Expedited Appeals in Traditional Medicare For Home Health Services In Light of *Jimmo v. Sebelius*

You do not have to improve to qualify for Medicare coverage!

No Improvement Standard

Restoration potential is not necessary. Medicare 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; Medicare Benefit Policy Manual, Chapter 7, Sections 20.1.2, 40.1.1, 40.2.2E; See also, 42 CFR § 409.32(c).

Notice of Medicare Non-Coverage

- ✓ Your home health agency must give you the Notice of Medicare Non-Coverage two days before your covered services end.
- ✓ This notice must show the date your skilled nursing and/or therapy is scheduled to end and provide information about how to file an expedited appeal with the Beneficiary and Family Centered Quality Improvement Organization (BFCC-QIO).

Redetermination by the QIO

- ✓ You must file the appeal by noon the day after you received the notice.
- ✓ After receiving notice about the appeal from the QIO, the home health agency must provide you with a Detailed Explanation of Non-Coverage.
- ✓ The QIO must make a determination within 72 hours of receiving your request.
- ✓ Take this time to request your medical records and ask the physician who ordered your care to submit a written statement explaining why you continue to need intermittent skilled nursing or therapy services.

Reconsideration by the QIC

- ✓ If the QIO decides against you, you must request an expedited reconsideration from the Qualified Independent Contractor (QIC) by noon the following day.
- ✓ The QIC must make a decision within 72 hours of your request.
- ✓ You have the right to extend this period up to 14 days to gather support for your case and prepare your argument.

Center for Medicare Advocacy
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Check List

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Administrative Law Judge Hearing

- ✓ If the QIC decides against you, you must request a hearing before an administrative law judge (ALJ) within 60 days of receiving the QIC's decision.
- ✓ ALJ hearings are not expedited. For beneficiary-initiated appeals, the ALJ should make a decision within 90 days of receiving the request for a hearing.
- ✓ You must submit your evidence with the request for hearing, by the date specified in the request for hearing, or, if a hearing has been scheduled, within 10 days of receiving the notice of hearing.

Medicare Appeals Council

- ✓ If the ALJ decides against you, you must request a review by the Medicare Appeals Council within 60 days of receiving the ALJ's decision.
- ✓ For beneficiary-initiated appeals, the Appeals Council should make a decision within 90 days of receiving the request for a hearing.

Federal District Court

- ✓ If the Appeals Council decides against you, follow the directions in the denial to file for judicial review in federal district court.
- ✓ You must file within 60 days of receiving the Appeals Council's decision.
- ✓ You must meet the amount in controversy requirement. The amount in controversy is adjusted annually.

Remember

- A home health agency's decision to terminate your Medicare-covered care based on an erroneous "Improvement Standard" is a violation of your rights under Medicare.
- An expedited appeal only addresses the decision to terminate Medicare-covered services. If you wish to continue receiving uncovered care from the home health agency, an Advanced Beneficiary Notice of Non-Coverage (ABN) must be issued. A standard appeal should be pursued for any services you continue to receive.
- If you do not win your appeal or decide not to take further action, you will be responsible for the cost of your care after the termination date on the Notice of Medicare Non-Coverage.

For additional information, see the Center for Medicare Advocacy's Improvement Standard Homepage.