Self Help Packet for Home Health Care Appeals Including "Improvement Standard" Denials

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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 beneficiary to appeal an unfair denial; we urge you to do so.

For additional assistance, contact your State Health Insurance Assistance Program (SHIP). You can find your state program's information at https://shipnpr.shiptalk.org/shipprofile.aspx.

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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 detailed description.

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," contact the "Beneficiary and Family-Centered Care Quality Improvement Organization" (BFCC-QIO) 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.

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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.
2. The patient is **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.
    - **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.

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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.

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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), CMS 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)
2. 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 Medicare Advantage 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 mus 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 not 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 www.shiptalk.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.)
