

Medicare Home Health Coverage and Appeals In Light of *Jimmo v. Sebelius*

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

On January 24, 2013, the U.S. District Court for the District of Vermont approved the settlement agreement in [*Jimmo v. Sebelius*, No. 5:11-CV-17 \(D. VT\)](#). As a result of the *Jimmo* Settlement, the Centers for Medicare & Medicaid Services (CMS) was required to confirm that Medicare coverage is determined by a beneficiary's need for skilled care and not on a beneficiary's potential for improvement. 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](#)).

The *Jimmo* Settlement means that Medicare beneficiaries should not be denied coverage for maintenance nursing or therapy provided under Medicare's home health benefit when skilled personnel must provide or supervise the care for it to be safe and effective. Medicare-covered skilled services include care that improves, maintains, or slows the decline of a patient's condition. Medicare coverage should not be denied solely because an individual has an underlying condition that won't get better, such as MS, ALS, or Parkinson's disease.

Unfortunately, the Center for Medicare Advocacy still regularly hears from beneficiaries and their families about coverage denials for skilled care services based on some variation of an "Improvement Standard." The Center has created this Checklist Toolkit to assist individuals in responding to unfair terminations of care and denials. Each of the Checklists below provide valuable information on the rights of beneficiaries in regards to home health coverage, expedited appeals in traditional Medicare, and fast-track appeals in Medicare Advantage. Although challenging a Medicare termination or denial may seem daunting, beneficiaries and their representatives can win appeals when equipped with the right information.

**Coverage Criteria in
Light of *Jimmo***

**Expedited Appeals in
Traditional Medicare**

**Fast-Track Appeals in
Medicare Advantage**

Medicare Home Health Coverage In Light of *Jimmo v. Sebelius*

Coverage Criteria → **You do not have to improve to qualify!**

Homebound

- ✓ You must be confined to your home. This means you are unable to leave without the assistance of another individual or a supportive device, or you have a condition that makes leaving your home medically contraindicated. You must also have a normal inability to leave your home and doing so requires a considerable and taxing effort. Being homebound does not mean that you are bedbound. You can still leave for health care treatments and for short or infrequent periods, such as family gatherings.

Physician's Order

- ✓ A physician must order your home health care, sign, and certify your plan of care. You must also have a face-to-face meeting with a physician or a recognized non-physician health care professional 90 days before the start of your home health care or within 30 days of your care's start date. A document about the meeting must be signed by the physician and included in the certification.

Skilled Care

- ✓ You must require skilled nursing care on an intermittent basis, or skilled physical therapy or speech-language pathology services. You may receive skilled occupational therapy once Medicare coverage begins. Skilled nursing care is intermittent if it is provided less than seven days a week or daily for less than eight hours a day for periods of 21-days or less (extensions are possible under limited circumstances).

No Improvement Standard

- ✓ 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, Section 20.1.2

Certified Home Health Agency

- ✓ Your home health care must be furnished by, or under arrangement with, a Medicare certified home health agency (HHA).

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.

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

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 can contact the [Beneficiary Help Line](#) at (844) 419-3358 to ensure that your appeal receives priority processing.
- ✓ 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.

Fast-Track Appeals in Medicare Advantage For Home Health Care In Light of *Jimmo v. Sebelius*

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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 a fast-track appeal with the [Beneficiary and Family Centered Quality Improvement Organization](#) (BFCC-QIO).

Appealing to the QIO

- ✓ You must file the appeal by noon the day after you received the notice.
- ✓ The QIO must make a decision “by close of business of the day after it receives the information necessary to make the decision.”
- ✓ After receiving notice about the appeal from the QIO, the home health agency must provide you with a [Detailed Explanation of Non-Coverage](#).
- ✓ 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 daily skilled care.

Reconsideration by the QIO

- ✓ If the QIO decides against you, you must request a reconsideration within 60 days of receiving notice of the QIO’s decision.
- ✓ The QIO must make its determination “as expeditiously as the enrollee’s health condition requires but no later than within 14 days” of receiving the request.

Fast-Track Appeals in Medicare Advantage For Home Health Care In Light of *Jimmo v. Sebelius*

Administrative Law Judge Hearing

- ✓ If the QIO decides against you, you must request a hearing before an [administrative law judge](#) (ALJ) within 60 days of receiving the QIO'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 can contact the [Beneficiary Help Line](#) at (844) 419-3358 to ensure that your appeal receives priority processing.
- ✓ 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 decision to terminate your Medicare-covered care based on an erroneous "Improvement Standard" is a violation of your rights under Medicare.
- A fast-track appeal only addresses the decision to terminate Medicare-covered services. If you continue to receive services after the termination date on the NOMNC, you should request an organization determination for those services and follow the appeal instructions to appeal those subsequent services.
- 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.