Center for Medicare Advocacy
MedicareAdvocacy.org

Medicare Home Health Coverage and Access to Care

February 19, 2020

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About NCLER

The National Center on Law and Elder Rights (NCLER) provides the legal services and aging and disability communities with the tools and resources they need to serve older adults with the greatest economic and social needs. A centralized, one-stop shop for legal assistance, NCLER provides Legal Training, Case Consultations, and Technical Assistance on Legal Systems Development. Justice in Aging administers the NCLER through a contract with the Administration for Community Living's Administration on Aging.

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About the Center for Medicare Advocacy

The Center for Medicare Advocacy is a national, non-profit law organization founded in 1986 that works to advance access to comprehensive Medicare and quality health care.
Based in CT and DC with additional attorneys in CA, MA, NJ.

- Staffed by attorneys, advocates, and technical experts
- Education, legal analysis, writing, assistance, and advocacy
- Systemic change – Policy & Litigation
  - Based on our experience with the problems of real people
- Medicare appeals
- Medicare/Medicaid Third Party Liability Projects

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Agenda

- Overview of Medicare Home Health Coverage Criteria and Covered Services
- Skilled Services—Nursing and Therapy
- "Dependent" Services—Home Health Aides and Medical Social Services
- *Jimmo* Case and its Impact on Medicare Home Health Care
- Case Studies Addressing Access To Care
- Obstacles to Care, Advocacy Tools, and Practical Tips

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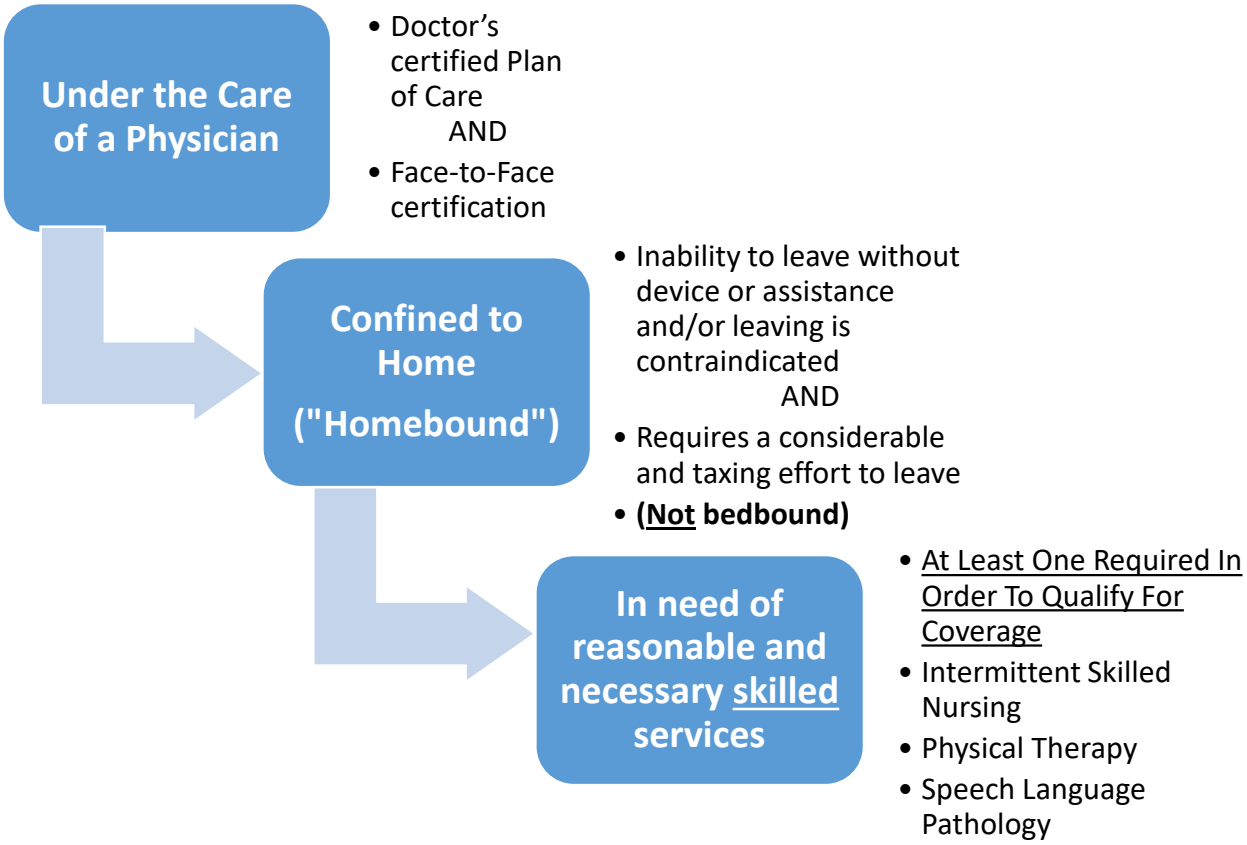
Home Health Coverage Criteria



42 C.F.R. § 409.40 et seq

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Under the Care of a Physician

Certifying physician must:

- Establish a written Plan of Care
  - Orders specifying medical treatments, the type of services, and frequency
  - Reviewed at least every 60 days
- Conduct or sign off on a "Face to Face" meeting

42 C.F.R. § 409.40 et seq;
42 C.F.R. § 424.22

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Confined To Home ("Homebound")

Intent of Medicare Benefit: Provide health care at home for people who lack an ordinary ability to leave home

- The individual must require assistance of another person or supportive device to leave home; OR
- It's contraindicated for them to be alone due to their medical, cognitive, psychological condition AND
- There is a normal inability to leave home
- Require "considerable and taxing effort" to leave home

Medicare Benefit Policy Manual, Ch. 7, Sec. 30.1.1

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Homebound (1 of 2)

May leave home for:

- Health care
  - Medical appointments, therapy not available at home, adult day care for the purpose of therapeutic, psychosocial, or medical treatment
- Infrequent absences or absences of short duration
  - Religious services, occasional trip to barber, walk around the block, family reunion, funeral, graduation, etc.

Medicare Benefit Policy Manual, Ch. 7, Sec. 30.1.1

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Homebound (2 of 2)
Questions To Ask About Absences

- Wheelchair or other assistive devices needed?
- Special transportation arrangements? Needs equipment?
- If electric w/c or scooter: Can't transfer self? Can't dress self? Look for issues like poor grip, upper body paralysis, incontinence, poor vision, mental status, requires escort/another person's assist.
- Evidence of "taxing effort"
- If no physical limitations – Does patient require supervision for safety's sake (Some people with dementia or psychiatric issues)?
- "Patient drives" – Does not always mean not homebound

Look at individual's overall condition and experience, rather than isolated period(s).

Medicare Benefit Policy Manual, Ch. 7, Sec. 30.1.1

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What Services Will "Trigger" Medicare Coverage? (Qualify an Individual For Coverage)

To trigger (begin) coverage, a beneficiary must require a skilled service:

- Intermittent skilled nursing services; or
- Skilled Physical Therapy (PT) or Speech Language Pathology (SLP) services

- Occupational Therapy (OT) to continue but not to trigger coverage

42 C.F.R. § 409.40 et seq

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Skilled Services

Skilled services (SN, PT, SLP, OT) must be medically reasonable and necessary

- "Skilled" = Qualified professional is needed for the care to be safe & effective
- To provide or supervise the care

Skilled Nursing / Therapy defined at 42 C.F.R. §409.33

- Same specific list of skilled nursing/therapy as for nursing home care 42 C.F.R. §409.42

No duration of time limit. Medicare home care coverage is available so long as skilled care required

Medicare Benefit Policy Manual, Ch. 7, Sec. 40.1.1

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Skilled Nursing Must be "Intermittent" or "Part Time"

1. At least once every 60 days **or,** if less frequently, on a predictable, recurring basis, **AND**

   Fewer than 7 days per week, **OR**

2. 7 days per week but less than 8 hours/day, for up to 21 days or less
   - Extensions to continue daily nursing possible in exceptional circumstances if the need for daily care is still expected to have a finite and predictable end point

42 U.S.C. §1395x(m)(7)(B)
Medicare Benefit Policy Manual, Ch. 7, Sec. 40.1.3

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Skilled Nursing (continued)

- Dr. can recertify if need for daily skilled nursing doesn't end after 21 days as expected, but there must be an expectation that daily nursing need will end.
- Exception: Daily Insulin injections can continue when the individual can not self-inject

Medicare Benefit Policy Manual
Ch. 7, Secs. 40.1.2.4A2 & 40.1.3

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Specific Skilled Nursing Services Defined 42 C.F.R. § 409.33(a)

Includes:

- Overall Management and Evaluation of Care Plan
- Observation and Assessment of Changing Condition
- Patient Education Services
- Specific skilled nursing services

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Skilled Nursing: Overall Management and Evaluation of Care Plan

- When patient requires nurse to manage a combination of non-skilled services
  - Considered reasonable & necessary "when underlying conditions or complications are such that only a registered nurse can ensure that essential non-skilled care is achieving its purpose".
    - **42 C.F.R. § 409.42(c)(1)(i)**
  - And a requirement for payment for these services is that in the patient's care plan "the physician includes a brief narrative describing the clinical justification for this need".
    - **42 C.F.R. § 424.22(a)(1)**

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Skilled Nursing: Observation and Assessment of Changing Condition

- The likelihood of change in a patient's condition requires skilled nursing to identify and evaluate the patient's need for possible modification of treatment, or
- Skilled nursing initiation of additional medical procedures until the medical regimen is essentially stabilized
- Information from the patient's medical history may support the likelihood of a future complication or acute episode and may justify the need for continued skilled observation and assessment beyond a 3 week period

Medicare Benefit Policy Manual, Ch. 7, Sec. 40.1.2.1

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Skilled Nursing / Observation (continued)

- "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 three weeks or so long as there remains a reasonable potential for such a change, complication or further acute episode."

Medicare Benefit Policy Manual, Chapter 7, Sec. 40.1.2.1

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Skilled Nursing: Patient Education Services

- Reasonable and necessary until "it is apparent, after a reasonable period of time, that the patient, family, or caregiver could not or would not be trained."
  - **42 C.F.R. § 409.42(c)(1)(ii)**

- "We believe it inappropriate to assign specific timeframes for patient education services because the length of time a patient or family or caregiver needs should be determined by assessing each patient's individual condition and other pertinent factors such as the skill required to teach the activity and the unique abilities of the patient. It is important to know that teaching activities must be related to the patient's functional loss, illness, or injury."
  - **74 Fed. Reg. 58115 (Nov. 10, 2009)**

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Skilled Nursing Services

- Specific Skilled nursing services listed in federal regulations
    - Intravenous or intramuscular injections
    - Intravenous & enteral feedings
    - Insertion and sterile irrigation of supra pubic catheters
  - Application of dressing involving prescription medications and aseptic techniques
  - Treatment of extensive decubitus ulcers and other widespread skin disorders
  - Nasopharyngeal / tracheostomy aspirations

42 C.F.R. § 409.33(b)

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Skilled Nursing: Advocacy Tip

- 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.

Medicare Benefit Policy Manual, Ch. 7, Sec. 40.1.1

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Skilled Nursing: Advocacy Tip (continued)

- Restoration potential is not the deciding factor for deciding whether Medicare coverage is available
  - "Even if full recovery is not possible, a patient may need skilled services to prevent further deterioration or preserve current capabilities" (42 C.F.R. § 409.32)
- Improvement is not required for a service to be skilled.

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Skilled Therapy (1 of 3)

- Physical Therapy
- Speech Language Pathology
- Occupational Therapy
  - Sufficient to continue, but not to trigger coverage

42 C.F.R. § 409.44(c)

Skilled Therapy (2 of 3)

- Must relate directly and specifically to a treatment regimen (established by the physician, after any needed consultation with the qualified therapist) that is designed to treat the individual's illness or injury
- Must be reasonable and necessary

42 C.F.R. § 409.44(c)

Skilled Therapy (3 of 3)

- "…There must be an expectation that the beneficiary's condition will improve materially in a reasonable (and generally predictable) period of time …**or** the skills of a therapist must be necessary to perform a safe and effective maintenance program."

42 C.F.R. § 409.44(c)(2)(iii)

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Skilled Maintenance Therapy

- **Maintenance Therapy Is A Covered Service –** "…when the specialized knowledge of a qualified therapist is required to design and establish a maintenance program based on an initial evaluation and periodic assessment of a patient's needs…"

42 C.F.R. § 409.33(c)(5)

- "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…."

Medicare Benefit Policy Manual, Ch. 7, Sec. 40.2.2.E

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Skilled Therapy: Occupational Therapy

- **Occupational Therapy** (OT) can be the only skilled service when:
  - OT is ordered along with some other skilled services (Example: Nursing, PT, or SLP); and
  - The other skilled service(s) are discontinued but OT continues to be necessary and provided.

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Key Points

1. An individualized assessment regarding eligibility for coverage is required
2. Restoration potential is not the deciding factor
3. Medicare should not be denied because the beneficiary has a chronic condition or needs services to maintain their condition
4. Skilled therapy and other services can be covered to:
   - Maintain current capabilities
   - Prevent or slow further deterioration
5. Home health care can continue so long as qualifying criteria are met

- **Note:** Home health agencies must submit claims to Medicare if a beneficiary requests (but the individual is responsible for payment until/unless Medicare coverage is granted)

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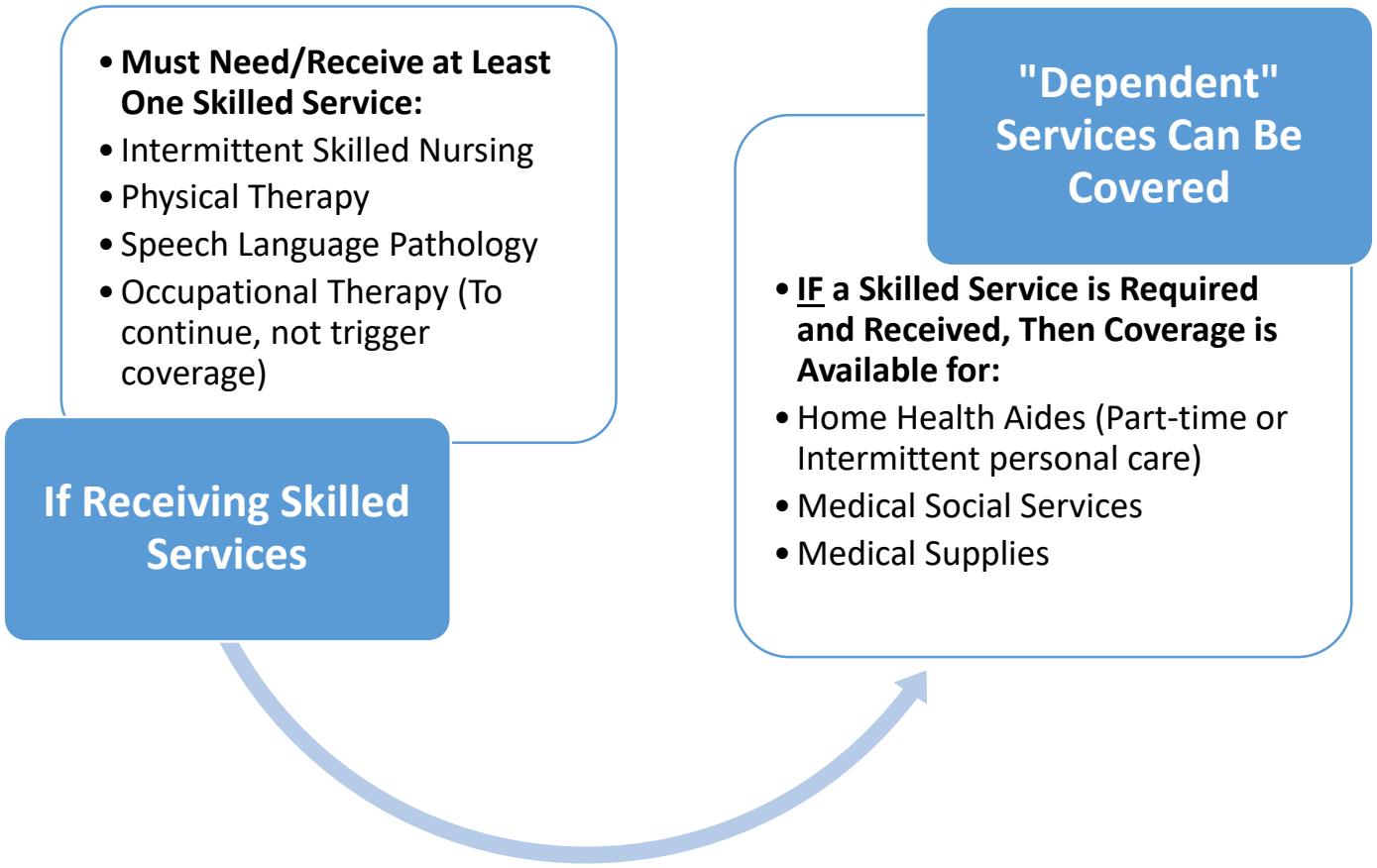
Covered Services



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Dependent Services

- If an individual receives intermittent skilled nursing or PT, SPL, or continuing OT…
- Then coverage is also available for "Dependent Services" (such as home health aides)

- **Note** – The amount of skilled services does not determine the amount of dependent/HH aides services

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Dependent Services (continued)

- **Home Health Aides**
- Medical social services
- Medical supplies (related to the illness/injury)
  - Examples: catheters, ostomy supplies
  - Not DME/Prosthetics & Orthotics → Covered separately under Part B

42 U.S.C. § 1395x(m)(7)(b)

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Home Health Aides—Law

How much can be covered – under the law?

- Combined with skilled nursing, can be provided up to 28 hours per week and any number of days per week as long as they are provided less than 8 hours each day
  - Subject to review on case by case basis, they may be available up to 35 hours per week
- Separately if the skilled service is therapy

42 U.S.C. § 1395x(m)(7)(b)
42 CFR §409.45(b)

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Home Health Aides—In Practice

How much can be covered – in practice?

- Too often told only 1 – 3 hours/week
  - Only for a bath
- Or, not available staff to provide
  - What if private pay?

- **Note:** Can mix payment sources

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Home Health Aides (continued)

- HH aides must provide **hands-on personal care**
  - Homemaker services alone are *not* covered
    - Only if incident to hands-on personal care
- "Custodial" Care
  - Medicare Act specifically establishes home health aide (custodial care) as a covered service under the Medicare home health benefit

42 U.S.C. § 1395x(m);
42 C.F.R. § 409.45(b)

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Home Health Aides (continued)
42 CFR §409.45(b)(1) – (4)

What is *Hands-on Personal Care*?

- Specifically defined to include:
  - Bathing, dressing, grooming, caring for hair, nails, oral hygiene to facilitate treatment or prevent deterioration
  - Changing bed linen of incontinent patient
  - Feeding assistance with elimination, routine catheter and colostomy care, skin, foot, ear care
  - Assistance with ambulation, changing position in bed, help with transfers
  - Assistance with Rx that doesn't require nurse

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Is Coverage Available If Caregivers Are At Home?

- A patient is entitled to have the costs of reasonable and necessary services reimbursed by Medicare without regard to whether there is someone available to furnish the services …
- Ordinarily it can be presumed that there is no able and willing person at home to provide services rendered by the home health aide or other HH personnel

Medicare Benefit Policy Manual, Ch. 7, Sec. 20.2

Jimmo vs. Sebelius

Impact on Medicare Home Health Care

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Jimmo V. Sebelius, No. 5:11-cv-17 (D. Vt. 2011), Settled 2013, Corrective Action Plan 2017

- Federal class action brought to end Medicare denials based on an "Improvement Standard" for skilled nursing facility (SNF), home health (HH), and outpatient therapy (OPT) care.
- **Filed Jan. 18, 2011**; Settled October 2012 (Court approved 1/2013); Back to Court for further implementation: 3/1/2016; CMS Corrective Action Plan **completed 2017.**
- Plaintiffs: 5 individuals and 6 organizations
    1. National MS Society
    2. Alzheimer's Association
    3. National Committee to Preserve Social Security & Medicare
    4. Paralyzed Veterans of America
    5. Parkinson's Action Network
    6. United Cerebral Palsy

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What *Jimmo* Means (1 of 2)

- Care that meets Medicare home health coverage criteria:
  - Doctor's order, homebound, skilled care; and
  - Is needed to maintain an individual's condition or slow decline…
- Is just as coverable by Medicare as care to improve an individual's condition.

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What *Jimmo* Means (2 of 2)

Coverage does not turn on the presence or absence of potential for improvement, but rather on the need for skilled care

- Includes Nursing and Therapy

Services can be skilled and covered when:

- Skilled professional is needed to ensure services are safe and effective
- To maintain, prevent, or slow decline

Medicare Benefit Policy Manual, Ch.7, Sec. 20.1.2

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Nursing to Maintain Function or Slow Deterioration

- Maintenance nursing services are Medicare-coverable when skilled nursing is necessary to maintain current condition or prevent or slow deterioration so long as the skills of a nurse are required to ensure the services are safe and effective

Medicare Benefit Policy Manual, Ch. 7, Sec. 40.1.1

- Decision regarding coverage should turn on whether skilled nursing is needed, not whether individual is expected to improve.

Medicare Benefit Policy Manual, Ch. 7, Sec. 20.1.2

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Therapy to Maintain Function or Slow Deterioration

- "Maintenance Therapy"
  - Where services that are required to maintain 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 procedures safely and effectively, the services would be covered physical therapy services."

Medicare Benefit Policy Manual, Chapter 7, Sec. 40.2.2.E

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Jimmo and Prior Law Support Maintenance Coverage and Require an Individualized Assessment

- Restoration potential is not the deciding factor
  - 42 CFR §409.32(c)
- Medicare should not use "rules of thumb"
- Must make "Individualized Assessment"

"Determination of whether skilled nursing care is reasonable and necessary must be based solely upon the beneficiary's unique condition and individual needs, without regard to whether the illness or injury is acute, chronic, terminal, or expected to last a long time."

42 C.F.R. §409.44(b)(3)(iii)
See also: 42 C.F.R. §409.44(a)

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Jimmo Summary

Questions to Ask:

- Is a skilled professional needed to ensure nursing or therapy is safe and effective?
  - **If yes → Medicare coverable**
- Is a qualified nurse or therapist needed to provide or supervise the care?
  - **If yes → Medicare coverable**

Regardless of whether the skilled care is needed to improve, maintain, slow deterioration of the condition, or if condition is *chronic*, *stable*, or has *plateaued*.

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Case Example #1

- A patient was discharged from the hospital with an open draining wound that requires irrigation, packing, and dressing twice each day. The home health agency (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.

Medicare Benefit Policy Manual, Chapter 7, Section 40.1.1, Example 5 (page 42)

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Case Example #1 - Analysis

- Patient leaves the hospital with a Physician's Order and Plan of Care for home health services, specifically wound care. She has had a Face-to-Face Encounter and she meets Homebound criteria.
- Order and Plan of Care include wound irrigation, packing and dressing which are skilled services, due to the complexity of caring for wounds, and the need for skilled observation and assessment for changes in condition (such as infection).
- Home health agency, chosen by the patient, performs a needs assessment to confirm specific goals.
- Family, if any and if willing and able, may be trained to safely and effectively perform some of the skilled tasks, some of the time.
- If wound care is daily, home health care can continue for 21 days (or longer if the physician indicates a predictable and finite end point).
- If wound care is not daily, services may be covered for as long as the patient needs.

Case Example #2

A Parkinson's patient 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 the maintenance program appropriate to the patient's capacity and tolerance to the treatment objectives of the physician, the instruction of the patient, family, or caregivers to carry out the program safely and effectively (unless the condition of the patient is such that a skilled therapist is needed to ensure the care is delivered safely and effectively), and such re-evaluations as may be required by the patient's condition would constitute covered skilled therapy. Each component of this process must be documented in the health record.

Medicare Benefit Policy Manual, Chapter 7, Section 40.2.2, Example 5 (page 69)

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Case Example #2 - Analysis

- Patient has a Physician's Order for a Physical Therapy (PT) evaluation. He has been at home (not in a hospital or other institution) and had a Face-to-Face Encounter with his treating provider and he meets Homebound criteria.
- Following the PT evaluation, the treating provider completes a Plan of Care with goals to prevent or slow decline in function.
- Home health agency, chosen by the patient, performs a needs assessment to confirm specific goals and design a PT program.
- Family and caregivers, if any and if willing and able, may be trained to safely and effectively perform some of the tasks, some of the time.
- Some services may usually not require a skilled PT (e.g. range of motion exercises) but patient's condition determines if skilled PT is needed for safe/effective services.
- Continual PT re-evaluations needed to assess effectiveness, safety, change in condition, re-designed and ongoing PT programs (hence, discharge not appropriate).

Case Example #3

A physician has ordered home health aide visits to assist the patient in personal care because the patient is recovering from a stroke and continues to have significant right side weakness that causes the patient to be unable to bathe, dress or perform hair and oral care. The plan of care established by the patient's home health aide nurse sets forth the specific tasks with which the patient needs assistance. Home health aide visits at an appropriate frequency would be reasonable and necessary to assist in these tasks.

Medicare Benefit Policy Manual, Chapter 7, Section 50.2, Example 1 (page 76)

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Case Example #3 - Analysis

- Patient has a Physician's Order for Skilled Service(s) and Home Health Aides. Following her stroke, she had a Face-to-Face Encounter with her treating provider and she meets Homebound criteria.
- The treating provider completes a Plan of Care with goals for Skilled Service(s) for home health services related to recovery from her stroke.
- Services of an Aide are ordered to complete unskilled tasks patient cannot do (in this case: bathe, dress, oral care and hair care).
- Home health agency, chosen by the patient, performs a needs assessment to confirm specific goals and personal care needs.
- Family and caregivers, if any and if willing and able, may be trained to safely and effectively perform some of the tasks, some of the time.
- Personal care needs include many more services. Find them at: 42 CFR § 409.45

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Medicare Home Health Care Access

Current Obstacles to Getting Care

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Obstacles To Care: Misinterpretation Of Coverage Laws

- By Home Health Agencies
- By Medicare Contractors
- Lack of understanding about *Jimmo*
- Fear of Medicare Audits

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Obstacles To Care: Medicare Payment Models

- Payment case-mix weights are not strong for people living with a chronic condition.
- Medicare certified home health agencies are not required to provide services to all Medicare patients.
- However, Medicare certified home health agencies are not allowed to discriminate by payer source.
- Medicare payments are higher for patients starting home health services within 14 days of being hospitalized.
- Medicare payments to home health agencies for patients served for more than 30 days are decreased.

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Obstacles To Care: Quality Rules

- Impact of the current Home Health Quality Reporting Program (HHQRP) and the "star rating" system measures include these "improvement" measures:
  - How often patients got better at walking around
  - How often patients got better at getting in and out of bed
  - How often patients got better at bathing
  - How often patients had less pain when moving around
  - How often patients' breathing improved
  - How often patients' wounds improved or healed after an operation

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Obstacles To Care: Arbitrary Discharge

- The patient still qualifies for care, but the home health agency says:
  - Medicare won't pay for your care any more
  - Medicare doesn't cover long term services
  - Medicare doesn't cover maintenance therapy
  - We don't have the staff to meet your needs
  - You only need custodial care and Medicare doesn't pay for that
  - You are not homebound

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Medicare Home Health Care

Advocacy Tools
& Practical Tips

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Review and Refer to Medicare Home Health Law & Regulations

- Medicare Act: 42 USC §1395x(m)
- Federal Regulations: 42 CFR §409.40
- See: New CMS MLN re Role of Coverage Law and Therapy under Home Health Patient Driven Groupings Model (PDGM) (2/10/2020)

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Refer to the Medicare Conditions Of Participation (COP) (Revised 1/13/2018)

- First major update to COP in over 25 years
- Generally expands beneficiary protections
- Affords greater protections for patients from arbitrary transfer or discharge from home health care
- Establishes an updated Patient Bill of Rights that must be clear and accessible to patients and home health staff
- Enhances patient assessment requirements to include psychosocial, functional, and cognitive components
- Requires more significant consideration of patient preferences

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Refer to the Medicare Conditions Of Participation

- Requires more patient involvement in care planning:
  - Includes patients, representatives, and aides on an interdisciplinary care team
  - Establishes more communication between patients, care representatives, and the home health agency
- Mandates home health agencies identify caregivers and their willingness/ability to assist with care (not assume it's available).
- Requires coordination/integration with all patient's physicians.

42 C.F.R. § 484.2 et. al.

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Refer to the Medicare Conditions Of Participation (Continued)

- Discharge and Transfer of Patients
  - Discharge is appropriate only when a physician and home health agency both agree that the patient has achieved measureable outcomes and goals established in the individual plan of care. (Note: Goals may include slowing deterioration of a condition or maintaining a condition.)
  - Home health agencies are responsible to make arrangements for safe and appropriate transfer of a patient to another agency.

42 C.F.R. § 484.50(d)(1); 42 C.F.R. § 484.50(d)(3)

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Refer to the Medicare Benefit Policy Manual

- Medicare-certified Home Health Agencies rely on the Medicare Benefit and Policy Manual
- Medicare Benefit Policy Manual, Chapter 7
  - All significantly revised by *Jimmo*
  - Section 20 (Medicare decisions should be based on whether skilled care is needed, not on whether individual will improve)
  - Section 30 (Homebound)
  - Section 40 (Coverage, including for nursing and therapy to maintain or slow decline)

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Visit Medicare Websites

- **CMS.gov:** Search for "*Jimmo*" for information about the *Jimmo* case and legal criteria, reiterating improvement is not required

- **Medicare.gov:** Review the **Home Health Compare** tool, it will provide contact information for all Medicare certified home health agencies that serve your zip code.
  - Contact agencies, including those that do NOT have 5 Star Ratings

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Refer to the CMS *Medicare & Home Health Care Booklet*

- Official CMS Booklet—October 2017 version contains significant updates and clarifications
  - Medicare and Home Health Booklet
- Topics include:
  - Medicare Coverage of Home Health Care
  - Choosing a Home Health Agency
  - Getting Home Health Care – including plan of care and a checklist for care needs
- Not perfect, but a strong advocacy tool

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Confirm There's Clear Documentation In Beneficiary's Medical Record

- Be certain orders and goals clearly indicate maintenance language if that is the intended outcome
- If improvement is initially expected and that goal is reached or changed:
  - **Get new order, with new goals if goal changes from improvement to maintain, deter, or slow decline**
  - Denials occur when this is not done
- Confirm the services are documented as delivered – "If it's not documented, it didn't happen."

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Confirm There's Clear Documentation In Beneficiary's Medical Record (Cont)

- Need for and receipt of skilled care must be evident
  - Document skilled care was needed and provided
- There are no magic words required in documentation:
  - But vague phrases like "patient tolerated treatment well," "continue with Plan of Care," "patient remains stable" are not sufficient to establish coverage.
  - Include language stating skilled nursing and/or therapy are required to maintain or slow and deter and why.
- If improvement does occur, document it!

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If Home Health Agency Says Medicare Won't Cover

- Continue to receive care, if possible.
- Ask the agency to submit a "Demand Bill" to Medicare for all the coverable services included on the plan of care. (Agencies must do so if the beneficiary insists. But, beneficiary payment for services is not waived.)
  - For up to 35 Hrs/Wk of home health aide and nursing combined and PT, SLP, OT, HH aides and other "dependent services"
  - Home Health Agency should use "Code 20" on demand bill claim form to ensure a medical review is done (rather than an automatic denial)

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Appeal Medicare Denials
Fast Track / Expedited Appeals

- When an agency plans to end all home health services, the beneficiary has a right to a fast ("expedited") appeal.
- The agency must give the beneficiary a written notice—a Notice of Medicare Non-Coverage (NOMNC) at least 2 days before all covered services end.
- The NOMNC includes rights to get more details about why discharge is happening and how to ask for a fast appeal.
- Appeal by noon of the day after receiving the NOMNC.
- In appealing, the beneficiary should show why care should continue.
  - Include support from physicians & providers.
- Note: No appeal rights unless all services are stopped.

42 CFR §§ 405.1200 - 405.1204, MCPM Chapter 30 (Traditional); 42 CFR §§ 422.624 - 422.626, MMCM Chapter 13 (Medicare Advantage)

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Appeal Medicare Denials
Standard Appeals (1 of 2)

- Appealing to obtain coverage for continued, subsequent services and for claim payment.

- A beneficiary must receive services in order to appeal. Appeals are not available for care that "should have happened."

- Standard Appeal levels in **Traditional Medicare**: Initial Determination, Medicare Administrative Contractor (MAC) Redetermination, Qualified Independent Contractor (QIC) Reconsideration, Administrative Law Judge (ALJ) Hearing, Medicare Appeals Council Review.

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Appeal Medicare Denials
Standard Appeals (2 of 2)

- Standard Appeal levels in **Medicare Advantage**: Organization Determination, Health Plan Reconsideration, Independent Review Entity (IRE) Reconsideration, ALJ hearing, Medicare Appeals Council Review.

- Appeal must be for at least $170 (2020) for ALJ Hearing & Council Review

- Thereafter, a claim can be appealed to Federal Court, if appeal is for at least $1,670 in 2020.

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Last Resort: Accept Less Than Individual Qualifies For

- To the greatest extent possible, exhaust all of the resources previously discussed.

- The Center for Medicare Advocacy is working for fair access. In the meantime, the reality may be that individual can only access limited Medicare-covered home care.

- Let us know! Stories help us remove unfair barriers to Medicare-covered home care.

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Resources From the Center For Medicare Advocacy

- Center for Medicare Advocacy Home Health Information
  - Jimmo Settlement and materials
  - Medicare Home Health Infographic/Factsheet
  - Health Toolkit
  - Home Health Brochure
  - Self-Help Packets
  - Articles on Home Health Topics
- Note: New CMS MLN re Role of Coverage Law and Therapy under Home Health Patient-Driven Groupings Model (PDGM) (2/10/2020)

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Center for Medicare Advocacy

MedicareAdvocacy.org

Questions and Comments?

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Case consultation assistance is available for attorneys and professionals seeking more information to help older adults. Contact NCLER at ConsultNCLER@acl.hhs.gov.

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