions about your health. The home health agency will also talk to your doctor about your care and keep your doctor updated about your progress. You need a doctor's order to start and continue care.

Your plan of care

Your home health agency will work with you and your doctor to develop your plan of care. A plan of care lists what kind of services and care you should get for your health condition. You have the right to be involved in any decisions about your plan of care. Your plan of care includes these:

- What services you need
- Which health care professionals should give these services
- Visit schedule
- How often you'll need the services
- The medical equipment you need
- What results your doctor expects from your treatment

Your home health agency must give you all of the home care listed in your plan of care, including services and medical supplies. The agency may do this through its own staff or through an arrangement with another agency. The agency could also hire nurses, therapists, home health aides, and medical social workers to meet your needs.

Words in red are defined on pages 27–28.

Your plan of care (continued)

Your doctor and home health team review your plan of care as often as necessary, but at least once every 60 days. If your health condition changes, the home health team should tell your doctor right away. Your health care team will review your plan of care and make any necessary changes with the approval of your doctor. Your home health team should tell you about any changes in your plan of care. If you have a question about your care, or if you feel your needs aren't being met, talk to both your doctor and the home health team.

The home health team will teach you (and your family or friends who are helping you) to continue any care you may need, including wound care, therapy, and disease management. You should learn to recognize problems like infection or shortness of breath, and know what to do or whom to contact if they happen.

Your rights getting home health care

In general, as a person with Medicare getting home health care from a Medicare certified home health agency, you're guaranteed certain rights, including these:

- To get a written notice of your rights before your care starts
- To have your home and property treated with respect
- To be told, in advance, what care you'll be getting and when your plan of care is going to change
- To participate in your care planning and treatment
- To get written information about your privacy rights and your appeal rights
- To have your personal information kept private
- To get written and verbal information about how much Medicare is expected to pay and how much you'll have to pay for services
- To make complaints about your care and have the home health agency follow up on them
- To know the phone number of the home health hotline in your state where you can call with complaints or questions about your care

Visit Medicare.gov to learn more about your rights and protections. You can also call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

Where to file a complaint about the quality of your home health care

If you have a complaint about the quality of care you're getting from a home health agency, you should call either of these organizations:

- Your state home health hotline. Your home health agency should give you this number when you start getting home health services.
- The Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO) in your state. To get the phone number for your BFCC-QIO, visit Medicare.gov/contacts. You can also call 1-800-MEDICARE.



Home Health Care Checklist

This checklist can help you (and your family or friends who are helping you) monitor your home health care. Use this checklist to help make sure that you're getting good quality home health care.

When I get my home health care	Yes	No	Comments
1. The staff is polite and treats me and my family with respect.			
2. The staff explains my plan of care to me and my family, lets us participate in creating the plan, and lets us know ahead of time of any changes.			
3. The staff is properly trained and licensed to perform the type of health care I need.			
4. The agency explains what to do if I have a problem with the staff or the care I'm getting.			
5. The agency responds quickly to my requests.			
6. The staff checks my physical and emotional condition at each visit.			
7. The staff responds quickly to changes in my health or behavior.			
8. The staff checks my home and suggests changes to meet my special needs and to ensure my safety.			
9. The staff has told me what to do if I have an emergency.			
10. The agency and its staff protect my privacy.			

Section 4: Getting the Help You Need

Help with questions about home health coverage

If you have questions about your Medicare home health care benefits or coverage and you have Original Medicare, visit Medicare.gov, or call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048. If you get your Medicare benefits through a Medicare Advantage Plan (Part C) or other Medicare health plan, call your plan.

You may also call the State Health Insurance Assistance Program (SHIP). SHIP counselors answer questions about Medicare's home health benefits and what Medicare, Medicaid, and other types of insurance pay for.

To get the phone number for your SHIP, visit shiptacenter.org or call 1-800-MEDICARE.

Words in red are defined on pages 27–28.

What you need to know about fraud

In general, most home health agencies are honest and use correct billing information. Unfortunately, there may be some who commit fraud. Fraud wastes Medicare dollars and takes money that could be used to pay claims. You play an important role in the fight to prevent Medicare fraud, waste, and abuse.

Look for these:

- Home health visits that your doctor ordered, but that you didn't get.
- Visits by home health staff that you didn't request and that you don't need.
- Bills for services and equipment you never got.
- Fake signatures (yours or your doctor's) on medical forms or equipment orders.
- Pressure to accept items and services that you don't need or that Medicare doesn't cover.
- Items listed on your "Medicare Summary Notice" (MSN) that you don't think you got or used.
- Home health services your doctor didn't order. The doctor who approves home health services for you should know you, and should be involved in your care. If your plan of care changes make sure that your doctor was involved in making those changes.
- A home health agency that offers you free goods or services in exchange for your Medicare number. Treat your Medicare card like a credit card or cash. Never give your Medicare or Medicaid number to people who tell you a service is free and they need your number for their records.

The best way to protect your home health benefit is to know what Medicare covers and to know what your doctor has planned for you. If you don't understand something in your plan of care, ask questions.

Reporting fraud

If you suspect fraud, you can:

• Contact your home health agency to be sure the bill is correct.

Contact the Office of Inspector General:

Phone: 1-800-HHS-TIPS (1-800-447-8477) **Fax:** 1-800-223-2164 (no more than 10 pages)

E-mail: HHSTips@oig.hhs.gov

Mail: Office of the Inspector General

HHS TIPS Hotline P.O. Box 23489

Washington, DC 20026

Please note that it's current Hotline policy not to respond directly to written communications.

 Call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

Important: If you're reporting a possible case of Medicare fraud, provide as much identifying information as possible. Include the person or company's name, address, and phone number. Details should include the basics of who, what, when, where, why, and how.



Important phone numbers

Doctor
Health insurance company
Notes

Definitions

Appeal—An appeal is the action you can take if you disagree with a coverage or payment decision made by Medicare, your Medicare health plan, or your Medicare Prescription Drug Plan. You can appeal if Medicare or your plan denies one of these:

- Your request for a health care service, supply, item, or prescription drug that you think you should be able to get
- Your request for payment for a health care service, supply, item, or prescription drug you already got
- Your request to change the amount you must pay for a health care service, supply, item or prescription drug

You can also appeal if Medicare or your plan stops providing or paying for all or part of a health care service, supply, item, or prescription drug you think you still need.

Durable medical equipment—Certain medical equipment, like a walker, wheelchair, or hospital bed, that's ordered by your doctor for use in the home.

Medicaid—A joint federal and state program that helps with medical costs for some people with limited income and resources. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid.

Medicare Advantage Plan (Part C)—A type of Medicare health plan offered by a private company that contracts with Medicare to provide you with all your Part A and Part B benefits. Medicare Advantage Plans include Health Maintenance Organizations, Preferred Provider Organizations, Private Fee-for-Service Plans, Special Needs Plans, and Medicare Medical Savings Account Plans. If you're enrolled in a Medicare

Advantage Plan, most Medicare services are covered through the plan and aren't paid for under Original Medicare. Most Medicare Advantage Plans offer prescription drug coverage.

Medicare health plan—Generally, a plan offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the plan. Medicare health plans include all Medicare Advantage Plans, Medicare Cost Plans, and Demonstration/Pilot Programs. Programs of All-inclusive Care for the Elderly (PACE) organizations are special types of Medicare health plans. PACE plans can be offered by public or private entities and provide Part D and other benefits in addition to Part A and Part B benefits.

Medigap policy—Medicare Supplement Insurance sold by private insurance companies to fill "gaps" in Original Medicare coverage.

Original Medicare—Original Medicare is a fee-for-service health plan that has 2 parts: Part A (Hospital Insurance) and Part B (Medical Insurance). After you pay a deductible, Medicare pays its share of the Medicare-approved amount, and you pay your share (coinsurance and deductibles).

State Health Insurance Assistance Program (SHIP)—A state program that gets money from the federal government to give free local health insurance counseling to people with Medicare.

Notice of Availability of Auxiliary Aids & Services

We're committed to making our programs, benefits, services, facilities, information, and technology accessible in accordance with Sections 504 and 508 of the Rehabilitation Act of 1973. We've taken appropriate steps to make sure that people with disabilities, including people who are deaf, hard of hearing or blind, or who have low vision or other sensory limitations, have an equal opportunity to participate in our services, activities, programs, and other benefits. We provide various auxiliary aids and services to communicate with people with disabilities, including:

Relay service — TTY users can call 1-877-486-2048.

Alternate formats — This product is available in accessible formats, including large print, Braille, audio, CD, or as an eBook.

To request a Medicare product in an accessible format, call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048. To request the Medicare & You handbook in an alternate format, visit Medicare.gov/medicare-and-you.

For all other CMS publications:

- 1. Call 1-844-ALT-FORM (1-844-258-3676). TTY users can call 1-844-716-3676.
- 2. Send a fax to 1-844-530-3676.
- 3. Send an email to AltFormatRequest@cms.hhs.gov.
- 4. Send a letter to:

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- Calling 1-800-368-1019. TTY users can call 1-800-537-7697.
- Visiting hhs.gov/ocr/civilrights/complaints.
- Writing:
 Office for Civil Rights
 U.S. Department of Health and Human Services
 200 Independence Avenue, SW
 Room 509F, HHH Building
 Washington, D.C. 20201

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

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Frequently Asked Questions

(www.CMS.gov)



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Frequently Asked Questions (FAQs) Regarding Jimmo Settlement Agreement

Q1: What is the Jimmo Settlement Agreement (January 2013)?

A1: The *Jimmo* Settlement Agreement clarified that when a beneficiary needs skilled nursing or therapy services under Medicare's skilled nursing facility (SNF), home health (HH), and outpatient therapy (OPT) benefits in order to maintain the patient's current condition or to prevent or slow decline or deterioration (provided all other coverage criteria are met), the Medicare program covers such services and coverage cannot be denied based on the absence of potential for improvement or restoration. In short, what the Settlement Agreement and the resulting revised manual provisions clarify is that Medicare coverage for skilled nursing and therapy services in these settings does not "turn on" the presence or absence of a beneficiary's potential for improvement, *i.e.*, it does not matter whether such care is expected to improve or maintain the patient's clinical condition. In addition, although such maintenance coverage standards do not apply to services furnished in an Inpatient Rehabilitation Facility (IRF) or a comprehensive outpatient rehabilitation facility (CORF), the *Jimmo* Settlement Agreement clarified that for services performed in the IRF setting, coverage should never be denied because a patient cannot be expected to achieve complete independence in the domain of self-care or because a patient cannot be expected to return to his or her prior level of functioning. The *Jimmo* Settlement Agreement provided that these clarifications be included in the Medicare Benefit Policy Manual.

Q2: What is the effect of the Jimmo Settlement Agreement on other requirements for receiving Medicare coverage?

A2: The *Jimmo* Settlement Agreement included language specifying that nothing in the settlement agreement modified, contracted, or expanded the existing eligibility requirements for receiving Medicare coverage. While the *Jimmo* Settlement Agreement resulted in clarifications of the coverage criteria for skilled nursing and therapy services in the SNF, HH, OPT, and IRF care settings, it did not affect other existing aspects of Medicare coverage and eligibility for these settings. A few examples of such other requirements would include that the services be reasonable and necessary, comply with therapy caps in the OPT setting, and not exceed the 100-day limit for Part A SNF benefits during a benefit period.

Q3: What are maintenance services addressed by the Jimmo Settlement Agreement?

A3: These are nursing or therapy services to maintain the patient's condition or to prevent or slow further deterioration. Even though no improvement is expected, there may be specific instances in the SNF, HH, and OPT settings where the skills of a qualified therapist, registered nurse, or (when provided by regulation) a licensed practical nurse are required to perform nursing/therapy maintenance services that would otherwise be considered unskilled because of the patient's special medical complications or where the needed services are of such complexity that the skills of such a practitioner are required to perform it safely and effectively. The *Jimmo* Settlement Agreement clarified that such skilled maintenance services are Medicare covered services.

Q4: How is coverage of skilled nursing and skilled therapy services under the SNF, HH, and OPT benefits to be determined?

A4: Coverage of skilled nursing and skilled therapy services under these benefits does not turn on the presence or absence of a beneficiary's potential for improvement or restoration, but rather on the beneficiary's need for skilled care. Skilled care may be necessary to improve a patient's current condition, to maintain the patient's current condition, or to prevent or slow further deterioration of the patient's condition. A beneficiary's lack of restoration potential cannot, in itself, serve as the basis for denying coverage under these benefits. An individualized assessment of the beneficiary's medical condition and the reasonableness and necessity of the treatment, care, or services is required to determine coverage. Coverage for skilled care under these benefits is not available where the beneficiary's care needs can be addressed safely and effectively through the use of unskilled personnel or caregivers. Any Medicare coverage or appeals decisions concerning skilled care coverage must reflect these basic principles. Claims for skilled care coverage must include sufficient documentation to substantiate that skilled care is required, that it was in fact provided, and that the services themselves are reasonable and necessary, thereby facilitating accurate and appropriate claims adjudication.

Q5: When are skilled nursing or therapy services to maintain a patient's current condition or prevent or slow further deterioration covered under the SNF, HH, and OPT benefits, assuming all other coverage criteria are met?

A5: As long as all other coverage criteria are met, skilled nursing and therapy services that maintain the patient's current condition or prevent or slow further deterioration are covered under the SNF, HH, and OPT benefits as long as an individualized assessment of the patient's clinical condition demonstrates that the specialized judgment, knowledge, and skills of a qualified therapist, registered nurse or, when provided by regulation, a licensed vocational or practical nurse, are necessary in order for the maintenance services to be safely and effectively provided.

Skilled nursing care is necessary only when the needed services are of such complexity that the skills of a registered nurse, or (when provided by regulation), a licensed practical nurse are required to furnish the services, or the particular patient's special medical complications require the skills of a such a practitioner to perform a type of service that would otherwise be considered non-skilled. However, when the individualized assessment of the patient's clinical condition does not demonstrate such a need for skilled care, including when the services needed do not require skilled nursing care because they could safely and effectively be performed by the patient or unskilled caregivers, such maintenance services are not covered under the SNF or HH benefits.

Skilled therapy is necessary for the performance of a safe and effective maintenance program only when the needed therapy procedures are of such complexity that the skills of a qualified therapist are needed to perform the procedure, or the patient's special medical complications require the skills of a qualified therapist to perform a therapy service that would otherwise be considered non-skilled. However, when the individualized assessment does not demonstrate such a need for skilled care, including when the performance of a maintenance program does not require the skills of a qualified therapist because it could be safely and effectively accomplished by the patient or with the assistance of non-therapists, including unskilled caregivers, such maintenance services are not covered under the SNF, HH, or OPT therapy benefits. To the extent provided by regulation, the establishment or design of a maintenance program by a qualified therapist, the instruction of the beneficiary or appropriate caregiver by a qualified therapist regarding a maintenance program, and the necessary periodic reevaluations by a qualified therapist of the beneficiary and maintenance program are covered to the degree that the specialized knowledge and judgment of a qualified therapist are required.

Q6: How can I find out if skilled nursing or therapy services are covered by Medicare for a particular condition?

A6: Medicare coverage for skilled nursing or therapy services is not determined solely by a patient's specific medical condition. Rather, an individualized assessment of the patient's medical condition, as documented in the patient's medical record, would be necessary in order to determine coverage. For questions regarding specific conditions and whether skilled nursing or therapy services would be covered:

Providers & Suppliers: Contact your local Medicare Administrative Contractor (MAC)

Beneficiaries: Call 1-800-MEDICARE.

Q7: Can a patient change from an improvement course of care to a maintenance course of care, and vice versa?

A7: Yes. The therapy plan of care should indicate the treatment goals based on an individualized assessment or evaluation of the patient. Skilled services would be covered where such skilled services are necessary to maintain the patient's current condition or prevent or slow further deterioration so long as the beneficiary requires skilled care for the services to be safely and effectively provided. The health care provider must continually evaluate the individual's need for skilled care, as well as whether such care meets Medicare's overall requirement for being reasonable and necessary to diagnose or treat the individual's condition, and make such determinations on an ongoing basis, altering – on a prospective and not a retrospective basis – the treatment plan and goals when necessary.

Q8: What is the role of "documentation" in facilitating accurate coverage determinations for claims involving skilled maintenance care?

A8: The revised Medicare Benefit Policy Manual provisions [Chapters 7(SNF), 8(HH), & 15(OPT)] include information on the role of appropriate documentation in facilitating accurate coverage determinations for claims involving skilled care. While the presence of appropriate documentation is not, in and of itself, an element of coverage, such documentation serves as the means by which a provider would be able to establish, and a Medicare contractor would be able to confirm, that skilled care is, in fact, needed and received in a given case. In revising the manual provisions pursuant to the settlement agreement, CMS has provided additional guidance in this area, both generally and as it relates to particular clinical scenarios.

We note that the manual revisions do not require the presence of any particular phraseology or verbal formulation as a prerequisite for coverage (although some areas of the Medicare Benefit Policy Manual do identify certain vague phrases like "patient tolerated treatment well," "continue with POC," and "patient remains stable" as being *insufficiently explanatory* to establish coverage). Rather, coverage determinations must consider the *entirety* of the clinical evidence in the file, and our enhanced guidance on documentation is intended to assist providers in their efforts to identify and include the kind of clinical information that can most effectively serve to support a finding that skilled care is needed and received— which, in turn, will help to ensure more accurate and appropriate claims adjudication.

Care must be taken to assure that documentation justifies the necessity of the skilled services provided. Justification for treatment would include, for example, objective evidence or a clinically supportable statement of expectation that, in the case of maintenance therapy, the skills of a qualified therapist are necessary to maintain, prevent, or slow further deterioration of the patient's functional status, and the services cannot be safely and effectively carried out by the beneficiary personally, or with the assistance of non-therapists, including unskilled caregivers.

Q9: Can a patient receive therapy services from multiple disciplines with differing goals for restoration and maintenance?

A9: Yes. A comprehensive treatment plan does not require all disciplines to have the same goals. Once setting-specific qualifying criteria are met, each individual discipline creates a care plan specific to that discipline. Based on the qualified therapist's assessment or evaluation and periodic reassessment or re-evaluation findings, each discipline will choose the most appropriate approach for the patient and must provide documentation that supports that decision.

Q10: How does the maintenance coverage standard under the *Jimmo* Settlement apply to skilled observation and assessment of homebound Medicare patients?

A10: As with all skilled nursing services under the HH benefit, skilled observation and assessment of the patient's condition by a nurse is a Medicare covered service regardless of whether there is an expectation of improvement from the nursing care or whether the services are designed to maintain the patient's current condition or prevent or slow further deterioration. Observation and assessment are reasonable and necessary skilled services where there is a reasonable potential for change in a patient's condition that requires skilled nursing personnel to identify and evaluate the patient's need for possible modification of treatment or initiation of additional medical procedures until the patient's clinical condition and/or treatment regimen has stabilized.

Q11: If a patient is not improving or is not expected to return to his or her prior level of function from skilled nursing or therapy, does Medicare coverage for skilled nursing or skilled therapy services stop unless the patient deteriorates?

A11: The Medicare program does not require a patient to decline before covering medically necessary skilled nursing or skilled therapy. For a patient who had been expected to improve, but is no longer improving, a determination as to whether skilled care is needed to maintain the patient's current condition or prevent or slow further deterioration must be made, and if such skilled care is needed, a plan of care to reflect the new maintenance goals must be developed. If, however, a patient is no longer improving and there is no expectation of improvement and skilled care is not needed to maintain the patient's current condition or to prevent or slow further deterioration, such skilled care services would not be covered.

Q12: If a qualified therapist discontinues a Medicare patient's outpatient therapy because the patient has stopped improving and the patient is not expected to return to his or her prior level of function, is additional therapy available?

A12: Yes, when the outpatient therapy services no longer meet the criteria for rehabilitative therapy service – whose goal is improvement of an impairment or functional limitation – the patient may be covered to receive skilled therapy services in certain circumstances as maintenance therapy under a maintenance program in order to maintain function or to prevent or slow decline or deterioration. Skilled therapy services are covered when the specialized judgment, knowledge, and skills of a qualified therapist are necessary for performance of a maintenance program, as previously discussed in response to Question 5. The deciding factors are always whether the services are considered reasonable, effective treatments for the patient's condition and require the skills of a qualified therapist, or whether they can be safely and effectively carried out by non-skilled personnel or caregivers.

Q13: Where can I find examples that demonstrate the coverage requirements for skilled services?

A13: Chapters 7 (HH), 8 (SNF), and 15 (OPT) of the Medicare Benefit Policy Manual (100-02) contain many examples.

Q14: Does the *Jimmo* Settlement Agreement apply to Medicare patients whose health care providers are in Accountable Care Organizations (ACO)?

A14: Yes. Medicare patients who see health care providers that are participating in a Medicare ACO maintain all their Medicare rights, including application of the standards for coverage of skilled care as clarified by the *Jimmo* Settlement Agreement.

Q15: Does the Jimmo Settlement Agreement apply to beneficiaries in Medicare Advantage plans?

A15: Yes. Medicare Advantage plans must cover the same Part A and Part B benefits as original Medicare, and must also apply the standards for coverage of skilled care as clarified by the *Jimmo* Settlement Agreement.

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Medicare Appeals Booklet

(www.Medicare.gov)

CENTERS for MEDICARE & MEDICAID SERVICES



This official government booklet has important information about:

- How to file an appeal if you have Original Medicare
- How to file an appeal if you have a Medicare Advantage Plan or other Medicare health plan
- How to file an appeal if you have Medicare prescription drug coverage
- Where to get help with your questions



The information in this booklet describes the Medicare Program at the time this booklet was printed. Changes may occur after printing. Visit Medicare.gov, or call 1-800-MEDICARE (1-800-633-4227) to get the most current information. TTY users can call 1-877-486-2048.

"Medicare Appeals" isn't a legal document. Official Medicare Program legal guidance is contained in the relevant statutes, regulations, and rulings.

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Relay service — TTY users can call 1-877-486-2048.

Alternate formats — This product is available in alternate formats, including large print, Braille, audio, CD, or as an eBook.

To request a Medicare product in an alternate format, call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048. To request the Medicare & You handbook in an alternate format, visit Medicare.gov/medicare-and-you.

For all other CMS publications:

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- 2. Send a fax to 1-844-530-3676.
- 3. Send an email to AltFormatRequest@cms.hhs.gov.
- 4. Send a letter to:

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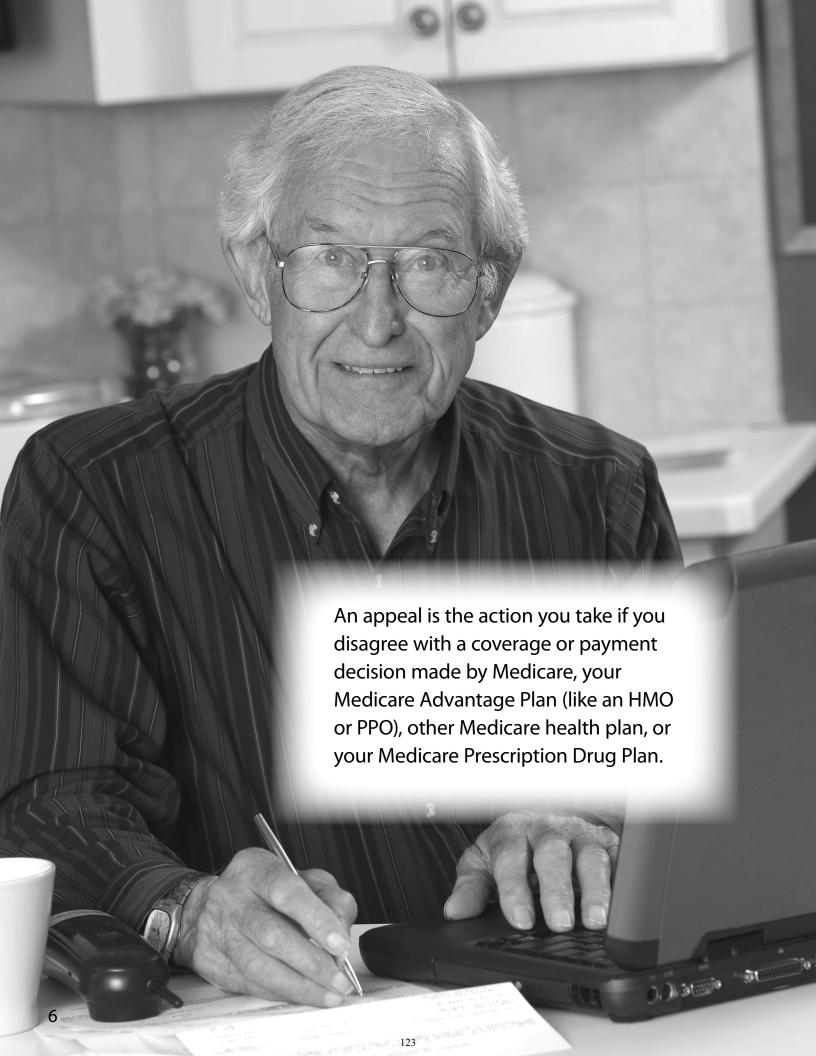
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- Calling 1-800-368-1019. TTY users can call 1-800-537-7697.
- Visiting hhs.gov/ocr/civilrights/complaints.
- Writing: Office for Civil Rights
 U.S. Department of Health and Human Services
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Note: Definitions of red words are on pages 59–62.



Section 1: What can I appeal?

You have the right to appeal if you disagree with the decision from Medicare, your Medicare health plan, or your Medicare Prescription Drug Plan for one of these requests:

- A request for a health care service, supply, item, or prescription drug that you think you should be able to get.
- A request for payment of a health care service, supply, item, or prescription drug you already got.
- A request to change the amount you must pay for a health care service, supply, item, or prescription drug.

You can also appeal if Medicare or your plan stops providing or paying for all or part of a health care service, supply, item, or prescription drug you think you still need.

See the sections in this booklet for information on how to file an appeal no matter how you get your Medicare. For more information, visit Medicare.gov/appeals, or call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

Can someone file an appeal for me?

If you want help filing an appeal, you can appoint a representative. Your representative can help you with the appeals steps explained in this booklet. Your representative can be a family member, friend, advocate, attorney, doctor, or someone else to act on your behalf.

You can appoint your representative in one of these ways:

1. Fill out an "Appointment of Representative" form (CMS Form number 1696). To get a copy, visit cms.gov/cmsforms/downloads/cms1696.pdf, or call 1-800-MEDICARE and ask for a copy.

What can

What can I appeal?

- 2. Submit a written request that includes:
 - Your name, address, phone number, and Medicare number (found on your red, white, and blue Medicare card).
 - A statement appointing someone as your representative.
 - The name, address, and phone number of your representative.
 - The professional status of your representative (like a doctor) or their relationship to you.
 - A statement authorizing the release of your personal and identifiable health information to your representative.
 - A statement explaining why you're being represented and to what extent.
 - Your signature and the date you signed the request.
 - Your representative's signature and the date they signed the request.

You must send the form or written request to the company that handles claims for Medicare or your Medicare health plan. If a representative is helping with your appeal, send the form or written request with your appeal request. Keep a copy of everything you send to Medicare as part of your appeal.

If you have questions about appointing a representative, call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

What can I appeal?

In some cases, your doctor can make a request on your behalf without being appointed your representative:

- If you have a Medicare Advantage Plan or other Medicare health plan:
 - Your treating doctor can request an organization determination or certain reconsiderations on your behalf, and you don't need to submit an "Appointment of Representative" form.
 - If you want your treating doctor to request a higher level of appeal on your behalf, you'll need to submit the "Appointment of Representative" form or a written request to appoint a representative as described below.
 - For more information on how to file an appeal if you have a Medicare Advantage Plan or other Medicare health plan, see Section 3.
- If you have a Medicare Prescription Drug Plan:
 - Your doctor or other prescriber can request a coverage determination, redetermination, or reconsideration from the Independent Review Entity (IRE) on your behalf, and you don't need to submit an "Appointment of Representative" form.
 - If you want your doctor or other prescriber to request a higher level of appeal on your behalf, you'll need to submit the "Appointment of Representative" form.
 - For more information on how to appeal if you have
 Medicare prescription drug coverage, see Section 4.

What can I appeal?



Section 2: How do I appeal if I have Original Medicare?

Original Medicare includes Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance). If you have Original Medicare, you get a "Medicare Summary Notice" (MSN) in the mail every 3 months if you get Part A and Part B-covered items and services. If you want to get your MSNs electronically (also called "eMSNs"), visit MyMedicare.gov to sign up.

The MSN shows all your items and services that providers and suppliers billed to Medicare during the 3-month period, what Medicare paid, and what you may owe the provider or supplier. The MSN also shows you if Medicare has fully or partially denied your medical claim. This is the initial determination, and it's made by the Medicare Administrative Contractor (MAC), which processes Medicare claims.

Read the MSN carefully. If you disagree with a Medicare coverage or payment decision, you can appeal the decision. The MSN contains information about your appeal rights. If you decide to appeal, ask your doctor, other health care provider, or supplier for any information that may help your case. Keep a copy of everything you send to Medicare as part of your appeal.

If you aren't sure if Medicare was billed for the items and services you got, write or call your doctor, other health care provider, or supplier and ask for an itemized statement. This statement should list all of your items and services that were billed to Medicare. You can also check your MSN to see if Medicare was billed.

What's the appeals process for Original Medicare?

The appeals process has 5 levels:

- Level 1: Redetermination by the Medicare Administrative Contractor (MAC)
- Level 2: Reconsideration by a Qualified Independent Contractor (QIC)
- Level 3: Hearing before an Administrative Law Judge (ALJ)
- Level 4: Review by the Medicare Appeals Council (Appeals Council)
- Level 5: Judicial review by a federal district court

If you disagree with the decision made at any level of the process, you can generally go to the next level. At each level, you'll get a decision letter with instructions on how to move to the next level of appeal.

Level 1: Redetermination by the Medicare Administrative Contractor (MAC), the company that handles claims for Medicare

Medicare contracts with the MACs to review your appeal request and make a decision. If you disagree with the initial determination on the MSN, you can request a redetermination (a second look or review). This is done by the MACs, but by people at the company who weren't involved with the first decision. You have 120 days after you get the MSN to request a redetermination.

How do I request a redetermination?

You can request a redetermination in one of these ways:

- 1. Read your MSN carefully, and follow the instructions for sending an appeal:
 - Circle the item(s) and/or service(s) you disagree with on the MSN.
 - Explain in writing on the MSN why you disagree with the decision, or write it on a separate piece of paper along with your Medicare number and attach it to the MSN.

- Include your name, phone number, and Medicare number on the MSN, and sign it.
- Include any other information you have about your appeal
 with the MSN. Ask your doctor, other health care provider,
 or supplier for any information that may help your case.
 Write your Medicare number on all documents you submit
 with your appeal request.
- You must send your request for redetermination to the company that handles claims for Medicare. The company's address is listed in the "File an Appeal in Writing" section of the MSN.
- 2. Fill out a "Medicare Redetermination Request" form (CMS Form number 20027). To get a copy, visit cms.gov/cmsforms/downloads/cms20027.pdf, or call 1-800-MEDICARE (1-800-633-4227) and ask for a copy. TTY users can call 1-877-486-2048. Send the completed form, or a copy, to the company that handles claims for Medicare listed on the MSN.
- 3. Submit a written request to the MAC. The company's address is listed on the MSN. Your request must include:
 - Your name and Medicare number.
 - The specific item(s) and/or service(s) for which you're requesting a redetermination and specific date(s) of service.
 - An explanation of why you don't agree with the initial determination.
 - Your signature. If you're appointed a representative, include the name and signature of your representative. For more information on appointing a representative, see Section 1.

Keep a copy of everything you send to Medicare as part of your appeal. You'll generally get a decision from the Medicare contractor (either in a letter or a MSN) within 60 days after they get your request. If Medicare covered the item(s) and/or service(s), it will be listed on your next MSN.

You can submit additional information or evidence to the MAC after the redetermination request has been filed, but it may take longer than 60 days for the MAC to make a decision. If you submit additional information or evidence after filing the request for redetermination, the contractor will get an extra 14 calendar days to make a decision for each submission.

If you disagree with the redetermination decision made by the MAC in level 1, you have 180 days after you get the "Medicare Redetermination Notice" to request a reconsideration by a Qualified Independent Contractor (QIC), which is level 2.

Level 2: Reconsideration by a Qualified Independent Contractor (QIC)

A QIC is an independent contractor that didn't take part in the level 1 decision. The QIC will review your request for a reconsideration and will make a decision.

How do I request a reconsideration?

Follow the directions on the "Medicare Redetermination Notice" you got in level 1 to file a request for reconsideration. You must send your request to the QIC that will handle your reconsideration. The QIC's address is listed on the redetermination notice. You can request a reconsideration in one of these ways:

1. Fill out a "Medicare Reconsideration Request" form (CMS Form number 20033), which is included with the "Medicare Redetermination Notice." You can also get a copy by visiting cms.gov/cmsforms/downloads/cms20033.pdf, or calling 1-800-MEDICARE (1-800-633-4227) and asking for a copy. TTY users can call 1-877-486-2048.

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How do I appeal if I have Original Medicare?

- 2. Submit a written request that includes:
 - Your name and Medicare number.
 - The specific item(s) or service(s) for which you're requesting a reconsideration and the specific date(s) of service. See your redetermination notice for this information.
 - The name of the company that made the redetermination (the company that handles claims for Medicare), which you can find on the MSN and on the redetermination notice.
 - An explanation of why you disagree with the redetermination decision.
 - Your signature. If you've appointed a representative, include the name and signature of your representative.
 For more information on appointing a representative, see Section 1.

No matter how you choose to request a reconsideration, the request should clearly explain why you disagree with the redetermination decision from level 1. Send a copy of the "Medicare Redetermination Notice" with your request for a reconsideration to the QIC. You should also include with your request any information that may help your case. You can submit additional information or evidence after the reconsideration request has been filed, but it may take longer for the QIC to make a decision. Keep a copy of everything you send to Medicare as part of your appeal.

In most cases, the QIC will send you a written response called a "Medicare Reconsideration Notice" about 60 days after the QIC gets your appeal request. If the QIC doesn't issue a timely decision, you may ask the QIC to move your case to the next level of appeal.

Note: Some IREs call themselves "Part C QICs."

If you disagree with the reconsideration decision in level 2, you have 60 days after you get the "Medicare Reconsideration Notice" to request a hearing by an Administrative Law Judge (ALJ), which is level 3.

Level 3: Hearing before an Administrative Law Judge (ALJ)

A hearing before an ALJ allows you to present your appeal to a new person who will independently review the facts of your appeal and listen to your testimony before making a new and impartial decision. An ALJ hearing is usually held by phone or video-teleconference, or in some cases, in person. You can also ask the ALJ to make a decision without a hearing, and the ALJ may also issue a decision without holding a hearing if evidence in the hearing record supports a decision that's fully in your favor.

To get an ALJ hearing, the amount of your case must meet a minimum dollar amount. For 2017, the required amount is \$160. The "Medicare Reconsideration Notice" will include a statement that tells you if your case meets the minimum dollar amount. However, it's up to the ALJ to make the final decision. You may be able to combine claims to meet the minimum dollar amount.

How do I request a hearing with an ALJ?

Follow the directions on the "Medicare Reconsideration Notice" you got from the QIC in level 2 to request a hearing before an ALJ. You must send your request to the appropriate Office of Medicare Hearings and Appeals (OMHA) Central Operations. The address is listed in the QIC's reconsideration notice. You can file a request for a hearing in one of these ways:

1. Fill out a "Request for Medicare Hearing by an Administrative Law Judge" form (CMS Form Number 20034 A/B), which is included with the "Medicare Reconsideration Notice." You can also get a copy by visiting cms.gov/cmsforms/downloads/cms20034ab.pdf, or calling 1-800-MEDICARE (1-800-633-4227) and asking for a copy. TTY users can call 1-877-486-2048.

icare?

How do I appeal if I have Original Medicare?

- 2. Submit a written request to the OMHA office that will handle your ALJ hearing that includes:
 - Your name, address, and Medicare number. If you've appointed a representative, include the name and address of your representative.
 - The appeal number included on the QIC reconsideration notice, if any.
 - The dates of service for the items or services you're appealing. See your MSN or reconsideration notice for this information.
 - An explanation of why you disagree with the reconsideration decision being appealed.
 - Any information that may help your case. If you can't include this information with your request, include a statement explaining what you plan to submit and when you'll submit it.

Keep a copy of everything you send to Medicare as part of your appeal. For more information about the ALJ hearing process, visit hhs.gov/omha and select "Coverage and Claims Appeals." If you need help filing an appeal with an ALJ, call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

If the ALJ doesn't issue a timely decision, you may ask the ALJ to move your case to the next level of appeal.

If you disagree with the ALJ's decision in level 3, you have 60 days after you get the ALJ's decision to request a review by the Medicare Appeals Council (Appeals Council), which is level 4.

Level 4: Review by the Medicare Appeals Council (Appeals Council)

You can request that the Appeals Council review your case regardless of the dollar amount of your case.

How do I request a review?

To request that the Appeals Council review the ALJ's decision in your case, follow the directions in the ALJ's hearing decision you got in level 3. You must send your request to the Appeals Council at the address listed in the ALJ's hearing decision. You can file a request for Appeals Council review in one of these ways:

- 1. Fill out a "Request for Review of an Administrative Law Judge (ALJ) Medicare Decision/Dismissal" form (DAB-101). To get a copy, visit hhs.gov/dab/divisions/dab101.pdf, or call 1-800-MEDICARE (1-800-633-4227) and ask for a copy. TTY users can call 1-877-486-2048.
- 2. Submit a written request to the Appeals Council that includes:
 - Your name and Medicare number. If you've appointed a representative, include the name of your representative.
 - The specific item(s) and/or service(s) and the specific dates of service you're appealing. See your MSN or your ALJ hearing decision for this information.
 - A statement identifying the parts of the ALJ's decision with which you disagree and an explanation of why you disagree.
 - The date of the ALJ decision.
 - Your signature. If you've appointed a representative, include the signature of your representative.
 - If you're requesting that your case be moved from the ALJ to the Appeals Council because the ALJ hasn't issued a timely decision, include the hearing office in which the request for hearing is pending.

Keep a copy of everything you send to Medicare as part of your appeal. For more information about the Appeals Council review process, visit hhs.gov/dab and select "Medicare Operations Division." If you need help filing a request for Appeals Council review, call 1-800-MEDICARE.

If the Appeals Council doesn't issue a timely decision, you can ask the Appeals Council to move your case to the next level of appeal.

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How do I appeal if I have Original Medicare?

If you disagree with the Appeals Council's decision in level 4, you have 60 days after you get the Appeals Council's decision to request judicial review by a federal district court, which is level 5.

Level 5: Judicial review by a federal district court

If you disagree with the decision issued by the Appeals Council, you can request judicial review in federal district court. To get a review, the amount of your case must meet a minimum dollar amount. For 2017, the minimum dollar amount is \$1,560. You may be able to combine claims to meet this dollar amount.

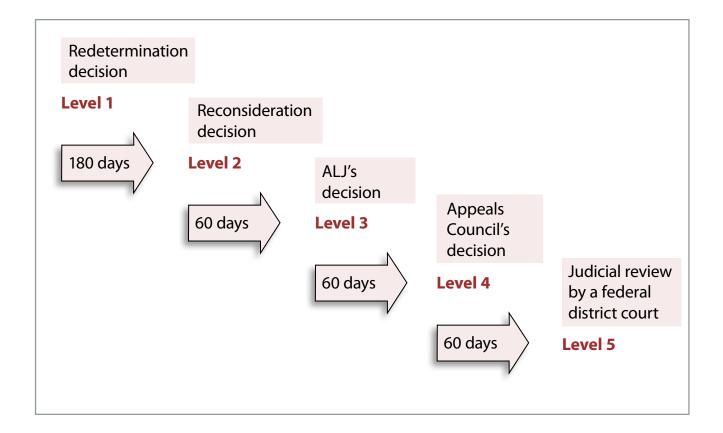
How do I request a review?

Follow the directions in the Appeals Council's decision letter you got in level 4 to file a complaint in federal district court.

For more information on the appeals process

- Visit Medicare.gov/appeals.
- Call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.
- Visit Medicare.gov/claims-and-appeals/file-an-appeal/appeals-forms.html for appeals forms.
- Call your State Health Insurance Assistance Program (SHIP) for free, personalized health insurance counseling, including help with appeals. To get the phone number for the SHIP in your state, visit shiptacenter.org, or call 1-800-MEDICARE.

How do I appeal if I have Original Medicare?



2

How do I appeal if I have Original Medicare?

How do I get an expedited (fast) appeal in a hospital?

When you're admitted as an inpatient to a hospital, you have the right to get the hospital care that's necessary to diagnose and treat your illness or injury. If you think you're being discharged from the hospital too soon, you have the right to ask your Beneficiary and Family Centered Quality Improvement Organization (BFCC-QIO) to review your case. To get the BFCC-QIO's phone number, visit Medicare.gov/contacts, or call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

Within 2 days of your admission, you should get a notice called "An Important Message from Medicare about Your Rights" (sometimes called the "Important Message from Medicare" or the "IM"). If you don't get this notice, ask for it. This notice lists the BFCC-QIO's contact information and explains:

- Your right to get all medically necessary hospital services
- Your right to be involved in any decisions that the hospital, your doctor, or anyone else makes about your hospital services and to know who will pay for them
- Your right to get the services you need after you leave the hospital
- Your right to appeal a discharge decision and the steps for appealing the decision
- The circumstances under which you will or won't have to pay for charges for continuing to stay in the hospital
- Information on your right to get a detailed notice about why your covered services are ending

If the hospital gives you the IM more than 2 days before your discharge day, it must either give you a copy of your original, signed IM or provide you with a new one (that you must sign) before you're discharged.

How do I ask for a fast appeal?

You may have the right to ask the BFCC-QIO for a fast appeal. Follow the directions on the IM to request a fast appeal if you think your Medicare-covered hospital services are ending too soon. You must ask for a fast appeal no later than the day you're scheduled to be discharged from the hospital.

If you ask for your appeal within this timeframe, you can stay in the hospital without paying for your stay (except for applicable coinsurance or deductibles) while you wait to get the decision from the BFCC-QIO.

If you miss the deadline for a fast appeal, you can still ask the BFCC-QIO to review your case, but different rules and timeframes apply. For more information, contact the BFCC-QIO.

What will happen during the BFCC-QIO's review?

When the BFCC-QIO gets your request within the fast appeal timeframe, it will notify the hospital. Then, the hospital will give you a "Detailed Notice of Discharge" by noon of the day after the BFCC-QIO notifies the hospital. The notice will include:

- 1. Why your services are no longer reasonable and necessary, or are no longer covered
- 2. The applicable Medicare coverage rule or policy, including a citation to the applicable Medicare policy, or information on how you can get a copy of the policy
- 3. How the applicable coverage rule or policy applies to your specific situation

The BFCC-QIO will look at your medical information provided by the hospital and will also ask you for your opinion. The BFCC-QIO will decide if you're ready to be discharged within one day of getting the requested information.

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How do I appeal if I have Original Medicare?

If the BFCC-QIO decides that you're being discharged too soon, Medicare will continue to cover your hospital stay as long as medically necessary (except for applicable coinsurance or deductibles).

If the BFCC-QIO decides that you're ready to be discharged and you met the deadline for requesting a fast appeal, you won't be responsible for paying the hospital charges (except for applicable coinsurance or deductibles) until noon of the day after the BFCC-QIO gives you its decision. If you get any inpatient hospital services after noon of that day, you may have to pay for them.

If you have any questions about fast appeals in hospitals, call the BFCC-QIO at the phone number listed on the notice the hospital gives you. You can also visit Medicare.gov/contacts or call 1-800-MEDICARE (1-800-633-4227) to get the BFCC-QIO's phone number. TTY users can call 1-877-486-2048.

How do I get an expedited (fast) appeal in a setting other than a hospital?

You have the right to a fast appeal if you think your Medicare-covered skilled nursing facility (SNF), home health agency (HHA), comprehensive outpatient rehabilitation facility (CORF), or hospice services are ending too soon.

While you're getting SNF, HHA, CORF, or hospice services, you should get a notice called the "Notice of Medicare Non-Coverage" at least 2 days before covered services end. If you don't get this notice, ask for it. This notice explains:

- The date that your covered services will end
- That you may have to pay for services you get after the coverage end date given on your notice
- Information on your right to get a detailed notice about why your covered services are ending
- Your right to a fast appeal and information on how to contact your BFCC-QIO to request a fast appeal

How do I ask for a fast appeal?

Ask the BFCC-QIO for a fast appeal no later than noon of the day after you get the "Notice of Medicare Non-Coverage." Follow the instructions on the notice to do this.

If you miss the deadline for requesting a fast appeal, you can still ask the BFCC-QIO to review your case, but different rules and timeframes apply. For more information, contact the BFCC-QIO. To get the BFCC-QIO's phone number, visit Medicare.gov/contacts, or call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

What will happen during the BFCC-QIO's review?

When the BFCC-QIO gets your request, it will notify the provider. Then, by the end of the day that the provider gets the notice from the BFCC-QIO, the provider will give you a "Detailed Explanation of Non-Coverage." The notice will include:

- Why your Medicare services are no longer reasonable and necessary, or are no longer covered
- The applicable Medicare coverage rule or policy, including a citation to the applicable Medicare policy, or information on how you can get a copy of the policy
- How the applicable Medicare coverage rule or policy applies to your situation

If the BFCC-QIO decides that your services are ending too soon, Medicare may continue to cover your SNF, HHA, CORF, or hospice services (except for applicable coinsurance or deductibles).

If the BFCC-QIO decides that your services should end, you won't be responsible for paying for any SNF, HHA, CORF, or hospice services provided before the termination date on the "Notice of Medicare Non-Coverage." If you continue to get services after the coverage end date, you may have to pay for those services.

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How do I appeal if I have Original Medicare?

If you have questions about your rights regarding SNF, HHA, CORF, or hospice services, including appealing the BFCC-QIO's decision, getting notices, or learning about your rights after missing the filing deadline, call the BFCC-QIO at the phone number listed on the notice the provider gives you. You can also visit Medicare.gov/contacts, or call 1-800-MEDICARE (1-800-633-4227) to get the BFCC-QIO's phone number. TTY users can call 1-877-486-2048.

What's an "Advance Beneficiary Notice of Noncoverage" (ABN)?

If you have Original Medicare and your doctor, other health care provider, or supplier thinks that Medicare probably (or certainly) won't pay for items or services, he or she may give you a written notice called an ABN. This notice is used by doctors, suppliers, and certain health care providers, like independent physical and occupational therapists, laboratories, and outpatient hospitals.

The ABN lists the items or services that Medicare isn't expected to pay for, an estimate of the costs for the items and services, and the reasons why Medicare may not pay. The ABN gives you information to make an informed choice about whether or not to get items or services, understanding that you may have to accept responsibility for payment.

You'll be asked to choose an option box and sign the notice to say that you read and understood it. You must choose one of these options:

- Option 1—You want the items or services that may not be paid for by Medicare. Your provider or supplier may ask you to pay for them now, but you also want them to submit a claim to Medicare for the items or services. If Medicare denies payment, you're responsible for paying, but since a claim was submitted, you can appeal to Medicare.
- Option 2—You want the items or services that may not be paid for by Medicare, but you don't want your provider or supplier to bill Medicare. You may be asked to pay for the items or services now, but because you request your provider or supplier to not submit a claim to Medicare, you can't file an appeal.

Option 3—You don't want the items or services that may not be paid for by Medicare, and you aren't responsible for any payments.
 A claim isn't submitted to Medicare, and you can't file an appeal.

An ABN isn't an official denial of coverage by Medicare. If payment is denied when a claim is submitted, you have the right to file an appeal.

Other types of ABNs

1. "Skilled Nursing Facility Advance Beneficiary Notice" (SNFABN)

A skilled nursing facility (SNF) will issue you a SNFABN if there's reason to believe that Medicare may not cover or continue to cover your care or stay because it isn't reasonable or necessary, or is considered custodial care.

The SNFABN lets you know Medicare will likely no longer pay for your services. If you choose to get the services that may not be covered under Part A, you don't have to pay for these services until a claim is submitted and Medicare officially denies payment. However, while the claim is processed, you have to continue paying costs that you would normally have to pay, like the daily coinsurance and costs for services and supplies Medicare generally doesn't cover.

The SNF may use the ABN and collect money from you now for Part B items or services. If Medicare pays, the SNF will refund any payments you made, except copayments or deductibles.

2. "Hospital Issued Notice of Noncoverage" (HINN)

Hospitals use a HINN when all or part of your inpatient hospital care may not be covered by Medicare. This notice will tell you why the hospital thinks Medicare won't pay, and what you may have to pay if you keep getting these services.

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How do I appeal if I have Original Medicare?

Services & supplies Medicare generally doesn't cover

Doctors, other health care providers, and suppliers don't have to (but still may) give you an ABN for services that Medicare generally doesn't cover, like:

- Dental services
- Hearing aids
- Routine eye exams
- Routine foot care

What notices are given by home health agencies?

Home health agencies are required to give people with Original Medicare written notices in these situations:

1. "Home Health Change of Care Notice" (HHCCN)

The HHCCN is a written notice that your home health agency should give you when your home health plan of care is changing because of one of these:

- The home health agency makes a business decision to reduce or stop giving you some or all of your home health services or supplies.
- Your doctor changed your orders, which may reduce or stop giving you certain home health services or supplies.

The HHCCN lists the services or supplies that will be changed, and it gives you instructions on what you can do if you don't agree with the change.

The home health agency isn't required to give you a HHCCN when the "Notice of Medicare Non-Coverage" (NOMNC) is issued. See page 28 for more information.

How do I appeal if I have Original Medicare?

2. "Advance Beneficiary Notice of Noncoverage" (ABN)

When the home health agency believes that Medicare may not pay for certain home health items and services or all of your home health care, the agency should give you an ABN. See page 25 for more information on ABNs.

Home health agencies are required to give you an ABN if care is reduced or terminated, or before you get any items or services that may not be paid for by Medicare because of any of these reasons:

- They're not considered medically reasonable and necessary.
- The care is custodial.
- You aren't confined to your home.
- You don't need intermittent skilled nursing care.

Note: "The Home Health Advance Beneficiary Notice" (HHABN) has been discontinued. It was replaced by the HHCCN and the ABN in 2013.

3. "Notice of Medicare Non-Coverage" (NOMNC)

Your home health agency will give you a NOMNC when all of your Medicare-covered services are ending. This notice will tell you when the services will end and how to appeal if you think the services are ending too soon. The NOMNC tells you how to contact your BFCC-QIO to ask for a fast appeal. If you don't get this notice, ask for it.

If you decide to ask for a fast appeal, you should call the BFCC-QIO within the timeframe listed on the notice. After you request a fast appeal, you'll get a second notice with more information about why your care is ending. The BFCC-QIO may ask you questions about your care. To help your case, ask your doctor for information, which you can submit to the BFCC-QIO.

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4. "Detailed Explanation of Non-Coverage" (DENC)

Your home health agency will give you a DENC when it's informed by the BFCC-QIO that you've requested a BFCC-QIO review of your case. The DENC will explain why your home health agency believes that Medicare will no longer pay for your home health care.

How do I appeal if I have Original Medicare?



Medicare Advantage Plans (like HMOs or PPOs) and Medicare Cost Plans are health plan options that are approved by Medicare and run by private companies. When you join a Medicare Advantage Plan or other Medicare health plan, you're still in the Medicare Program. Your Medicare Advantage Plan or other Medicare health plan will send you information that explains your rights. Call your plan if you have questions.

Medicare Cost Plans are types of HMOs that are available in certain areas of the country. You may be covered by a Medicare Cost Plan, even if you only have Part B. If you have a Medicare Cost Plan and go to a non-network provider, the services are covered under Original Medicare. You can either get your Medicare prescription drug coverage from the Cost Plan (if offered), or you can buy a Medicare Prescription Drug Plan to add prescription drug coverage. If you have a Medicare Cost Plan and want to appeal services you got outside of the plan's network, you'll need to follow the Original Medicare appeals process. See Section 2.

If you're in a PACE (Program of All-inclusive Care for the Elderly) program, your appeal rights are different. The PACE organization will provide you with written information about your appeal rights.

If you have a Medicare Advantage Plan or other Medicare health plan, you have the right to request an appeal to resolve differences with your plan. You have the right to ask your plan to provide or pay for items or services you think should be covered, provided, or continued.

If you decide to appeal, ask your doctor, other health care provider, or supplier for any information that may help your case. Keep a copy of everything you send to your plan as part of your appeal.

What's the appeals process for Medicare Advantage Plans or other Medicare health plans?

Request an organization determination

You have the right to ask your plan to provide or pay for items or services you think should be covered, provided, or continued. This is called an "organization determination." You, your representative, or your doctor can request an organization determination from your plan in advance to make sure that the services are covered or after payment of the services is denied.

If you think your health could be seriously harmed by waiting the standard 14 days for a decision, ask your plan for a fast decision. The plan must notify you of its decision within 72 hours if it determines, or your doctor tells your plan, that waiting for a standard decision may seriously jeopardize your life, health, or ability to regain maximum function.

If the plan won't cover the items or services you asked for, you'll get a notice explaining why your plan fully or partially denied your request and instructions on how to appeal your plan's decision by requesting a reconsideration. If you appeal the plan's decision, you may want to ask for a copy of your file containing medical and other information about your case. Your plan may charge you for this copy.

If you disagree with your plan's initial decision (also known as the organization determination), you can file an appeal. The appeals process has 5 levels:

- Level 1: Reconsideration from your plan
- Level 2: Review by an Independent Review Entity (IRE)
- Level 3: Hearing before an Administrative Law Judge (ALJ)
- Level 4: Review by the Medicare Appeals Council (Appeals Council)
- Level 5: Judicial review by a federal district court

If you disagree with the decision made at any level of the process, you can generally go to the next level. At each level, you'll get instructions on how to move to the next level of appeal.

How do I appeal if I have a Medicare Advantage Plan or other Medicare health plan?

Words in red are defined on pages 59–62.

Level 1: Reconsideration from your plan

If you disagree with your plan's initial decision (also known as the organization determination), you or your representative can request a reconsideration (a second look or review). If your appeal is for a service you haven't gotten yet, your doctor can request a reconsideration on your behalf and must notify you about it.

You must request the reconsideration within 60 days of the date of the notice of the organization determination.

How do I request a reconsideration?

You, your representative, or your doctor must file a written standard or expedited (fast) request unless your plan allows you to file a request over the phone, by fax, or by email. You can find your plan's address in your plan materials and on the organization determination notice.

Follow the directions in the "Notice of Denial of Medical Coverage" or the "Notice of Denial of Payment" you got with your unfavorable decision to request a reconsideration from your plan. Your written reconsideration request should include:

- Your name, address, and Medicare number.
- The items or services for which you're requesting a reconsideration, the dates of service, and the reason(s) why you're appealing.
- If you've appointed a representative, include the name of your representative and proof of representation. For more information on appointing a representative, see Section 1.

You should also include any other information that may help your case. Keep a copy of everything you send to your plan as part of your appeal.

Your plan must respond to your request for an appeal within these timeframes:

- Expedited (fast) request—72 hours
- Standard service request—30 days
- Payment request—60 days

How do I appeal if I have a Medicare Advantage Plan or other Medicare health plan?

Your request will be a fast request if your plan determines, or your doctor tells your plan, that waiting for a standard service decision may seriously jeopardize your life, health, or ability to regain maximum function.

The timeframe for completing standard service and fast service requests may be extended by up to 14 days. The timeframe may be extended if, for example, your plan needs more information from a non-contract provider to make a decision about the case and the extension is in your best interest. Your plan will notify you in writing if it decided to take an extension. Your plan will notify you of the reasons for the delay and inform you of your right to file an expedited (fast) grievance if you disagree with the plan's decision to take an extension.

If the plan decides against you (fully or partially), your appeal is automatically sent to an Independent Review Entity (IRE), which is level 2.

Level 2: Review by an Independent Review Entity (IRE)

You'll get a written notice from your plan about all appeal decisions. If your plan decides against you, your appeal is automatically sent to level 2. If this happens, the notice from your plan will give you the specific reason(s) for any full or partial denial.

You may send the IRE information about your case. They must get this information within 10 days after the date you get the notice telling you your case file has been sent to the IRE. The IRE's address is on the notice.

Generally, the IRE will send you its decision in a written "Reconsideration Determination" within these timeframes:

- Expedited (fast) request—72 hours
- Standard service request—30 days
- Payment request—60 days

You'll get a fast decision if the IRE determines that your life or health may be at risk by waiting for a standard decision.

Note: Some IREs call themselves "Part D QICs."

How do I appeal if I have a Medicare Advantage Plan or other Medicare health plan?

If you disagree with the IRE's decision in level 2, you have 60 days from the date of the IRE's decision to request an Administrative Law Judge (ALJ) hearing, which is level 3.

Level 3: Hearing before an Administrative Law Judge (ALJ)

A hearing before an ALJ allows you to present your appeal to a new person who will review the facts of your appeal independently before making a new and impartial decision. An ALJ hearing is usually held by phone or video-teleconference, or in some cases, in person. You can also ask the ALJ to make a decision without a hearing.

Words in red are defined on pages 59–62.

To get an ALJ hearing, the amount of your case must meet a minimum dollar amount. For 2017, the required minimum amount is \$160. The ALJ will decide if your case meets the minimum dollar amount. You may be able to combine claims to meet the minimum dollar amount.

How do I request a hearing?

Follow the directions in the IRE's reconsidered determination to ask for a hearing before an ALJ, or submit a written request with the information listed below within 60 days of the IRE's reconsidered determination. Note that if any of the required information is missing from your request, it can cause delays in the processing of your appeal. Your written request must include:

- Your name, address, and Medicare number. If you've appointed a representative, include the name and address of your representative.
- The document control number assigned by the IRE, if any.
- The dates of service for the items or services you're appealing.
- An explanation of why you disagree with the IRE's reconsideration or other determination being appealed.
- Any other information that may help your case. If you can't include this information with your request, include a statement explaining what you plan to submit and when you'll submit it.

How do I appeal if I have a Medicare Advantage Plan or other Medicare health plan?

Keep a copy of everything you send to your plan as part of your appeal. To request an ALJ hearing, follow the instructions in the IRE's reconsideration decision. Your request for an ALJ hearing must be filed with the IRE and the IRE will forward your request and the case file to the ALJ. To learn more about the ALJ hearing process, visit hhs.gov/omha and select "Coverage and Claims Appeals." If you need help filing an appeal with an ALJ, call your plan.

If the ALJ decides in your favor, the plan has the right to appeal this decision by asking the Medicare Appeals Council (Appeals Council) for a review.

If you disagree with the ALJ's decision in level 3, you have 60 days after you get the ALJ's decision to request a review by the Appeals Council, which is level 4.

Level 4: Review by the Medicare Appeals Council (Appeals Council)

You can request that the Appeals Council review your case regardless of the dollar amount of your case.

How do I request a review?

To request that the Appeals Council review the ALJ's decision in your case, follow the directions in the ALJ's hearing decision you got in level 3. You must send your request to the Appeals Council at the address listed in the ALJ's hearing decision. You can file a request for Appeals Council review in one of these ways:

- 1. Fill out a "Request for Review of an Administrative Law Judge (ALJ) Medicare Decision/Dismissal" form (DAB-101). To get a copy, visit hhs.gov/dab/divisions/dab101.pdf, or call your plan or 1-800-MEDICARE (1-800-633-4227) and ask for a copy. TTY users can call 1-877-486-2048.
- 2. Submit a written request to the Appeals Council that includes:
 - Your name and Medicare number. If you've appointed a representative, include the name of your representative.

How do I appeal if I have a Medicare Advantage Plan or other Medicare health plan?

- The specific item(s) and/or service(s) you're appealing and the specific dates of service. See your reconsideration or ALJ hearing decision for this information.
- A statement identifying the parts of the ALJ's decision with which you disagree and an explanation of why you disagree.
- The date of the ALJ decision.
- Your signature. If you've appointed a representative, include the signature of your representative.
- If you're requesting that your case be moved from the ALJ to the Appeals Council because the ALJ hasn't issued a timely decision, include the hearing office in which the request for hearing is pending.

Keep a copy of everything you send to your plan as part of your appeal. For more information about the Appeals Council review process, visit hhs.gov/dab and select "Medicare Operations Division." If you need help filing a request for Appeals Council review, call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

If the Appeals Council doesn't issue a timely decision, you can ask the Appeals Council to move your case to the next level of appeal.

If you disagree with the Appeals Council's decision in level 4, you have 60 days after you get the Appeals Council's decision to request judicial review by a federal district court, which is level 5.

Level 5: Judicial review by a federal district court

If you disagree with the decision issued by the Appeals Council (or if the Appeals Council denied your request for review), you can request judicial review in federal district court. To get a review, the amount of your case must meet a minimum dollar amount. For 2017, the required minimum claim amount is \$1,560. You may be able to combine claims to meet this dollar amount.

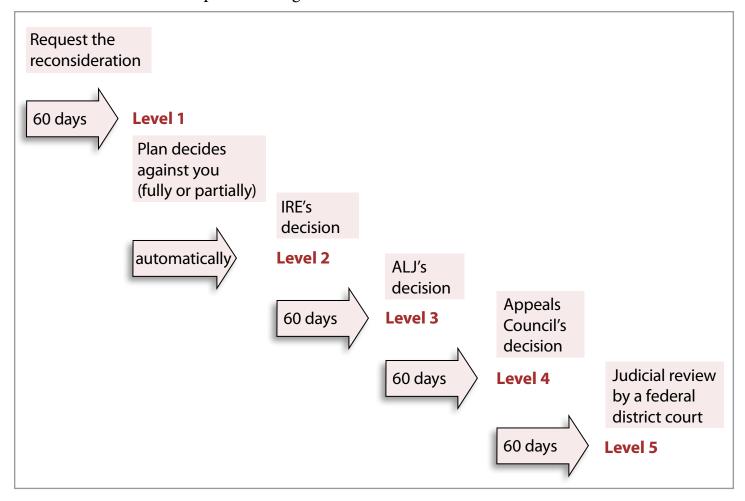
How do I appeal if I have a Medicare Advantage Plan or other Medicare health plan?

How do I request a review?

Follow the directions in the Appeals Council's decision letter you got in level 4 to file a complaint in federal district court.

For more information on the appeals process

- Visit Medicare.gov/appeals.
- Call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.
- Visit Medicare.gov/claims-and-appeals/file-an-appeal/appeals-forms.html for appeal forms.
- Call your State Health Insurance Assistance Program (SHIP) for free, personalized health insurance counseling, including help with appeals. To get the phone number for the SHIP in your state, visit shiptacenter.org, or call 1-800-MEDICARE.



How do I appeal if I have a Medicare Advantage Plan or other Medicare health plan?

How do I get an expedited (fast) appeal in a hospital?

When you're admitted as an inpatient to a hospital, you have the right to get the hospital care that's necessary to diagnose and treat your illness or injury. If you think you're being discharged from the hospital too soon, you have the right to ask your Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO) to review your case. To get the BFCC-QIO's phone number, visit Medicare.gov/contacts, or call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

During your hospital stay, you should get a notice called "An Important Message from Medicare about Your Rights" (sometimes called the "Important Message from Medicare" or the "IM"). If you don't get this notice, ask for it. This notice lists the BFCC-QIO's contact information and explains:

- Your right to get all medically necessary hospital services
- Your right to be involved in any decisions that the hospital, your doctor, or anyone else makes about your hospital services, and who will pay for them
- Your right to get services you need after you leave the hospital
- Your right to appeal a discharge decision and the steps for appealing the decision
- The circumstances under which you will or won't have to pay for charges for continuing to stay in the hospital
- Information on your right to get a detailed notice about why your covered services are ending

You should get the IM within 2 days of your hospital admission. If the hospital gives you the notice more than 2 days before your discharge day, it must either give you a copy of your original, signed IM or provide you with a new one (that you must sign) before you're discharged.

How do I appeal if I have a Medicare Advantage Plan or other Medicare health plan?

How do I ask for a fast appeal?

You have the right to a fast appeal if you think you're being discharged too soon. Ask the BFCC-QIO for a fast appeal. Follow the directions on the IM to do this. You must ask for a fast appeal no later than the day you're being discharged from the hospital.

If you meet this deadline, you can stay in the hospital after your discharge date without paying for it (except for applicable coinsurance or deductibles) while you wait to get the decision from the BFCC-QIO.

Words in red are defined on pages 59–62.

If you miss the deadline for a fast appeal, you can request an expedited (fast) reconsideration from your plan, but your Medicare health plan will only cover hospital services if there's a decision issued in your favor.

To ask for a fast appeal, contact your State Health Insurance Assistance Program (SHIP). To get the phone number for your SHIP, visit shiptacenter.org, or call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

What will happen during the BFCC-QIO's review?

When the BFCC-QIO gets your request, it will notify the plan and the hospital. Once your plan and the hospital are notified by the BFCC-QIO, you plan or the hospital will provide you a "Detailed Notice of Discharge" by noon on that day that includes:

- Why your services are no longer reasonable and necessary, or are no longer covered
- The applicable Medicare coverage rule or policy, including a citation to the applicable Medicare policy, or information on how you can get a copy of the policy
- How the applicable coverage rule or policy applies to your specific situation

You can also ask your plan for copies of any of the materials that your plan sent to the BFCC-QIO about your hospital discharge. The BFCC-QIO will look at your medical information provided by the plan and the hospital and will also ask you for your opinion. Within one day of getting that information, the BFCC-QIO will decide if you're ready to be discharged.

How do I appeal if I have a Medicare Advantage Plan or other Medicare health plan?

If the BFCC-QIO decides that you're being discharged too soon, the plan will continue to provide for your Medicare-covered hospital stay as long as medically necessary (except for applicable coinsurance or deductibles) if your plan previously authorized coverage of the inpatient admission or the inpatient admission was for emergency or urgently needed care. If your plan never authorized the inpatient admission and it wasn't for emergency or urgently needed care, you may need to appeal the denial of coverage for your plan to pay.

If the BFCC-QIO decides that you're ready to be discharged and you met the deadline for requesting a fast appeal, you won't be responsible for paying the hospital charges (except for applicable coinsurance or deductibles) incurred through noon of the day after the BFCC-QIO gives you its decision. If you get any inpatient hospital services after noon on the day that the BFCC-QIO gives you its decision, you might have to pay for them.

If you have any questions about fast appeals in hospitals, you can call the BFCC-QIO at the phone number listed on the notice the hospital gives you. You can also visit Medicare.gov/contacts, or call 1-800-MEDICARE (1-800-633-4227) to get the BFCC-QIO's phone number. TTY users can call 1-877-486-2048.

How do I get an expedited (fast) appeal in a setting other than a hospital?

You have the right to a fast appeal if you think your services from a Medicare-covered skilled nursing facility (SNF), home health agency (HHA), or comprehensive outpatient rehabilitation facility (CORF) are ending too soon. During a fast appeal, the BFCC-QIO looks at your case and decides if your health care services need to continue.

How do I appeal if I have a Medicare Advantage Plan or other Medicare health plan?

While you're getting SNF, HHA, or CORF services, you should get a notice called "Notice of Medicare Non-Coverage" at least 2 days before covered services end. If you don't get this notice, ask for it. This notice explains:

- The date that your covered services will end
- That you may have to pay for services you got after the coverage end date indicated on your notice
- Information on your right to get a detailed notice about why your covered services are ending
- Your right to a fast appeal and information on how to contact your BFCC-QIO to request a fast appeal

How do I ask for a fast appeal?

Ask the BFCC-QIO for a fast appeal no later than noon of the first day after the day you get the "Notice of Medicare Non-Coverage." Follow the instructions on the termination notice.

If you miss the deadline for requesting a fast appeal from the BFCC-QIO, you can request an expedited (fast) reconsideration from your plan, but services will only be covered if there's a decision issued in your favor.

Words in red are defined on pages 59–62.

What will happen during the BFCC-QIO's review?

When the BFCC-QIO gets your request, it will notify the plan and the provider. You'll get a "Detailed Explanation of Non-Coverage" by the end of the day. The notice will include:

- Why your plan intends to stop covering your services
- The applicable Medicare coverage rule or policy, including citation to the applicable Medicare policy, or information on how you can get a copy of the policy your plan is using to explain why your coverage is ending
- Any applicable plan policy, contract provision, or reason on which your discharge decision was based

How do I appeal if I have a Medicare Advantage Plan or other Medicare health plan?

The BFCC-QIO will:

- Ask you why you believe coverage for the services should continue.
- Look at your medical records and the information provided by the plan.
- Make a decision by close of business the day after it gets the information it needs to make a decision.

If the BFCC-QIO decides that your services are ending too soon, your plan will continue to provide for your Medicare-covered SNF, HHA, or CORF services (except for applicable coinsurance or deductibles).

If the BFCC-QIO decides that your services should end, you won't be responsible for paying for any SNF, HHA, or CORF services provided before the termination date on the "Notice of Medicare Non-Coverage." If you continue to get services after the coverage end date, you may have to pay for those services.

If you have questions about your rights regarding SNF, HHA, or CORF services, including appealing the BFCC-QIO's decision, getting notices, or learning about your additional appeal rights after missing the filing deadline, call the BFCC-QIO at the phone number listed on the notice the provider gives you, or call your health plan (their phone number is in your plan materials). You can also visit Medicare.gov/contacts or call 1-800-MEDICARE (1-800-633-4227) to get the BFCC-QIO's phone number. TTY users can call 1-877-486-2048.

How do I file a grievance?

If you have concerns or problems with your Medicare Advantage Plan or other Medicare health plan that don't involve requests to provide or pay for items or services, you can file a "grievance."

■ If your complaint involves the quality of care you got or are getting, you can file a grievance with your plan and/or your BFCC-QIO. For the phone number of the BFCC-QIO, visit Medicare.gov/contacts, or call 1-800-MEDICARE.

How do I appeal if I have a Medicare Advantage Plan or other Medicare health plan?

- You may file a grievance with your Medicare health plan if:
 - You believe your plan's customer service hours of operation should be different.
 - You believe there aren't enough specialists in the plan to meet your needs.
 - The company offering your plan is sending you materials that you didn't ask to get and aren't related to your plan.
 - The plan didn't make a decision about a reconsideration within the required timeframe. See the level 1 appeal on page 33.
 - The plan didn't send your case to the IRE. See level 2 on page 34.
 - You disagree with the plan's decision not to grant your request for a fast appeal or you disagree with the plan's decision to extend the timeframe for making its decision.
 - The plan didn't provide the required notices.
 - The plan's notices don't follow Medicare rules.

When you join a Medicare Advantage Plan or other Medicare health plan, the plan will send you information about how to file grievances in its membership materials. Read the information carefully, and keep it where you can find it if you need it. Call your plan if you have questions.

Section 4: How do I appeal if I have Medicare prescription drug coverage?

If you have Medicare prescription drug coverage through a Medicare Prescription Drug Plan (PDP), a Medicare Advantage Plan with prescription drug coverage (MA-PD), or other Medicare plan, your plan will send you information that explains your rights (called an "Evidence of Coverage"). Call your plan if you have questions about your "Evidence of Coverage."

You have the right to ask your plan to provide or pay for a drug you think should be covered, provided, or continued. You have the right to request an appeal if you disagree with your plan's decision about whether to provide or pay for a drug.

If you decide to appeal, ask your doctor or other health care provider for any information that may help your case. Keep a copy of everything you send to your plan as part of your appeal.

What if my plan won't cover a drug I think I need?

If your pharmacist tells you that your Medicare drug plan won't cover a drug you think should be covered, or it will cover the drug at a higher cost than you think you should have to pay, you have these options:

1. Talk to your prescriber.

Ask your prescriber if you meet prior authorization or step therapy requirements. For more information on these requirements, visit Medicare.gov, or call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048. You can also ask your prescriber if there are generic, over-the-counter, or less expensive brand-name drugs that could work just as well as the ones you're taking now.

How do I appeal if I have Medicare prescription drug coverage?

2. Request a coverage determination (including an "exception").

You, your representative, your doctor, or other prescriber can request (orally or in writing) that your plan cover the prescription you need. You can request a coverage determination if your pharmacist or plan tells you one of these:

- A drug you believe should be covered isn't covered.
- A drug is covered at a higher cost than you think you should have to pay.
- You have to meet a plan coverage rule (like prior authorization) before you can get the drug you requested.
- It won't cover a drug on the formulary because the plan believes you don't need the drug.

You, your representative, your doctor, or other prescriber can request a coverage determination called an "exception" if:

- You think your plan should cover a drug that's not on its formulary because the other treatment options on your plan's formulary won't work for you.
- Your doctor or other prescriber believes you can't meet one of your plan's coverage rules, like prior authorization, step therapy, or quantity or dosage limits.
- You think your plan should charge a lower amount for a drug you're taking on the plan's non-preferred drug tier because the other treatment options in your plan's preferred drug tier won't work for you.

If you request an exception, your doctor or other prescriber will need to give a supporting statement to your plan explaining why you need the drug you're requesting. Check with your plan to find out if the supporting statement is required to be made in writing. The plan's decision-making time period begins once your plan gets the supporting statement.

How do I appeal if I have Medicare prescription drug coverage?

You can either request a coverage determination before you pay for or get your prescriptions, or you can decide to pay for the prescription, save your receipt, and request that the plan pay you back by requesting a coverage determination. Check the "Evidence of Coverage" you get from your plan for more information on getting reimbursed for out-of-pocket costs.

You can file a standard request for any coverage determination, or if you haven't already paid for the drug yourself, you can file an expedited (fast) request. See timeframes below.

How do I file a standard coverage determination?

You, your representative, your doctor, or other prescriber can request a coverage determination (including an exception) by following the instructions that your plan sends you. Once your plan has gotten your request, it has 72 hours to notify you of its decision with respect to requests for drug benefits, and 14 calendar days for requests for payment.

You can call your plan, write them a letter, or send them a completed "Model Coverage Determination Request" form to ask your plan for a coverage determination or exception. This form is available at cms.gov/medprescriptdrugapplgriev/13_forms.asp, or call your plan and ask for a copy. Your plan must accept any written request for a coverage determination from you, your representative, your doctor, or your other prescriber.

How do I file an expedited (fast) coverage determination?

You, your representative, your doctor, or other prescriber can call or write your plan to request that a fast decision be made within 24 hours of your request. You'll get a fast decision if your plan determines, or your doctor or other prescriber tells your plan, that waiting 72 hours for a decision may seriously jeopardize your life, health, or ability to regain maximum function. You can't request (and won't get) a fast decision if you've already paid for and gotten the drug.

How do I appeal if I have Medicare prescription drug coverage?

You can call your plan, write them a letter, or send them a completed "Model Coverage Determination Request" form to ask your plan for a fast coverage determination or exception. This form is available at cms.gov/medprescriptdrugapplgriev/13_forms.asp, or call your plan and ask for a copy.

What if I disagree with the decision?

Your Medicare drug plan will send you a written decision. If you disagree with this decision, you have the right to appeal.

What's the appeals process for Medicare prescription drug coverage?

The appeals process has 5 levels:

Level 1: Redetermination from your plan

Level 2: Reconsideration by an Independent Review Entity (IRE)

Level 3: Hearing before an Administrative Law Judge (ALJ)

Level 4: Review by the Medicare Appeals Council (Appeals Council)

Level 5: Judicial review by a federal district court

If you disagree with the decision made at any level of the process, you can generally go to the next level. At each level, you'll get instructions on how to move to the next level of appeal.

Level 1: Redetermination from your plan

If you disagree with your plan's initial denial (coverage determination), you can request a redetermination.

You must request the redetermination within 60 days from the date of the coverage determination.

How do I appeal if I have Medicare prescription drug coverage?

How do I request a redetermination?

Follow the directions in the plan's initial denial notice and plan materials. You, your representative, your doctor, or other prescriber can request a standard or expedited (fast) redetermination. You can't request a fast redetermination if it's an appeal about payment for a drug you already got. Standard requests must be made in writing, unless your plan allows you to file a standard request orally, like by phone. You'll get a fast decision if your plan determines, or your doctor or other prescriber tells your plan, that waiting for a standard decision may seriously jeopardize your life, health, or ability to regain maximum function.

Your plan must accept any written request for a redetermination from you, your representative, your doctor, or other prescriber. A written request to appeal should include:

- Your name, address, and Medicare number or member number.
- The name of the drug you want your plan to cover.
- Reason(s) why you're appealing.
- If you've appointed a representative, include the name of your representative and proof of representation. For more information on appointing a representative, see Section 1.

Send your request along with any other information that may help your case, including medical records. Your plan's address and phone number is in your plan materials and will also be in any written plan decision you get.

Your plan will respond in a "Redetermination Notice" within these timeframes:

- Expedited (fast) redetermination decision—as quickly as your health condition requires, but no later than 72 hours
- Standard redetermination decision—7 days

If you disagree with the plan's redetermination decision in level 1, you can request a reconsideration by an Independent Review Entity (IRE), which is level 2, within 60 days from the date of the redetermination decision.

How do I appeal if I have Medicare prescription drug coverage?

Level 2: Reconsideration by an Independent Review Entity (IRE)

If your Medicare drug plan decides against you in level 1, it will send you a written decision. If you disagree with the plan's redetermination, you, your representative, or your doctor or other prescriber can request a standard or expedited (fast) reconsideration by an IRE. You can't request a fast redetermination if it's an appeal about payment for a drug you already got.

How do I request a reconsideration?

To request a reconsideration by an IRE, follow the directions in the plan's "Redetermination Notice." If your plan issues an unfavorable redetermination, it should also send you a "Request for Reconsideration" form that you can use to ask for a reconsideration. If you don't get this form, call your plan and ask for a copy. This form is also available at cms.gov/medprescriptdrugapplgriev/13_forms.asp.

Send your request to the IRE at the address or fax number listed in the plan's redetermination decision letter that's mailed to you. You'll get a fast reconsideration decision if the IRE determines, or your prescriber tells the IRE, that waiting for a standard decision may seriously jeopardize your life, health, or ability to regain maximum function.

Once the IRE gets the request for review, it will send you its decision in a "Reconsideration Notice" within these timeframes:

- Expedited (fast) reconsideration decision—as quickly as your health condition requires, but no later than 72 hours
- Standard reconsideration decision—7 days

Note: Some IREs call themselves "Part D QICs."

If you disagree with the IRE's decision in level 2, you have 60 days after you receive the IRE's decision to request an Administrative Law Judge (ALJ) hearing, which is level 3.

How do I appeal if I have Medicare prescription drug coverage?

Level 3: Hearing before an Administrative Law Judge (ALJ)

A hearing before an ALJ allows you to present your appeal to a new person who will review the facts of your appeal independently and listen to your testimony before making a new and impartial decision. An ALJ hearing is usually held by phone or video-teleconference, or in some cases, in person. You can also ask the ALJ to make a decision without a hearing, and the ALJ may also issue a decision without holding a hearing if the evidence in the hearing record supports a decision that's fully in your favor.

At the ALJ hearing, you'll have the chance to explain why your Medicare drug plan should cover your drug or pay you back. You can also ask your doctor or other prescriber to join the hearing and explain why he or she believes the drug should be covered.

To get an ALJ hearing, the amount of your case must meet a minimum dollar amount. For 2017, the required minimum amount is \$160. The ALJ will decide if your case meets the minimum dollar amount. You may be able to combine claims to meet the minimum dollar amount.

Words in red are defined on pages 59–62.

How do I request a hearing?

Follow the directions on the IRE's reconsideration notice to request an ALJ hearing. Your request must be sent to the Office of Medicare Hearings and Appeals (OMHA) address listed in the IRE's reconsideration notice. Only you or your representative can file a request in one of these ways:

1. Fill out a "Request for Hearing by an Administrative Law Judge" form (CMS Form number 20034 A/B). To get a copy visit cms.gov/cmsforms/downloads/cms20034ab.pdf, or call 1-800-MEDICARE (1-800-633-4227) and ask for a copy. TTY users can call 1-877-486-2048.

How do I appeal if I have Medicare prescription drug coverage?

- 2. Submit a written request to the OMHA office. Your letter must include:
 - Your name, address, phone number, Medicare number, and the name of your Medicare Prescription Drug Plan. If you've appointed a representative, include the name, address, and phone number of your representative.
 - The appeal case number included on the reconsideration notice.
 - The prescription drug in dispute. See your redetermination or reconsideration notice for this information.
 - The reason why you disagree with the reconsideration decision.
 - Any other information that may help your case. If you can't include this information with your request, include a statement explaining what you plan to submit and when you'll submit it.
 - If you're requesting an expedited (fast) decision, include a statement that indicates this.
- 3. If you're requesting an expedited (fast) hearing, you can make an oral request. Follow the instructions in the IRE's decision notice to do this. The ALJ will give you a fast decision if your doctor or other prescriber indicates, or the ALJ determines, that waiting 90 days for a decision may seriously jeopardize your life, health, or ability to regain maximum function. You can't request (and won't get) a fast decision if you already got the drug.

Once the ALJ gets the request for review, you'll get a decision. If you request an expedited (fast) ALJ decision, you'll get a decision as quickly as your health condition requires, but generally no later than 10 days beginning on the day your request for hearing is received by the appropriate OMHA field office, unless that time period is extended.

To learn more about the ALJ hearing process, visit hhs.gov/omha and select "Coverage and Claims Appeals." If you need help filing an appeal with an ALJ, call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

How do I appeal if I have Medicare prescription drug coverage?

Words in red are defined on pages 59–62.

If you disagree with the ALJ's decision in level 3, you have 60 days after you get the ALJ's decision to request a review by the Medicare Appeals Council (Appeals Council), which is level 4.

Level 4: Review by the Medicare Appeals Council (Appeals Council)

You can request that the Appeals Council review your case, regardless of the dollar amount of your case.

How do I request a review?

To request that the Appeals Council review the ALJ's decision in your case, follow the directions in the ALJ's hearing decision you got in level 3. Your request must be sent to the Appeals Council at the address listed in the ALJ's hearing decision. You or your representative can file a request for Appeals Council review in one of these ways:

- 1. Fill out a "Request for Review of an Administrative Law Judge (ALJ) Medicare Decision/Dismissal" form (DAB-101). To get a copy, visit hhs.gov/dab/divisions/dab101.pdf, or call 1-800-MEDICARE (1-800-633-4227) and ask for a copy. TTY users can call 1-877-486-2048.
- 2. Submit a written request to the Appeals Council that includes:
 - Your name, address, phone number, Medicare number, and the name of your Medicare Prescription Drug Plan. If you've appointed a representative, include the name and address of your representative.
 - The prescription drug in dispute. See your IRE reconsideration notice or your ALJ hearing decision for this information.
 - A statement identifying the parts of the ALJ's decision with which you disagree and an explanation of why you disagree.
 - The ALJ appeal case number.

How do I appeal if I have Medicare prescription drug coverage?

- If you're requesting an expedited (fast) decision, include a statement that indicates this.
- Your signature. If you've appointed a representative, include the signature of your representative.
- 3. If you're requesting an expedited (fast) review, you can make an oral request. Follow the instructions in the ALJ's decision notice to do this. The Appeals Council will give you a fast decision if your doctor or other prescriber indicates, or the Appeals Council determines, that waiting 90 days for a decision may seriously jeopardize your life, health, or ability to regain maximum function. You can't request (and won't get) a fast decision if you already got the drug.

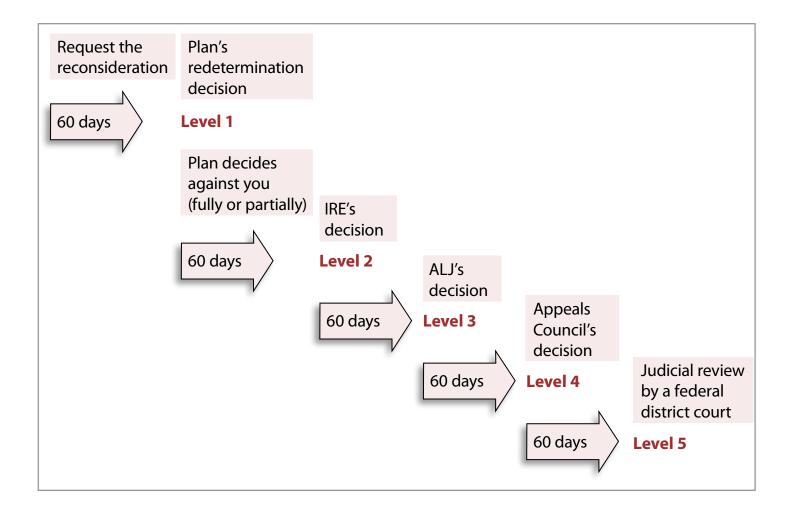
Once the Appeals Council gets the request for review, you'll get a decision. Expedited (fast) Appeals Council decision, you'll get a decision as quickly as your health condition requires, but generally no later than 10 days beginning on the day the Appeals Council receives the request for review, unless that time period is extended.

To learn more about the Appeals Council review process, visit hhs.gov/dab and select "Medicare Appeals Council." If you need help filing a request for Appeals Council review, call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

Words in red are defined on pages 59–62.

If you disagree with the Appeals Council's decision in level 4, you have 60 days after you get the Appeals Council's decision to request judicial review by a federal district court, which is level 5.

How do I appeal if I have Medicare prescription drug coverage?



Level 5: Judicial review by a federal district court

If you disagree with the decision issued by the Appeals Council, you can request judicial review in federal district court. To get a review, the amount of your case must meet a minimum dollar amount. For 2017, the minimum dollar amount is \$1,560. You may be able to combine claims to meet this dollar amount.

How do I request a review?

Follow the directions in the Appeals Council's decision letter you got in level 4 to file a complaint in federal district court. You should check with the clerk's office of the federal district court for instructions about how to file the appeal. The court location is on the Appeals Council's decision notice.

How do I appeal if I have Medicare prescription drug coverage?

For more information on the appeals process:

- Visit Medicare.gov/appeals.
- Call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.
- Visit Medicare.gov/claims-and-appeals/file-an-appeal/ appeals-forms.html.
- Call your State Health Insurance Assistance Program (SHIP) for free, personalized health insurance counseling, including help with appeals. To get the phone number for the SHIP in your state, visit shiptacenter.org, or call 1-800-MEDICARE.

How do I file a grievance or complaint?

If you have a concern or a problem with your plan that isn't a request for coverage or reimbursement for a drug, you have the right to file a complaint (also called a "grievance").

Some examples of why you might file a complaint include:

- You believe your plan's customer service hours of operation should be different.
- You have to wait too long for your prescription.
- The company offering your plan is sending you materials that you didn't ask to get and aren't related to the drug plan.
- The plan didn't make a timely decision about a coverage determination in level 1 and didn't send your case to the IRE.
- You disagree with the plan's decision not to grant your request for an expedited (fast) coverage determination or first-level appeal (called a "redetermination").
- The plan didn't provide the required notices.
- The plan's notices don't follow Medicare rules.

How do I appeal if I have Medicare prescription drug coverage?

If your complaint involves the quality of care you got or are getting, you can file a grievance with your plan and/or your Beneficiary and Family Centered Quality Improvement Organization (BFCC-QIO). For the phone number of your BFCC-QIO, visit Medicare.gov/contacts, or call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

If you want to file a complaint:

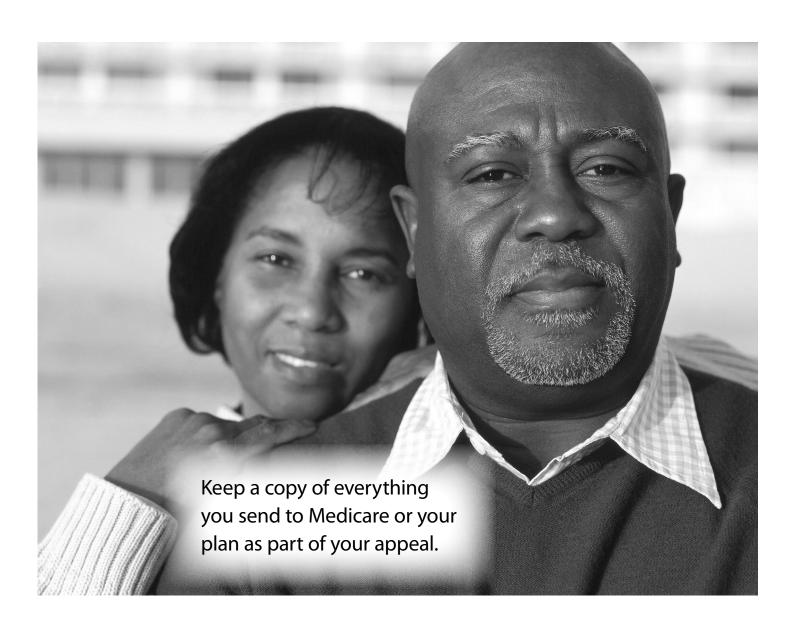
- You must file your complaint within 60 days from the date of the event that led to the complaint.
- You can file your complaint with the plan over the phone or in writing.
- You must be notified of the plan's decision generally no later than 30 days after the plan gets the complaint.
- If the complaint relates to a plan's refusal to make an expedited (fast) coverage determination or redetermination and you haven't yet purchased or received the drug, the plan must notify you of its decision within 24 hours after it gets the complaint.

If the plan doesn't address your complaint, call 1-800-MEDICARE.

More information on filing a complaint

- Visit Medicare.gov/appeals.
- Call your SHIP for free, personalized counseling and help filing a complaint. To get the phone number of the SHIP in your state, visit shiptacenter.org, or call 1-800-MEDICARE.

How do I appeal if I have Medicare prescription drug coverage?



Section 5: Definitions

Appeal—An appeal is the action you can take if you disagree with a coverage or payment decision made by Medicare, your Medicare health plan, or your Medicare Prescription Drug Plan. You can appeal if Medicare or your plan denies one of these:

- Your request for a health care service, supply, item, or prescription drug that you think you should be able to get
- Your request for payment for a health care service, supply, item, or prescription drug you already got
- Your request to change the amount you must pay for a health care service, supply, item or prescription drug

You can also appeal if Medicare or your plan stops providing or paying for all or part of a health care service, supply, item, or prescription drug you think you still need.

Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO)—A type of QIO (a group of doctors and other health care experts under contract with Medicare) that uses doctors and other health care experts to review complaints and quality of care for people with Medicare. The BFCC-QIO makes sure there is consistency in the case review process while taking into consideration local factors and local needs, including general quality of care and medical necessity.

Claim—A request for payment that you submit to Medicare or other health insurance when you receive items and services that you think are covered.

Coinsurance—An amount you may be required to pay as your share of the cost for services after you pay any deductibles. Coinsurance is usually a percentage (for example, 20%).

Comprehensive outpatient rehabilitation facility (CORF)—A facility that provides a variety of services on an outpatient basis, including physicians' services, physical therapy, social or psychological services, and rehabilitation.

Definitions

Copayment—An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit, or a prescription drug. A copayment is usually a set amount, rather than a percentage. For example, you might pay \$10 or \$20 for a doctor's visit or prescription drug.

Custodial care—Nonskilled personal care, such as help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around, and using the bathroom. It may also include the kind of health-related care that most people do themselves, like using eye drops. In most cases, Medicare doesn't pay for custodial care.

Deductible—The amount you must pay for health care or prescriptions, before Original Medicare, your prescription drug plan, or your other insurance begins to pay.

Formulary—A list of prescription drugs covered by a prescription drug plan or another insurance plan offering prescription drug benefits. Also called a drug list.

Grievance—A complaint about the way your Medicare health plan or Medicare drug plan is giving care. For example, you may file a grievance if you have a problem calling the plan or if you're unhappy with the way a staff person at the plan has behaved towards you. However, if you have a complaint about a plan's refusal to cover a service, supply, or prescription, you file an appeal.

Health care provider—A person or organization that is licensed to give health care. Doctors, nurses, and hospitals are examples of health care providers.

Home health agency (HHA)—An organization that provides home health care.

Definitions

Hospice—A special way of caring for people who are terminally ill. Hospice care involves a team-oriented approach that addresses the medical, physical, social, emotional, and spiritual needs of the patient. Hospice also provides support to the patient's family or caregiver.

Medically necessary—Health care services or supplies needed to diagnose or treat an illness, injury, condition, disease, or its symptoms and that meet accepted standards of medicine.

Medicare—The federal health insurance program for people who are 65 or older, certain younger people with disabilities, and people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant, sometimes called ESRD).

Medicare Advantage Plan (Part C)—A type of Medicare health plan offered by a private company that contracts with Medicare to provide you with all your Part A and Part B benefits. Medicare Advantage Plans include Health Maintenance Organizations, Preferred Provider Organizations, Private Fee-for-Service Plans, Special Needs Plans, and Medicare Medical Savings Account Plans. If you're enrolled in a Medicare Advantage Plan, Medicare services are covered through the plan and aren't paid for under Original Medicare. Most Medicare Advantage Plans offer prescription drug coverage.

Medicare health plan—Generally, a plan offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the plan. Medicare health plans include all Medicare Advantage Plans, Medicare Cost Plans, and Demonstration/Pilot Programs. Programs of All-inclusive Care for the Elderly (PACE) organizations are special types of Medicare health plans that can be offered by public or private entities and provide Part D and other benefits in addition to Part A and Part B benefits.

Definitions

Medicare Part A (Hospital Insurance)—Part A covers inpatient hospital stays, care in a skilled nursing facility, hospice care, and some home health care.

Medicare Part B (Medical Insurance)—Part B covers certain doctors' services, outpatient care, medical supplies, and preventive services.

Medicare Prescription Drug Plan (Part D)—Part D adds prescription drug coverage to Original Medicare, some Medicare Cost Plans, some Medicare Private-Fee-for-Service Plans, and Medicare Medical Savings Account Plans. These plans are offered by insurance companies and other private companies approved by Medicare. Medicare Advantage Plans may also offer prescription drug coverage that follows the same rules as Medicare Prescription Drug Plans.

Medicare Summary Notice (MSN)—A notice you get after the doctor, other health care provider, or supplier files a claim for Part A or Part B services in Original Medicare. It explains what the doctor, other health care provider, or supplier billed for, the Medicare-approved amount, how much Medicare paid, and what you must pay.

Original Medicare—Original Medicare is a fee-for-service health plan that has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance). After you pay a deductible, Medicare pays its share of the Medicare-approved amount, and you pay your share (coinsurance and deductibles).

Skilled nursing facility (SNF)—A nursing facility with the staff and equipment to give skilled nursing care and, in most cases, skilled rehabilitative services and other related health services.

State Health Insurance Assistance Program (SHIP)—A state program that gets money from the federal government to give free local health insurance counseling to people with Medicare.

Supplier—any company, person, or agency that gives you a medical item or service, except when you're an inpatient in a hospital or skilled nursing facility.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services 7500 Security Blvd. Baltimore, MD 21244-1850

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CMS Product No. 11525 Revised January 2017



This booklet is available in Spanish. To get a free copy, call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

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Medicare Home Health Coverage Booklet

(www.MedicareAdvocacy.org)



MedicareAdvocacy.org

PO Box 350 Willimantic, Connecticut 06226 (860)456-7790 (800)262-4414

1025 Connecticut Ave, NW Suite 709 Washington, DC 20036 (202)293-5760

MEDICARE HOME HEALTH COVERAGE

Se habla español

Produced under a grant from the Connecticut State Unit on Aging in conjunction with the CHOICES Program

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WHAT IS NEEDED TO QUALIFY FOR MEDICARE HOME HEALTH COVERAGE?

- The patient must be homebound. (This does <u>not</u> mean the patient can never leave home. For example, patients can leave home occasionally, go to adult day care, religious services, medical appointments, special occasions);
- The patient must require <u>skilled nursing</u> on an intermittent basis (from once a day for finite, recurring periods of 21 days at a time, to once every 60 days), or physical therapy, speech language pathology or occupational therapy to continue care;
- A physician must order the care and sign a "Plan of Care;"
- A physician or appropriate non-physician health care professional must have seen the patient face-to-face prior to certifying the need for home health services;
- Documentation about the face-to-face meeting must be included in the home health care certification, signed by a physician; and
- The care must be provided by, or under arrangements with, a Medicare-certified home health agency.

WHAT SERVICES WILL MEDICARE COVER?

- Part-time or intermittent nursing care provided by or under the supervision of a registered nurse; *
- Physical therapy, occupational therapy, and speech language pathology;
- Part-time or intermittent home health aides, to provide hands-on personal care services; *
- Medical social services provided under the direction of a physician; and
- Medical supplies such as wound dressings when ordered by a physician as part of a patient's care;

THE PATIENT DOES <u>NOT</u> HAVE TO IMPROVE TO QUALIFY FOR MEDICARE COVERAGE

- <u>Medicare coverage</u> <u>does not turn on the presence or</u> <u>absence of a beneficiary's potential for improvement,</u> but rather on the need for skilled care.
- It is not necessary for the patient to improve in order to qualify for Medicare coverage. The patient <u>can</u> have a chronic or long-term condition.
- Skilled nursing and/or therapy to maintain a patient's condition, or to slow decline, <u>can</u> be covered by Medicare.

^{*} Under the law, Medicare can cover up to 28 hours combined of home health aide and nursing. (Up to 35 hours, on a case-by-case basis if needed).

UNFAIR DENIALS OF MEDICARE OCCUR WITH SURPRISING FREQUENCY

Because Medicare administrators sometimes use rules and procedures which may improperly restrict coverage and payment, patients are sometimes denied coverage and required to pay for care which should be covered by Medicare.

WHAT TO DO IF MEDICARE COVERAGE IS ENDING OR DENIED

- If the home health agency issues a notice that states services will be ending, the patient has a right to an expedited appeal when "a physician certifies that failure to continue the provision of such services is likely to place [the patient's] health at significant risk."
- Ask the patient's doctor to instruct the home health agency to continue to provide necessary services. Home health care should not be ended or reduced unless the change has been ordered by the doctor.
- The home health agency must give at least two days advanced notice before ending services. A request for an expedited review, orally or in writing, must be made by noon of the next calendar day to preserve expedited appeal rights.
- If the patient receives a written denial from the home health agency, ask the agency, in writing, to submit the claim to Medicare for a coverage determination from Medicare. Sometimes coverage will be granted. If not, further appeal is then possible.

IMPORTANT ADVOCACY TIPS

- There is no legal limit to the duration of Medicare home health coverage for people who continue to meet the coverage criteria. Medicare coverage is available for necessary home health care even if it extends over a long period of time.
- Do not accept arbitrary caps on coverage. For example, do not accept assertions that home health aide services in excess of one visit per day or week cannot be covered.
- Family members cannot be required to provide care in order for the beneficiary to obtain Medicare coverage and beneficiaries cannot be required to accept care from family members.
- In order to appeal a Medicare denial, the home health agency must file a Medicare claim for the patient's care. If the patient wants to pursue coverage, he/she should tell the home health agency to file a Medicare claim, even if the agency thinks Medicare coverage is not available.
- If the beneficiary requests, the home health agency must submit the claim to Medicare. (But the beneficiary <u>can</u> be required to pay pending Medicare's decision, and if Medicare is denied.)
- The doctor is the patient's most important ally. If it appears that Medicare coverage will be denied, ask the doctor who ordered the care to help explain the need for the care.

RESTORATION POTENTIAL IS NOT REQUIRED TO OBTAIN MEDICARE COVERAGE.

MEDICARE CAN BE AVAILABLE IF:

A skilled professional is needed to maintain current capabilities or prevent further deterioration.

MEDICARE COVERAGE SHOULD NOT BE DENIED:

Simply because the individual's condition will not improve, is chronic, or expected to last a long time.

Need help?

Contact your State's Health Insurance Assistance Program (SHIP)

In Connecticut, this is CHOICES, (800) 994-9422.

For additional information and self-help materials, visit the Center for Medicare Advocacy's website:

MedicareAdvocacy.org

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CENTER FOR MEDICARE ADVOCACY, INC.

The Center for Medicare Advocacy, founded in 1986, is a national non-profit law organization that works to ensure fair access to Medicare and quality health care. The Center is based in Connecticut and Washington, DC, with offices around the country.

Based on our work with real people, the Center advocates for policies and systemic change that will benefit all those in need of health care coverage and services.

Staffed by attorneys, legal assistants, nurses, and information management experts, the organization represents thousands of individuals in appeals of Medicare denials. The work of the Center also includes responding to over 7,000 calls and emails annually from older adults, people with disabilities, and their families, and partnering with CHOICES, the Connecticut State health insurance program (SHIP).

Only through advocacy and education can older people and people with disabilities be assured that Medicare and health care are provided fairly:

- We offer education and consulting services to help others advance the rights of older and disabled people and to provide quality health care.
- We draw upon our direct experience with thousands of Medicare beneficiaries to educate policy-makers about how their decisions play out in the lives of real people.

The Center for Medicare Advocacy is the most experienced organization for Medicare beneficiaries and their families.

Visit our website: MedicareAdvocacy.org

Rev. 1/2018



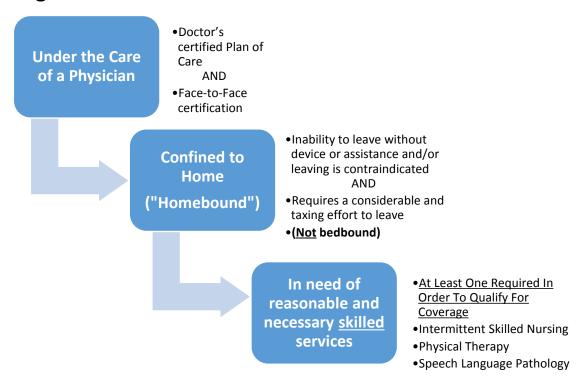
Medicare Home Health Coverage Flowchart

(www.MedicareAdvocacy.org)



Medicare Home Health Coverage

Coverage Criteria



Covered Services

- Must Need/Receive at Least One Skilled Service:
- Intermittent Skilled Nursing
- Physical Therapy
- Speech Language Pathology
- Occupational Therapy (To continue, not trigger coverage)

If Receiving Skilled Services

"Dependent" Services Can Be Covered

- <u>IF</u> a Skilled Service is Required and Received, Then Coverage is Available for:
- Home Health Aides (Part-time or Intermittent personal care)
- Medical Social Services
- Medical Supplies

12/14/2017



Medicare Home Health Coverage is Not a Short-Term, Acute Care Benefit

(www.MedicareAdvocacy.org)

Medicare Home Health Coverage is <u>Not</u> a Short-Term, Acute Care Benefit Congress Acted to in 1980 to Provide for Longer-Term Coverage

Medicare home health coverage is often erroneously described as a short-term, acute care benefit. This is not true. Although it may be implemented in this way, under the law people who meet the threshold qualifying criteria (legally homebound and needing skilled care), are eligible for Medicare home health coverage so long as they need skilled care. In fact, Congress actually acted affirmatively to authorize long term Medicare home health coverage in 1980 – removing the annual cap on visits and rescinding the prior hospital stay requirement.

Congressional Action and Legislative History

The Omnibus Reconciliation Act of 1980 (OBRA 1980)², expanded the Medicare home health benefit. Prior to this, beneficiaries only enrolled in Part A were eligible for up to 100 home health visits annually, following a three day hospital stay. Coverage was also available under Part B, also limited to 100 visits per calendar year, but this coverage was not dependent on a prior hospitalization. OBRA 1980 eliminated the annual visit cap and the Part A prior hospitalization requirement, thus affirmatively expanding coverage for beneficiaries.

In the OBRA 1980 legislative history, Congress expressed a desire to further liberalize home care coverage, noting there were many "meritorious and deserving alternatives" proposed, and that agreement was reached on these particular improvements.³ Thus, it is reasonable to infer that these changes – which made it clear that Medicare home care coverage is not short term or linked to acute care – were decisions Congress carefully considered and agreed upon.

Elimination of the Annual Cap on the Number of Covered Home Health Visits

Prior to 1980, coverage was capped under both Medicare Parts A and B at 100 home health visits per year. In the legislative history of OBRA 1980, Congress expressly stated that "unlimited visits would be available" and that the "bill provides Medicare coverage for unlimited home health visits." The Congressional intent is clear: By removing the annual visit cap, Congress meant to authorize home health coverage for the long term – when appropriate and when other coverage criteria are met.

¹ Medicare Benefit Policy Manual, Chapter 7 §§ 40.1.1 and 40.2.1.

² P.L. 96-499.

³ Medicare Amendments of 1979, Report of the Committee on Ways and Means – 11/5/1979.

⁴ Amendments to the Medicare Program, Subcommittee on Health of the Committee on Ways and Means – 6/15/1979.

⁵ Conference Report, House Congressional Record, Pg 31375 – 12/1/1980.

Elimination of the Three-Day Prior Hospital Stay

Previously, beneficiaries only enrolled in Medicare Part A could not access home health coverage without a prior three-day hospital stay. This requirement did not apply to beneficiaries who also had Part B, as coverage under Part B was not predicated on a prior hospital stay. OBRA 1980 repealed the Part A prior hospital requirement. The Subcommittee on Health of the Committee on Ways and Means stated "Part A was designed to encourage early discharge of hospital and skilled nursing facility (SNF) patients who continue to need skilled care but not at the intensive level provided for in a hospital or SNF. The Part B benefit - no prior hospitalization required - offers those who require skilled care as an alternative to or postponement of hospitalization."

Congress eliminated the three day requirement under Part A, aligning it with Part B. (Thus allowing coverage under both Parts A and B "to postpone or avoid hospitalization.") At the time, more than 1.1 million beneficiaries had Part A only and would benefit from the repeal of the prior hospital requirement. Now, all beneficiaries can qualify for Medicare home health coverage whether they were recently hospitalized or not. Medicare home health coverage is available for homebound beneficiaries who need skilled nursing or therapy, whether they are recovering from an acute illness or injury and are expected to improve, or have a longer-term problem and need home care to maintain or slow decline of their condition. As Congress intended in 1980, Medicare-covered home care can often help beneficiaries forego avoidable hospitalizations.

Conclusion

Medicare can be a source of coverage for long-term home health care for people who qualify. The relevant legislative history for OBRA 1980 makes it clear that Congress intended to "liberalize" the Medicare home health benefit, and that the changes were seen as "benefit increases" which would be "important to beneficiaries."

Congress' 1980 action to reframe and expand Medicare home health coverage appears to be all but forgotten today. Home health care is often mistakenly referred to as a short-term, acute care benefit. This is in conflict with Congressional intent and long-standing Medicare law. The Center for Medicare Advocacy will continue to refute this fiction and advocate for beneficiaries who need and are eligible for long-term Medicare home health coverage and care.

November 7, 2017

⁶ Amendments to the Medicare Program, Subcommittee on Health of the Committee on Ways and Means – 6/15/1979.

⁷ Medicare Amendments of 1980, House Report of the Committee on Interstate and Foreign, Pg 47.

⁸ Conference Report, House Congressional Record, Pg 24206 – 9/4/1980.



Medicare Home Health Hot Topics

(www.MedicareAdvocacy.org)



MEDICARE HOME HEALTH HOT TOPICS

Medicare Home Health Coverage Can be Available for Daily Skilled Nursing

Medicare home health coverage is sometimes available for daily skilled nursing. Medicare law authorizes coverage for daily skilled nursing under the home health benefit for less than 8 hours each day, for periods of 21 days or less. Extensions of the 21-day period care can occur in exceptional circumstance when the need for additional daily nursing care is finite and predictable.

(See, 42 U.S.C. § 1395x(m)(7)(B); Medicare Claims Processing Manual, Ch. 7 Section 40.1.3)

• Family Members Cannot Be Required to Provide Care as a Condition of Obtaining Medicare

Family members cannot be required to provide care, and patients cannot be required to accept care from family members, when considering eligibility for Medicare-covered services. In fact, it is to be presumed that there is no able and willing person in the home to provide services being rendered by the home health aide, unless the patient or family indicates otherwise or the home health agency has first-hand knowledge to the contrary. For example, a home health aide would be reasonable and necessary when a daughter is unwilling to bathe her elderly father and assist him with an exercise program. If a home health aide trains a family member to perform dressing changes, the home health aide can continue to see the patient for the wound care that is needed during the time the family member is not available and willing to provide the dressing changes.

(See, 42 CFR §409.45(b); Medicare Claims Processing Manual, Ch. 7 Section 20.2; Medicare Claims Processing Manual, Ch. 7 40.1.1)

Home Health Agencies Must Submit a Claim to Medicare Upon the Request of a Beneficiary

Medicare beneficiaries have a right to have a claim submitted to Medicare if their home health agencies decide that their care does not meet Medicare coverage criteria. In these situations, the home health agency must provide the patient with a written notice (known as an Advance Beneficiary Notice, or ABN) explaining why it thinks Medicare won't cover. Beneficiaries are then responsible to pay for continued care, but they can insist that their home health agency submits a bill to Medicare, so they can get an official coverage determination and appeal if coverage is denied. This process is called Demand Billing since the home health agency must submit a bill to Medicare if the beneficiary requests ("demands") that they do so.

A Demand Bill is submitted when the agency itself does not think Medicare will cover the care because the care is not reasonable and necessary or the individual does not meet Medicare's homebound, intermittent or skilled care requirements. If a beneficiary decides to continue care while a Demand Bill is processed, s/he is responsible for the cost of care, but will be reimbursed if Medicare decides coverage is available, and can appeal if the Demand Bill results in an initial Medicare denial.

(See, Medicare Claims Processing Manual, Ch. 10 – Home Health Agency Billing, Section 50)



Frequently Asked Questions

(www.MedicareAdvocacy.org)



Frequently Asked Questions (FAQs) Regarding the Jimmo v. Sebelius "Improvement Standard" Settlement

medicareadvocacy.org/jimmo-v-sebelius-the-improvement-standard-case-faqs/

General

1. **Question:** Are professional therapy services available under Medicare only for patients who are improving or who are expected to improve?

Answer: No. The *Jimmo* Settlement confirms that services by a physical therapist, occupational therapist, and speech and language pathologist are covered by Medicare, Parts A and B, and by Medicare Advantage Plans in skilled nursing facilities, home health, and outpatient therapy, when the services are necessary to maintain a patient's current condition or to prevent or slow a patient's further decline or deterioration.

2. **Question:** Is it fraud for a skilled nursing facility, home health agency, or outpatient therapy provider to continue to provide skilled nursing or skilled therapy services to a patient who is not improving?

Answer: No. As long as the *Jimmo* Settlement is followed, the patient continues to need professional nursing or professional therapy services to maintain the patient's condition or to prevent or slow the patient's decline or deterioration, and all relevant coverage criteria for the particular health care setting are met, Medicare covers the services and the health care provider is not committing fraud.

3. **Question:** Does *Jimmo* apply only to specified medical conditions, such as multiple sclerosis and Parkinson's Disease?

Answer: No. The Settlement is not limited to any particular condition or disease. It applies to any Medicare patient who requires skilled nursing or skilled therapy to maintain the patient's current condition or to prevent or slow the patient's further decline or deterioration, regardless of the patient's underlying illness, disability, or injury. The Settlement is not limited to people with chronic conditions and applies equally, for example, to patients who had a stroke. The fundamental issue for coverage under the standard clarified by *Jimmo* is whether the patient needs professional services to maintain function or to prevent or slow decline or deterioration.

4. **Question:** Are there time limits for the coverage of skilled nursing and skilled therapy services?

Answer: The *Jimmo* Settlement does not include any time limits for Medicare coverage.

The rules for the health care settings covered by Jimmo vary.

For **home health**, as long as the skilled nursing or skilled therapy services are necessary to maintain the patient's functioning or to prevent or slow the patient's decline or deterioration, there are no time limits to home health care. Medicare beneficiaries are entitled to ongoing coverage, which may last years, as long as all coverage criteria are met.

There are similarly no time limits for **outpatient therapy**. Medicare has <u>therapy "caps"</u> for payment for covered services, but there is an exceptions process that authorizes coverage for medically necessary therapy services that exceed the caps. The exceptions process is applicable to maintenance therapy as well as to therapy that is provided with an expectation of improvement.

Coverage for a stay in a **skilled nursing facility** under Medicare Part A is limited to 100 days in a benefit period for residents needing therapy services five days a week. (Under Part A, Medicare covers room and board, nursing services, therapy services, and medications.) However, if a skilled nursing facility resident has used all 100 days in a benefit period or if the resident needs fewer than five days a week of skilled therapy services, these services can be covered by Medicare Part B. The coverage standards for therapy under Parts A and B are the same. However, Part B payments can continue indefinitely, if coverage standards are met.

5. **Question:** Does the *Jimmo* Settlement apply only in the state of Vermont?

Answer: No. The Settlement applies to the entire country. The federal district court judge certified a nationwide class of Medicare beneficiaries.

6. **Question:** If a patient has plateaued, does Medicare coverage for skilled nursing or skilled therapy services stop, unless the patient deteriorates?

Answer: No. The Medicare program does not require a patient to decline before covering medically necessary skilled nursing or skilled therapy. If a patient is no longer improving and the basis of Medicare coverage is expected to shift to maintenance, the nurse or therapist must assess the patient and develop a plan of care to reflect the new maintenance goals. The nurse or therapist must document the maintenance goals in the plan of care and in the nursing or therapy notes.

7. Question: Does the *Jimmo* Settlement apply to patients who have dementia?

Answer: Yes. Dementia is not a disqualifying condition for Medicare coverage. If the patient needs skilled therapy to maintain the patient's current condition or to prevent or slow the patient's decline or deterioration, Medicare covers the therapy services, as long as all other coverage criteria are met. Skilled professional therapists are trained to work with patients who have dementia.

8. **Question:** What are some appropriate goals for maintenance therapy?

Answer: Maintenance therapy goals include preventing unnecessary, avoidable complications from a chronic condition, such as deconditioning, muscle weakness from lack of mobility, and muscle contractures. Maintenance therapy goals also include reducing fatigue, promoting safety, and maintaining strength and flexibility.

For a patient with a progressive neurologic condition, appropriate maintenance therapy goals include maintaining joint flexibility, preventing contractures, reducing the risk for skin breakdown, and ensuring appropriate positioning.

9. **Question:** Does the *Jimmo* Settlement apply to Medicare patients whose health care providers are in Accountable Care Organizations (ACO)?

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

Example: After a hospitalization, a patient receives skilled physical and occupational therapy in a skilled nursing facility for 14 days. While she is no longer improving, she still requires daily skilled therapy to maintain and prevent deterioration, and otherwise meets all coverage requirements. It is appropriate for her to continue to receive Medicare coverage in the skilled nursing facility, regardless of whether her providers are in an ACO. Just as for any other person in Medicare, there is no arbitrary cut-off for coverage in a skilled nursing facility for patients in ACOs. An individualized assessment is necessary, and coverage may continue as long as the patient has a continuing need for skilled therapy or nursing. Note that the maximum of 100 days per benefit period still applies, and that the medical record must support the fact that the patient requires skilled care.

10. **Question:** Does the *Jimmo* Settlement apply to beneficiaries in Medicare Advantage plans?

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

Example: After an acute episode a patient in a Medicare Advantage plan is receiving skilled nursing home visits and home health aides covered by her plan. She has congestive heart failure, diabetes, leg and foot ulcers, and, after three weeks, is deemed to be "chronic." The training and judgment of a skilled nurse are still necessary to monitor, manage, and assess

her multiple serious conditions, which have the reasonable potential to change and result in an adverse event. It is appropriate for her plan to continue coverage. The fact that she is "chronic" or in a Medicare Advantage plan is not relevant. Note that all other coverage criteria, such as being "homebound," must also continue to be met, and the documentation should reflect the reasons why the skilled nursing visits continue to be reasonable and necessary.

Therapy Services (All Settings)

11. **Question**: Do maintenance therapy patients have goals?

Answer: Yes. A patient who is receiving skilled therapy, as outlined in the law, regulations, and Medicare Benefit Policy Manual, requires a discipline-specific, patient-centered care plan. One component of this care plan is goal statements, developed by the qualified therapist and based on an assessment of the patient. The goals reflect the intent and scope of the skilled therapy.

12. **Question:** What qualifies a patient for therapist-provided maintenance services under the Medicare benefit?

Answer: Since maintenance services are considered skilled care, the patient must meet the setting-specific qualifying criteria outlined in the law, regulations, and Medicare Benefit Policy Manual. Once those criteria have been confirmed, the qualified therapist will, after completion of a thorough assessment of the patient, select the focus of care in collaboration with the physician. If the patient is currently at a point where material improvement is not expected and decline is probable without skilled therapy care, a maintenance course of care may be developed and implemented.

13. **Question:** What qualifies a patient for discharge when receiving maintenance therapy?

Answer: A patient receiving therapy as outlined in the law, regulations, and Medicare Benefit Policy Manual, is appropriate for discharge from skilled service when the patient no longer requires the skills of an occupational therapist, physical therapist, and/or speech-language pathologist. "Skilled" services are those that can only be provided by a qualified therapist, due to the complex nature of the needed therapy procedures and/or the patient's special medical complications that require the skills of a qualified therapist to perform a therapy service that would otherwise be considered non-skilled.

14. **Question:** What diagnoses qualify a patient for maintenance therapy?

Answer: There are no specific diagnoses that qualify a patient for maintenance therapy in and of themselves. While patients with progressive neurological conditions, such as Parkinson's Disease, multiple sclerosis, or amyotrophic lateral sclerosis (ALS), are "logical" maintenance therapy candidates, Medicare coverage is not limited to patients with these

conditions. Coverage decisions cannot be based on only one piece of information, such as diagnosis. The qualified therapist must consider all relevant information, such as identified impairments and functional limitations, and determine if skilled interventions are essential to stabilize the situation. Per the Medicare Benefit Policy Manual Chapter 7 – Home Health Services; 40.4 – Skilled Therapy Services: "a patient's diagnosis or prognosis should never be the sole factor in deciding that a service is or is not skilled. The key issue is whether the skills of a therapist are needed to treat the illness or injury, or whether the services can be carried out by unskilled personnel."

15. **Question:** Do maintenance therapy patients have to be reassessed?

Answer: Yes. Periodic reassessment of both the patient and the plan of care is expected to determine if the course of care is effective in situations where improvement is expected and when it is not. There are setting-specific time frames associated with formal requirements for performing reassessments. These time frames should be considered the minimum standard, as determining effectiveness should be occurring over the entire course of care.

16. **Question:** Are objective tests and measures appropriate for use with maintenance therapy patients?

Answer: Yes. Patients determined to be appropriate for maintenance therapy service(s) require assessment by a qualified therapist. This assessment, as with patients receiving therapy services under an improvement (restorative or rehabilitative) focus of care, should include a baseline quantification of impairments. When available and appropriate, the inclusion of objective tests and measures should be utilized to quantify impairments. Objective tests and measures provide valid and reliable findings that demonstrate the effectiveness of therapy and support clinical decision-making regarding continuation or discharge from therapy service(s).

The presence or absence of change in objective tests and measures from baseline to subsequent assessments may vary, depending on whether the patient is on an improvement (restorative/rehabilitative) or maintenance (stabilization) course of care.

17. **Question:** If a patient is receiving maintenance services from one discipline, must all other disciplines also provide maintenance care?

Answer: No. A maintenance focus of care does not require all disciplines to take the same approach. Once setting-specific qualifying criteria are met, each individual discipline creates a care plan specific to that discipline. Based on the assessment and periodic reassessment findings, each discipline will choose the most appropriate approach for the patient and must provide documentation that clearly supports that decision.

18. **Question:** Can a patient change from an improvement course of care to a maintenance course of care?

Answer: Yes. When it is determined by the qualified therapist that a patient requires continued skilled service and the expectation of improvement is no longer indicated, however, it may be appropriate to transition from an improvement approach to a maintenance course of care. This decision would be based on a reassessment of the patient by the qualified therapist at that point, with expectation that modification and/or updates to the existing therapy care plan, in coordination with the physician, occur prior to that transition.

19. **Question:** Can a patient change from a maintenance course of care to an improvement course of care?

Answer: Yes. A patient may need maintenance therapy to maintain strength and flexibility and to prevent deconditioning while, for example, recovering from surgery or healing from an amputation. Following the recovery or healing, the patient may then become able to participate in additional therapy, with the goal of improving. A patient who is not weight-bearing may need maintenance therapy to maintain strength and flexibility and to prevent deconditioning, but once the patient becomes weight-bearing, she may need additional therapy to regain her ability to walk.

20. **Question:** If the patient has a progressive condition, such as Parkinson's Disease, multiple sclerosis, or amyotrophic lateral sclerosis (ALS), is it expected that the patient show "progress" when receiving maintenance services?

Answer: Yes. "Progress" is not synonymous with "improvement." Progress in maintenance therapy would be the *responsiveness* of the patient to the established course of care. Maintenance therapy is intended to stabilize or slow the natural course of deterioration with a progressive condition, <u>or</u> to prevent potential sequelae that may occur due to the presence of that progressive condition, such as soft tissue contracture due to limb paralysis.

Progress, or responsiveness to therapy, would be determined by the patient's capacity to function at an optimal level, consistent with the stage or severity of the underlying progressive condition.

21. **Question:** If a patient is receiving maintenance therapy through home health care, can an aide be included in the Plan of Care?

Answer: Yes, if the patient is under a home health plan of care and at least one qualifying professional service is being provided, aide services can be included as indicated, whether the focus of care is improvement or maintenance.

22. **Question:** If a patient is on a maintenance therapy program, should the patient's "rehab potential" be considered "poor?"

Answer: No. "Rehab potential" is not a *prognosis* of the patient's underlying condition(s), but rather the qualified therapist's clinical assessment of the patient's ability to progress/be responsive to the maintenance therapy program (see answer #20 above). A patient with a progressive condition, such as multiple sclerosis or amyotrophic lateral sclerosis (ALS), would be expected to be responsive to the individualized, patient-centered maintenance therapy care plan developed by the qualified therapist following assessment.

23. **Question:** Once a patient can walk a specified number of feet, does skilled physical therapy end in skilled nursing facilities, home health, or outpatient therapy?

Answer: No. The ability to walk a specified distance is not the sole goal of physical therapy. Physical therapy ensures that the patient can safely navigate the patient's own actual and personal environment. Mobility and maintenance goals are tied to the patient's environment. Relevant factors for therapy in home care, for example, may include whether the patient needs to climb stairs to enter the home, whether the patient's home has one floor or more, and whether the patient needs to navigate curbs and different surfaces.

Home Health Care

24. **Question:** Are there time limits in how long skilled nursing or skilled therapy can be provided in home care?

Answer: No. As long as the skilled nursing or skilled therapy services are necessary to maintain the patient's functioning or to prevent or slow the patient's decline or deterioration, there are no time limits to home care. Medicare patients are entitled to ongoing coverage, which may last years, as long as all coverage criteria are met.

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

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

The determination of coverage for maintenance nursing should be made based on the individualized assessment of the patient's overall medical condition, and the reasonableness

and necessity of the treatment, care, or services in question.

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

Outpatient Therapy

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

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

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

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

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

Answer: Yes. The *Jimmo* Settlement allows patients to receive Medicare coverage for necessary outpatient therapy maintenance programs by skilled providers. Medicare is available when the therapy is required to maintain the patient's functioning and requires a qualified therapist to be safe and effective. In such circumstances, the provider should seek an "exception" to the therapy cap to continue therapy services. In addition, patients who exceed the \$1920 therapy cap or the \$3,700 threshold of manual medical review (in 2017) for therapy expenditures can seek a further review to determine whether the outpatient therapy services continue to be reasonable and necessary.

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

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

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

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

29. **Question:** Can Medicare coverage continue for outpatient therapy if a physician prescribes the therapy to a Medicare patient to prevent or slow further deterioration, even if the patient continues to deteriorate?

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

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

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

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

establishment of a new maintenance program would also be covered.

Example: A patient with functional and cognitive deficits following a traumatic brain injury who carries out therapy on his own as part of a maintenance plan may have his therapy plan reevaluated either (1) on a periodic basis to ensure that it is properly addressing his needs or (2) following some change in his condition that may necessitate corresponding changes to the therapy program.

Skilled Nursing Facilities

31. **Question:** Are there time limits in how long skilled therapy can be provided in a skilled nursing facility?

Answer: Medicare covers a maximum of 100 days in a Part A benefit period. If a skilled nursing facility resident has used all 100 days or if the resident needs fewer than five days a week of skilled therapy services (and does not need skilled nursing seven days per week) and if the resident, in either situation, continues to need skilled therapy services, these services can be covered by Medicare Part B. While the coverage standards for Parts A and B are the same, Part B payments for skilled therapy can continue indefinitely, if coverage standards are met.

32. Question: Is maintenance therapy available for patients who are not weight-bearing?

Answer: Yes. The physician may order therapy to maintain a patient's strength and flexibility, and to prevent deconditioning, until such time as the patient becomes weight-bearing and can safely participate in additional therapy. Similarly, a patient who needs to learn to use a prosthesis may receive maintenance therapy at the beginning of his or her stay in a skilled nursing facility in order to maintain upper body strength while the site of the amputation heals. Maintenance therapy may be provided first in these situations, followed by therapy to improve the patient's functioning, once the patient becomes weight-bearing or the patient's site of amputation has healed.

Inpatient Rehabilitation Hospitals

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

Answer: Yes. Under the *Jimmo* Settlement, a Medicare patient's claim for inpatient rehabilitation hospital care cannot be denied simply because the patient is not expected to return to his or her prior level of functioning. While the IRH regulations do include a modified improvement standard, the patient must only be reasonably expected to make measurable improvement that will be of practical value to improve the patient's functional capacity or adaptation to impairments. The expected improvement is to be accomplished within a

reasonable period of time. Therefore, as long as there is a reasonable expectation that the patient can make some improvement in functional status, it is not required that the patient be able to return to his or her prior level of functioning.

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

34. **Question:** Can inpatient rehabilitation be covered for a Medicare beneficiary who is currently making improvement, but will never be able to independently care for him- or herself?

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

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

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

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

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

36. **Question:** Can an IRH continue to treat a patient if the patient has shown no improvement but the physician continues to believe there is a reasonable expectation

that the patient will demonstrate measurable improvement?

Answer: Yes. In order for the patient to receive a Medicare-covered inpatient rehabilitation stay, the patient's medical record must demonstrate ongoing and sustainable improvement that is of practical value to the patient. However, if the expectation for measurable improvement existed at the time of the patient's admission and can realistically be documented in the medical record even after no initial improvement, it is possible the IRH stay may be covered.

Example: If a formerly independent, debilitated patient does not make measurable improvement within the first seven days of an IRH stay but the physician documents the continued expectation for measurable improvement of practical value, with support from the medical record, Medicare coverage can continue.

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

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

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

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

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

home. The counseling and instruction towards getting the patient ready to go home are considered part of the therapy and meet the end goal of enabling the patient to safely live at home.

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

39. **Question:** Can an IRH admit a functionally impaired patient whose function is deteriorating in order to prevent further deterioration and teach the patient new skills?

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

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



Self-Help Packet for Home Health Appeals

(www.MedicareAdvocacy.org)



Self-Help Packet for Home Health Care Appeals Including "Improvement Standard" Denials

medicareadvocacy.org/self-help-packet-for-expedited-home-health-care-appeals-including-improvement-standard-denials/

- 1. Introduction
- 2. Checklist for Home Health Appeals
- 3. Quick Screen: Should My Home Health Care Be Covered By Medicare?
- 4. Home Health Appeal Details
- 5. Additional Information
 - The "Improvement Standard" Myth and Home Health Care
 - Glossary of Terms
 - Federal Regulations Home Health Coverage
 - Federal Regulations Expedited Appeals
 - Centers for Medicare & Medicaid Services (CMS) Home Health Manual Provisions

1. Introduction

The Center for Medicare Advocacy has produced this packet to help you understand Medicare coverage and how to file an appeal if appropriate.

Medicare is the national health insurance program to which many disabled individuals and most older people are entitled under the Social Security Act. All too often, Medicare claims are erroneously denied. It is your right as a Medicare <u>beneficiary</u> to appeal an unfair denial; we urge you to do so.

For additional assistance, contact your <u>State Health Insurance Assistance Program (SHIP)</u>. You can find your state program's information at https://shipnpr.acl.gov/Default.aspx.

2. Checklist for Home Health Appeals

Note: Detailed information is available by clicking links included in the checklist below, or scrolling down the page to the <u>detailed description</u>.

There are several levels of appeal. The process begins when you receive the "Notice of Medicare Provider Non-Coverage" or "Generic Notice" from your home health agency.

- 1. Review the "Quick Screen" included in this packet to determine whether the care you need is covered by Medicare.
- 2. (1st Appeal Level) After you receive the "Notice of Medicare Provider Non-Coverage," <u>contact the "Beneficiary and Family-Centered Care Quality Improvement Organization" (BFCC-QIO)</u> at the number given on the notice.
- 3. Gather support for your case.
 - Ask your physician to explain why your care continues to be medically reasonable and necessary.
 - Your physician must submit a written statement to the BFCC-QIO explaining that your "health will be jeopardized" if your care is discontinued. Fax the statement to the BFFCC-QIO.
 - Ask your physician to be available to the BFCC-QIO by telephone to answer questions.
 - Request your medical record from the provider. At your request, the home health agency must
 give you a copy of, or access to, any documentation it sends to the BFCC-QIO, including records
 of any information provided by telephone. Note that many states allow facilities to charge a fee for
 copying medical records.
 - If you get these records, give a copy to the physician who ordered your care.
- 4. Receive the BFCC-QIO decision.
 - The BFCC-QIO is supposed to make its decision about Medicare coverage within 72 hours.
 - If successful, you will continue to get your home health care.
 - If the BFCC-QIO agrees with the home health agency's denial, you will be financially responsible for your continued care.
- 5. (2nd Appeal Level) If the BFCC-QIO issues a denial, request an "Expedited Reconsideration," which is performed by the Qualified Independent Contractor (QIC). Call the QIC no later than noon of the next calendar day after you get the BFCC-QIO denial.
 - Unless you request an extension of time, the QIC must tell you its decision within 72 hours of receipt of your call, as well as if any medical or other records are needed for the Expedited Reconsideration.
 - You have the right to extend this period to up to 14 days to gather medical records and prepare your argument.
 - If you did not get your medical record during the first review, you can get it from the BFCC-QIO now. The BFCC-QIO can charge you for the cost of copying. It must comply with your request for records by no later than close of business of the first day after your request for the documents.
 - If you did not submit support from the physician who ordered your care at the BFCC-QIO level, use the 14 day extension to get and submit that support to the QIC now.
 - During your appeal, you will be financially responsible for your continued home health care.
- 6. Receive the QIC decision.
- 7. (3rd Appeal Level) If the QIC issues a denial, please review the detailed section on Administrative Law Judge (ALJ) Hearings below.

3. Quick Screen: Should My Home Health Care Be Covered By Medicare?

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 for home health services.
- The patient is <u>homebound</u>. 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.
 - A Medicare beneficiary does not need to be bedbound to be eligible for Medicare coverage of home health care. Furthermore, being homebound does not mean that the beneficiary never leaves home.
 - Beneficiaries can leave home as frequently as needed to attend: religious services; adult day care where they are participating in therapeutic, psychosocial, or medical treatments; or medical appointments.
 - Medicare beneficiaries are considered homebound if leaving home for social reasons or errands is difficult and thus happens infrequently or only for short periods of time. Absences from the home for special occasions such as family celebrations or occasional outings should not disqualify Medicare beneficiaries from Medicare home health care coverage.
- 3. The patient must have seen his or her physician. The physician must write a brief narrative describing the patient's clinical condition and how the patient's condition supports homebound status and the need for home health skilled services.
 - Skilled care is care that must be provided or supervised by a skilled professional in order to be safe and effective.
 - Unfortunately, Medicare does not cover home health care when it is only "custodial" and no skilled nursing or therapy services are required. Examples of custodial care include the administration of oral medications or assisting a patient with bathing or toileting.
- 4. The patient needs skilled nursing care on an intermittent basis (from as much as every day for recurring periods of 21 days if there is a predictable end to the need for daily care to as little as once every 60 days) or physical or speech therapy.
- 5. The care must be provided by, or under arrangements with, a Medicare-certified provider.

Coverable Home Health Services

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

- Part-time or intermittent nursing care provided by or under the supervision of a registered professional nurse;
- Physical, occupational, or speech therapy;

- Medical social services under the direction of a physician and;
- To the extent permitted in regulations, part-time or intermittent services of a home health aide.

Additional Tips:

- Medicare coverage should not be denied simply because the patient's condition is "chronic," "stable," or unlikely to improve. "Restorative potential" is not necessary.
- Resist arbitrary caps on coverage imposed by the intermediary. For example, do not
 accept provider or intermediary assertions that aide services in excess of one visit per
 day are not covered, or that daily nursing visits can never be covered.
- There is no legal limit to the duration of the Medicare home health benefit. Medicare coverage can be available for necessary home care even if it is to extend over a long period of time.
- The doctor is the patient's most important ally. If it appears that Medicare coverage will be denied, ask the doctor to help demonstrate that the standards above are met. Home care services should not be ended or reduced unless it has been ordered by the doctor.
- Prior to the discontinuance of Medicare covered services the home health agency must issue a written Notice of Non-Coverage. If you disagree with the discharge, exercise the appeal rights described on the written Notice.

4. Home Health Care Appeals

Beneficiaries in traditional Medicare have a legal right to an Expedited Appeal when home health providers plan to **discharge** them or **discontinue Medicare-covered skilled care**. This right is triggered when the home health agency plans to *stop* providing skilled therapy and/or nursing. It can also be triggered if the provider no longer believes the beneficiary is homebound. It is **not** triggered when the provider **lowers the frequency** of skilled care. For instance, there is no right to an expedited appeal if physical therapy is decreased from three times per week to one time per week.

Typical Scenario: You are a Medicare beneficiary who is receiving medical care from a home health care provider. Medicare is paying for this care because some of your care is provided by a skilled professional (a nurse or a physical, occupational or speech therapist). You are told that the care will be discontinued because you have "plateaued," returned to "baseline," or require "maintenance only" services. You believe you continue to need and will continue to benefit from the provided skilled care.

The home health provider gives you (or your representative) a Notice of Medicare Provider Non-Coverage (also known as a Generic Notice). This standardized notice that coverage for your care is ending must be given at least two days prior to the last day of covered care, or – in the event that the span of time between visits exceeds two days – the provider must give the notice no later than the next-to-last time services are to be furnished. The notice must include the date that coverage of care ends, the date you will become financially responsible for continued care from the home health care provider, and a description of your right to an expedited determination.

Action Steps: Medicare only pays for care that has been provided, not care that should have been provided. In other words, once your care is discontinued, it will be essentially impossible to remedy the problem with a Medicare appeal. So the first order of business is to keep the care in place. The best way to keep care in place is an Expedited (Fast) Appeal with support from your attending physician (the doctor who ordered, and/or is overseeing, your home health care). Review the Quick Screen for home health care, included in this packet, to see if your care seems to qualify for Medicare coverage. Remember that skilled care can be covered when it is necessary to maintain or improve your condition, not just when improvement is expected.

To Prevent the Discontinuation of Medicare Covered Care, Take the Following Action Steps.

1. Contact the Beneficiary Family-Centered Care Quality Improvement Organization (BFCC-QIO)

- Read the standardized (Generic) Notice. It will contain the telephone number for your region's BFCC-QIO.
- To start the Expedited Appeal, you or your representative **must** contact the QIO **by no** later than noon of the calendar day following receipt of the standardized notice.

- You can do this in writing or by telephone. If you call, get the name of the person you speak to, and keep written notes of what you are told.
- Once the BFCC-QIO contact is made, the home health provider should give you a more specific notice which will include a detailed explanation as to why it believes the Medicare covered care should end, a description of any applicable Medicare coverage rules and information about how to obtain them, and other facts specific to your case.

2. While the BFCC-QIO is gathering information for its decision, gather support for your case.

- In order to win the appeal, you must get a statement from your attending physician indicating that if your care is discontinued, your health will be placed at significant risk.
- The physician should explain in writing why "your health will be jeopardized" if your care is discontinued, using that exact phrase.
- Have the physician fax this statement to the QIO.
- Additionally, ask your attending physician to be available to the QIO by telephone to answer questions.

3. Watch for the BFCC-QIO Decision

- The BFCC-QIO is supposed to make its decision about Medicare coverage within 72 hours after a review is requested.
- Prior to making a decision, the BFCC-QIO must review your medical records, give the home health care provider an opportunity to explain why it believes the discontinuation of care is appropriate, and get your opinion.
- Legally, the home health care provider must prove its decision to discharge you from
 covered care is correct. However, you should be prepared to explain to the QIO why
 it is you continue to need ongoing care. For instance, you may continue to need
 physical therapy because your home has stairs and you have not yet regained the
 strength and coordination necessary to climb stairs.

4. You have a legal right to review your medical record.

- At your request or the request of your representative, the home health care provider must give you a copy of or access to any documentation it sends to the QIO, including records of any information provided by telephone.
- In most states the provider may charge you the cost of copying and sending documents.
 However, some states, including Connecticut and Massachusetts, prohibit providers from
 billing patients for copies of their medical records when they are appealing Medicare
 denials of coverage.
- The provider must honor your request by no later than close of business of the first day after the material is requested.
- This information can be very helpful in supporting the medical need for the continuation of your care and in helping your attending physician to understand your current medical

condition.

If you get these records, be sure to give a copy to your attending physician.

If the BFCC-QIO agrees with you:

You will continue to get your Medicare covered care.

If the BFCC-QIO agrees with the home health care provider:

 You will be financially responsible for your continued care from the home health care provider.

5. You have the right to another appeal – an "Expedited Reconsideration."

- Expedited reconsiderations are performed by an organization called the Qualified Independent Contractor (QIC).
- If the BFCC-QIO decided that Medicare coverage should end, it should give you the telephone number for the next appeal, to the QIC.
- If the BFCC-QIO ruled against you and you wish to continue your appeal, you or your representative must call the QIC no later than noon of the calendar day following notification by the QIO of its decision.

6. Watch for the Reconsideration Decision

- Ordinarily, the QIC must tell you its decision within 72 hours of receipt of your call and any medical or other records needed for an Expedited Reconsideration.
- You have the right to extend this period to up to 14 days so that you can gather medical records and prepare your argument.
- If you did not get your medical records during the QIO review, you can get them at this stage. You can request them from the QIO who must send you a copy of or give you access to any documentation it sent to the QIC. The QIO may charge for the cost of duplicating documents and for the cost of delivery. The QIO must comply with your request no later than close of business of the first day after your request for the documents.
- If you were not able to submit support from your attending physician to the QIO at the
 first stage of appeal, it is a good idea to use the 14 day extension to get and submit that
 support at this second stage of appeal. If you get your medical records, be sure and
 share them with your doctor.

If the QIC agrees with you:

You will continue to get your Medicare covered care and it will be covered by Medicare.

If the QIC believes that your care is no longer medically reasonable and necessary:

You have the right to appeal at an Administrative Law Judge (ALJ) hearing.

7. Request an ALJ Hearing

- The ALJ level is the best chance to obtain Medicare coverage.
- The QIC should provide a written copy of its decision with information about how to request an ALJ hearing.
- You must request the hearing within 60 days of notice from the QIC that it has denied Medicare coverage for your care.
- Unfortunately, ALJ hearings and decisions are not expedited. This means that you may
 have to wait a long time (several months) before your hearing is held. Further, while the
 ALJ is supposed to issue a decision within 90 days of receipt of the request for hearing,
 it often takes longer.
 - To get a hearing decision as soon as possible, be sure to note on the envelope and the request for hearing that you are a "Medicare beneficiary."
 - If you started your appeal to keep nursing or therapy services in place, and the care has already stopped, be aware that it will probably be several months more before the judge hears your case and issues a decision.
- If you request an ALJ hearing and continue to get care from the home health care provider, you will be financially responsible for the ongoing care unless the ALJ issues a favorable decision.
 - If a favorable decision is issued, whoever paid for the care will be reimbursed.
- If the ALJ issues an unfavorable decision, you will remain financially responsible for the continued care unless you successfully appeal to the next step, the Medicare Appeals Council. The ALJ's decision will tell you how to do so.

Conclusion

The best way to keep Medicare covered home health care in place is to exercise your expedited appeal rights. You are most likely to succeed if you have the support of your physician.

5. Additional Information – The Medicare "Improvement" Myth: Skilled Care to Maintain an Individual's Condition *Can* Be Covered

There is a long standing myth that Medicare coverage is not available for beneficiaries who have an underlying condition from which they will not improve. This is not true. In fact, the notion of "improvement" is only mentioned once in the Medicare Act – and it is not about coverage for home health care.

As an overarching principle, the Medicare Act states that no payment will be made except for items and services that are "reasonable and necessary for the diagnosis or treatment of an illness or injury, or to improve the functioning of a malformed body member." 42 USC §1395y(a)(1)(A). While it is not clear what a "malformed body member" is, clearly this language does not limit Medicare coverage only to services, diagnoses or treatments that will improve illness or injury. Yet, in practice, beneficiaries are often denied coverage on the grounds that they are not likely to improve, or are "stable" or "chronic," or require long-term care, or "maintenance services only." **These are not legitimate reasons for Medicare denials.**

This issue was finally resolved in federal court in *Jimmo v. Sebelius*, (D.VT 1/24/2013). In *Jimmo* the judge approved a settlement stating that **Medicare coverage for home health** care does <u>not</u> depend on the individual's potential for improvement, but rather on his or her need for skilled care – which <u>can</u> be to maintain or slow deterioration of the individual's condition.

Medicare Coverage for Home Health Care

Medicare coverage can be available for long term home health care if the qualifying criteria are met. There is no statutory or regulatory limit on the length of time for which home health coverage is available. Further, Medicare covers home health services in full, with no required deductible or co-payments from the beneficiary. For coverage, the following criteria must be met:

- 1. Services must be reasonable and medically necessary;
- 2. A physician has signed or will sign a plan of care;
- 3. 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.
 - 42 USC §1395f(a)(2)(C); 42 USC §1395f (a)(8), CMS Policy Manual 100-02, Chapter 7, §30.1.1
- 4. The patient was seen by the ordering physician (or APRN or PA) and the physician certifies the patient is homebound and needs skilled care.
- 5. The patient needs or will need physical or speech therapy, *or* intermittent skilled nursing (from once a day for periods of 21 days at a time if there is a predictable end to the need for daily nursing care, to once every 60 days).

- 42 USC §1395f(a)(2)(C); 42 USC §1395x(m); 42 CFR §409.42(c)(1), <u>CMS</u> Policy Manual 100-02, Chapter 7, §40.1.3
- 6. The home health care is provided by, or under arrangement with, a Medicare-certified provider.
 - 42 USC §1395f(a)(2)(C); 42 USC §1395n(a)(2)(A); 42 USC §1395x(m); 42 CFR §409.42(e)

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

- Part-time or intermittent nursing care provided by or under the supervision of a registered professional nurse
 - For information about skilled nursing see, 42 CFR §409.33; 42 CFR §409.44(b)
- Physical, occupational, or speech therapy
 - For information about skilled therapy see, 42 CFR §409.33; 42 CFR §409.44(c)
- Medical social services under the direction of a physician; and
- To the extent permitted in regulations, part-time or intermittent services of a home health aide.
 - 42 USC §1395x(m)(1) and (4)

Important Advocacy Tips

Unfortunately, Medicare coverage is often denied to individuals who qualify under the law. In particular, beneficiaries are often denied coverage because they have certain chronic conditions such as Alzheimer's disease, Parkinson's disease, and Multiple Sclerosis, or because they need nursing or therapy "only" to maintain their condition. Again, these are not legitimate reasons for Medicare denials.

Medicare is available for skilled care necessary to maintain an individual's condition. The question to ask is "does the patient meet the qualifying criteria listed above and need skilled nursing and/or therapy on a daily basis" – NOT "does the patient have a particular disease or will she recover."

- 1. Each person should get an individualized assessment regarding Medicare coverage based on his/her unique medical condition and need for care.
 - 42 CFR §409.44(a); 42 CFR §409.44(b)(3)(iii)
- 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 expected to last a long period of time.
 - 42 CFR §409.44(b)(3)(iii)
- 3. The restoration potential of a patient is not the deciding factor in determining whether skilled services are needed. Coverage can be available even if the illness or injury is chronic, terminal, or the patient's condition is stable.
 - 42 CFR §409.32(c); 42 CFR §409.44(b)(3)(iii); 42 §CFR 409.44 (c)(2)(iii)(C);
 - CMS Policy Manual 100-02, Chapter 8, §30.2.2 and 100-02, Chapter 7, §40.1.1

- 4. Medicare recognizes that skilled care can be required to maintain an individual's condition or functioning, or to slow or prevent deterioration, including physical therapy to maintain the individual's condition or function.
 - 42 CFR §409.42(c) and 42 CFR§409.44(c)(2)(C)(iii)
- 5. The doctor is the patient's most important ally. Ask the doctor to help demonstrate that the standards described above are met. In particular, ask the individual's doctor to state in writing that the individual is homebound and why the skilled care and other services are required.

If a home health agency or <u>Medicare Advantage</u> plan says Medicare coverage is not available and the patient seems to satisfy the criteria above, ask the home care agency to submit a claim for a formal Medicare coverage determination. The agency must submit a claim if the patient or representative requests.

Conclusion

Medicare coverage for home health care can be a long-term benefit if the individual meets the qualifying criteria. Unfortunately, however, coverage is often erroneously denied for individuals with chronic conditions, for people who are not improving, who need services for a long time and/or to maintain their condition.

The Medicare program has an appeal system to contest such denials. Beneficiaries and their advocates should use this system to appeal Medicare determinations that unfairly deny or limit coverage.

For more information about *Jimmo* and the Improvement Standard, see: http://www.medicareadvocacy.org/medicare-info/improvement-standard/.

Glossary of Terms

BENEFICIARY

An individual enrolled in the Medicare program.

CLAIMANT

An individual requesting reimbursement from Medicare for expenses incurred for medical care (or the individual requesting payment on behalf of a Medicare enrollee).

CO-INSURANCE

The amount a beneficiary must pay as his or her share of the cost of a given service. For example, a beneficiary must pay part of the cost of days 21 through 100 in a skilled nursing facility. There is also a co-insurance (20% of the reasonable charge) which must be paid for Part A or B services.

CMS (Centers for Medicare and Medicaid Services)

The federal agency which administers the Medicare program: part of the Unites States Department of Health and Human Services.

DEDUCTIBLE

The amount which a beneficiary must pay before Medicare (or other insurance program) will begin to cover the bill. Each calendar year a deductible must be paid before Medicare will cover hospital care under Part A, or physician visits and other services under Medicare Part B.

HEALTH INSURANCE CLAIM NUMBER

The Social Security number under which you receive benefits. This number is the number on your health insurance (Medicare) card.

HOMEBOUND

42 USC § 1395n(a)(2)(f): "...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 and 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 health care treatment, including regular absences for the purpose of participating in therapeutic, psychosocial, or medical treatment in an adult day-care program that is licensed or certified by a State, or accredited, to furnish adult day-care services in the State shall not disqualify an individual from being

considered to be "confined to his home".[sic] 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."

INPATIENT

An individual admitted to a hospital, skilled nursing facility, or other health care institution for treatment

MEDICARE ADVANTAGE

Medicare offered by private, for-profit insurance companies subsidized by the federal government. Coverage is required to be equivalent to traditional Medicare, but choice is generally limited.

MEDICARE CLAIM DETERMINATION

The written notice of denial of Medicare coverage issued by the intermediary.

MEDICARE CONTRACTOR

An agent of the federal government, often an insurance company, which makes Part A Medicare claim determinations for skilled nursing facility and home health coverage, and issues payments to providers.

MEDIGAP

Private insurance which covers the "gaps" in Medicare (such as deductibles and co-insurance amounts). Significantly, these policies generally do <u>not</u> pay when Medicare refuses coverage.

SHIP

State Health Insurance Assistance Program. These programs are funded to help beneficiaries with insurance choices, enrollment and appeals. See https://www.shiptacenter.org/.

SKILLED CARE

Care which requires the skill of technical or professional personnel in order to ensure its safety and effectiveness, and is furnished directly by, or under the supervision of, such personnel. (Nurses and physical or occupational therapists are examples of professional personnel.)

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Sample Letters

Date

Re: Need for ongoing Physical Therapy

To Whom it May Concern:
Mr is a year old man who has been under my care for years. He has (be specific about history: what happened?). Prior to the stroke lived a completely independent life.
Since he has been admitted toNursing Home for rehabilitation on, he has been progressing nicely and working towards returning to independent living. I feel that would continue to benefit from therapy because it would allow him to further
strengthen and achieve more functionality to transfer to his wheelchair, to use his walker, to gain access to the toilet, and to ultimately return to independent living (PLEASE PUT IN YOUR OWN WORDS).
In addition, his symptoms which include require further skilled physical therapy and occupational therapy services to prevent decline of physical and functional status in order to maintain clinical status and to return safely home or to an assisted living facility.
It is my medical and professional opinion that the skilled physical therapy services ofexercises are necessary to continue to maintain Stanley's current functional status, prevent falling and (PLEASE PUT IN YOUR OWN WORDS) He has no caregiver at home that can perform this exercise program with him. I am convinced that termination of these services would be detrimental to health, safety, wellbeing and may put him at risk for re-hospitalization.
has a track-record of superb performance with rehabilitation; he is highly motivated and eager to return to his life. I have no doubt that with continued assistance, at this time, he will be able to return to his life.
I would request that therapy be continued on an ongoing daily basis while in the nursing home and then when he returns to independent living, to secure his functional abilities.
Thank you for your prompt attention and consideration of this matter. If you have any questions please feel free to contact me at
Sincerely,

August 5, 2013

Re:

Issue: Need for ongoing Physical Therapy

Mrs. Is a 91 year old woman under my care for over a decade. She has congestive heart failure and longstanding anxiety, but has been in independent living until falling and sustaining a hip fracture June 14, 2013 requiring ORIF.

Since that time she has been receiving physical therapy in her assisted living facility

She had been progressing nicely and working towards return to independent living.

Therapy has been discontinued under Medicare guidelines, but I feel that she would continue to benefit from therapy to allow her to strengthen and achieve more functionality to transfer to her wheelchair, to use her walker, to gain access to the toilet, and to ultimately return to independent living.

Mrs. inas a track-record of superb performance with rehabilitation, having undergone extensive rehab in 2012 after a severe motor vehicle accident. Even after a prolonged hospitalization and multiple orthopedic injuries, she was able to resume independent living with the help of physical therapy to assist until she was able to function on her own. I have no doubt that with continued assistance, at this time, she will be able to do the same.

I would request that therapy be continued on an ongoing basis while in the

and then when she returns to independent living, to secure her functional abilities.

MD d

Re: Address:

DOB: Control ID:

To Whom It May Concern:

multiple sclerosis (MS) since 2008. Her advanced MS symptoms include motor weakness, spasticity, inability to ambulate, pathological fatigue and poor endurance. Ms. is wheelchair-bound and homebound because of her symptoms.

M requires skilled physical therapy and occupational therapy services at home to prevent decline of physical and functional status in order to maintain clinical status and safety at home. She is also in need of home health aide services to assist with activities of daily living and personal care including bathing, dressing, and meal preparation.

It is my medical and professional opinion that the skilled Physical Therapy services of stretching and strengthening exercises continue to maintain Ms.

'current functional status, prevent falling and prevent regression.

'is unable to perform self-range of motion and stretching to lower extremities secondary to severe MS symptoms. She has no caregiver at home that can perform this home exercise program once the home health aid from VNA is terminated. Termination of these services would be detrimental to her health, safety, wellbeing and may put her at risk for re-hospitalization.

Thank you for your prompt attention and consideration of this matter.

If you have any questions please feel free to contact me.

Sincerely,

, MD