



# Center for Medicare Advocacy, Inc.

Advancing fair access to Medicare and health care

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## HOME HEALTH CARE

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### A QUICK SCREEN TO AID IN IDENTIFYING COVERABLE CASES

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 care plan.
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. Attendance at an adult day care center or religious services is not an automatic bar to meeting the homebound requirement.
3. 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.
4. The care must be provided by, or under arrangements with, a Medicare-certified provider.

### COVERABLE HOME HEALTH SERVICES

If the triggering conditions above are met, the beneficiary is entitled to 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 directions of a physician and;

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- To the extent permitted in regulations, part-time or intermittent services of a home health aide.

**ADDITIONAL HINTS:**

1. Medicare coverage should not be denied simply because the patient's condition is "chronic" or "stable." "Restorative potential" is not necessary.
2. 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.
3. 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 to extend over a long period of time.
4. 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.
5. In order to be able to appeal a Medicare denial, the home health agency must have filed a Medicare claim for the patient's care. Request, in writing, that the home health agency file a Medicare claim even if the agency insists that Medicare will deny coverage.

**ADVOCACY TIPS FOR HOME HEALTH TERMINATIONS AND REDUCTIONS**

The Balanced Budget Act of 1997 (BBA) added a requirement to the Medicare statute that all costs for Medicare home health services be reimbursed under a prospective payment system (PPS). The Center for Medicare Advocacy has been informed that some beneficiaries are experiencing unlawful reductions or terminations of care under PPS, especially those with chronic conditions such as multiple sclerosis or Parkinson's Disease.

While the Balanced Budget Act of 1997 made significant changes to the Medicare program, and PPS changed the Medicare payment system for home care, they did not change the substantive coverage criteria for home health services. Whatever the real or imagined rationale, unwarranted terminations and reductions in necessary home health services should be vigorously opposed. In fact, former HCFA (now CMS) Administrator Nancy-Ann Min DeParle issued a memorandum in 1998 in which this is specifically stated. Click [HERE](#) to view a copy of this memorandum.

The Center for Medicare Advocacy is committed to helping beneficiaries fight inappropriate terminations and reductions in care. Please contact us if you or someone you know is experiencing such a problem.

**SOME IMMEDIATE ADVOCACY STEPS:**

1. Review the Medicare home health qualifying criteria in the Center's Home Health Quick Screen above. If you meet these criteria follow the advocacy steps below. (See also the attached Medicare Home Health Agency Manual and Federal Regulation provisions.)
2. Contact your treating physician, inform him or her of what is happening, and ask for support of the need for the services currently ordered. The treating physician should be the person who decides whether home health services are necessary and whether they should be reduced or terminated.
  - A. If the physician is able to help, request a written statement explaining the on-going need for the services and that the medical circumstances leading to the doctor's order for services are still present. Ask the physician not to sign a discharge order for home health services if s/he continues to think the services are medically appropriate.
  - B. If the physician is not able to provide this support, seek a second opinion and support from another physician.
  - C. Similarly, you may need to see if there is another home health agency willing to provide the necessary services which the physician orders.

3. Contact the home health agency and object orally and in writing to the reduction or termination of services.

A. If the patient's care plan has not changed and the patient's treating physician supports the need for a continuation of services, stress this with the home health agency. Again, ask the treating physician to write the agency ordering continued services. Ask him or her to send you a copy of what is written.

B. Insist that the services the physician orders continue and that the home health agency submit a bill to the Medicare fiscal intermediary for payment for the services.

C. If the home health agency still decides that services must be reduced or terminated, insist upon a written statement of the basis for the denial or reduction of services. You have a right to such a written notice.

D. Request that the home health agency hold a meeting with the patient and family prior to any termination or reduction in services to discuss the appropriateness of the proposed action.

4. Contact your local Health Insurance Counseling Program, legal assistance program, or Area Agency on Aging for help. These organizations should be listed in your phone book. They can also be located through the national ELDER LOCATOR program by calling (800)677-1116. In Connecticut the health insurance counseling program is called CHOICES; you can reach the Connecticut CHOICES program at (800)994-9422.

5. Contact your regional office of the Centers for Medicare & Medicaid Services (CMS) and report the home health agency, stating that you believe your care has been reduced or terminated inappropriately. You should also state whether you received written notice in advance of the reduction or termination and whether the notice informed you of your appeal rights.

6. Report the home health agency's actions to the agency in your state that handles home health agency licensing and certification.

7. Other advocacy efforts. Medicare advocates are working to obtain further clarification from CMS, stressing home care agencies' due process obligations when they seek to terminate or reduce services. In addition, advocates are asking CMS to insure the on-going provision of home health care services to eligible beneficiaries and to monitor and sanction providers who have erroneously terminated or otherwise denied home health services.

Advocates are developing fact sheets, client profiles, and legal analyses in order to highlight and protect this important benefit. For more information about these activities and assistance with home health service reductions contact the Center for Medicare Advocacy, Inc. at (860)456-7790 or (202)293-5760.

## **MEDICARE HOME HEALTH PROVISION ENHANCES HOMEBOUND DEFINITION**

### Introduction

Sections 501-508 of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) amended 42 U.S.C. " 1395f(n), 1395(n), 1395fff(b), 1395(x)(v) to modify the Medicare home health benefit. (Public Law 106-554, 12/21/2000.) The provisions discussed below clarified the threshold "homebound" criteria, making clear that individuals who attend adult day care or religious services may also qualify for Medicare home health coverage. These changes became effective upon date of enactment, December 21, 2000.

### Homebound Definition

The statutory language clarified and broadened the homebound eligibility criterion in two ways:

Absences attributable to the need to receive health care treatment, including regular absences to participate in therapeutic, psychosocial, or medical treatment at a licensed or accredited adult day-care program, will not disqualify a beneficiary from being considered homebound. For many years beneficiaries who attended adult day-care programs were routinely denied home health services.

Absences for the purpose of attending a religious service are deemed to be absences of infrequent or short duration. (Generally a beneficiary whose absences from the home are not considered infrequent or of short duration will not be considered to be homebound.)

The Current Homebound Definition in the Medicare Act reads as follows (language added by BIPA is in italics):

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 devise (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, 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". 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. For purposes of the preceding sentence, any absence for the purpose of attending a religious service shall be deemed to an absence of infrequent or short duration. [42 U.S.C. '1395n(a)(2)(F)]

#### **US HEALTH AND HUMAN SERVICES SECRETARY ISSUES CLARIFICATION TO MEDICARE HOMEBOUND DEFINITION: DIRECTS PROVIDERS TO BE MORE FLEXIBLE IN ORDER TO PROTECT BENEFICIARIES**

On July 26, 2002 Tommy Thompson, Secretary of the United States Department of Health and Human Services, issued a press release and changes to the Medicare Home Health Agency Manual. The Secretary directed Medicare providers and contractors to be more flexible in applying the Medicare homebound criteria. This is important to elders and disabled Medicare beneficiaries as an individual must be confined to home (homebound) in order to qualify for Medicare home health coverage.

In particular, the Medicare Home Health Agency Manual, §§204.1-204.2, was amended to include additional, not all inclusive examples of situations in which the homebound criteria is met. (Family reunion, funeral, graduation.) More importantly, the following general language was added to the Manual:

It is necessary (as in determining whether skilled nursing services are intermittent) to look at the patient's condition over a period of time rather than for short periods within the home health stay. For example, a patient may leave the home (under the conditions described above, e.g. severe and taxing effort, with the assistance of others) more frequently during a short period when, for example, the presence of visiting relatives provides a unique opportunity for such absences, than is normally the case. So long as the patient's overall condition and experience is such that he or she meets these qualifications, he or she should be considered confined

to home. (Emphasis added)

Although the new examples may be helpful in particular cases, this new direction from CMS to look at a long view, not a limited snapshot, to determine whether the beneficiary meets the coverage standard (for intermittent nursing as well as homebound) is most significant. Advocates have long maintained that cases should be reviewed, and qualification for coverage judged, by looking at services provided over the course of a year, not in fragmented 1-2 month segments.

While the new language does not really add to the already existing homebound criteria, it does provide important direction that the criteria are to be applied flexibly and with a broad view of the patients' condition. Advocates should use the Secretary's press release language and the manual language to help make these points when clients are erroneously denied coverage.

A copy of the Secretary's press release and Manual revisions are available from the Center for Medicare Advocacy (860)456-7790 and on the Centers for Medicare & Medicaid Services web site at: <http://www.cms.gov/pubforms/transmit/R302HHA.pdf>

## **HOME HEALTH PROSPECTIVE PAYMENT SYSTEM\***

### **A. Introduction**

The Balanced Budget Act of 1997 (BBA) added a requirement to the Medicare statute that all costs for Medicare home health services be reimbursed under a prospective payment system (PPS), effective July 3, 2000. Before PPS could even be implemented, subsequent legislation changed the effective date for PPS from October 1, 1999 to October 1, 2000 and removed some of the transitional payment requirements. Later legislation modified the items and services to be included in the PPS calculation and increased some of the payment rates. Final regulations to implement home health PPS were published in the Federal Register on July 3, 2000.

Before passage of the BBA, home health agencies (HHAs) were paid on a per visit retrospective system for the services they provided. BBA created an interim payment system (IPS) for reimbursement to be used until PPS was effectuated. IPS generated a lot of controversy, however. Its cap on reimbursement to HHAs caused HHAs to reduce care to patients and, in many instances, to terminate services or deny admission to patients because of their diagnosis or care needs.

PPS brought with it a new lexicon of acronyms with which advocates will have to become familiar in order to determine whether their clients have received the home health services to which they are entitled. Terms to look for include: PPS, OASIS, HHRG, RAP, LUPA, no-RAP LUPA, PEP, SCIC, and outlier.

Advocates need to remember that PPS is ostensibly only a payment system. PPS changes the claims and billing process for Medicare home health services. Eligibility and coverage criteria for Medicare home health benefits have not been changed. Nevertheless, because of its reliance on OASIS evaluations, PPS has affected eligibility as well.

### **B. OASIS and Case-Mix Index:**

The Outcome and Assessment Information Set (OASIS) is a group of data elements developed by the Centers for Medicare & Medicaid Services (CMS) under a research contract with Abt Associates to assess each home health care patient and to measure patient outcomes. The 79 OASIS elements do not constitute a comprehensive patient assessment, but are incorporated into the HHA's own assessment. CMS intends to use the OASIS information to perform quality assessment of HHAs and eventually to establish norms of service for the different kinds of services included in the Medicare home health benefit. CMS mandated the use of OASIS for all Medicare or Medicaid patients receiving skilled services effective July 19, 1999. HHAs must perform an initial OASIS assessment on each patient before care is provided.

OASIS forms the basis of the case-mix index. The case-mix index is one of the factors used to determine the PPS amount the HHA will be paid for each particular patient. When a HHA initially accepts a patient, the HHA must perform an OASIS assessment of the patient. Selected data elements from OASIS plus an additional data element measuring receipt of therapy services of at least 10 visits, form the case-mix index..

The case-mix index organizes the OASIS data elements into three dimensions: clinical severity, functional severity, and services utilization, and then assigns score values for each dimension. A computer program sums up the patient's scores within each of the

three dimensions and assigns them a severity level. The four clinical severity levels, five functional severity levels, and four service utilization severity levels result in 80 possible combinations, each of which defines a group for the case-mix system. Each patient is assigned to a home health resource group (HHRG) based on the combination of his or her severity levels.

#### C. 60-day episode of care:

Before PPS, home health beneficiaries needed to have their plan of care reviewed by their doctor every 62 days in order to receive Medicare coverage. PPS changes reimbursement, and therefore the frequency of physician review, to a prospective payment for a 60 day episode of care. The 60-day episode payment represents payment in full for all costs and services, with a few exceptions discussed below. Home health services are not covered unless the HHA submits a claim for services. Payments made under PPS are still "subject to a medical review adjustment reflecting beneficiary eligibility, medical necessity determinations, and HHRG assignment."

#### D. Consolidated Billing

HHAs will now be required to "consolidate" their bills or "bundle" together the services provided in the claims they submit to the regional home health intermediary (RHHI) for payment. Payment under PPS will be made to the HHA for all home health services, including medical supplies, regardless of whether they are provided directly through the HHA or through a medical supplier or other provider with an arrangement to provide services to the HHA's patients. The PPS rate as calculated by HCFA takes into account medical supplies.

Certain osteoporosis drugs are excluded from the bundled payment and may be reimbursed separately. Payment for durable medical equipment (DME) provided through the home health services now also are excluded from the PPS consolidated billing requirement as a result of a provision in the Balanced Budget Act Refinement Act of 1999. Separate payment will therefore be made for DME covered as a home health service under the DME fee schedule.

Although therapy services are a covered service under the Medicare home health benefit, some home health agencies did not provide the services directly, but utilized a separate therapy provider and billed for the services separately under Medicare Part B. HHAs will no longer be able to engage in such practices. Even if they provide therapy services through an arrangement with another provider, the claim for the therapy services must be consolidated with the other home health services provided, and will be paid for under the same PPS rate.

#### E. The Claims Process:

The claim submission process differs under PPS from the old fee-for-service process. PPS provides for split percentage payments. At the beginning of an episode of care, the HHA submits to the RHHI a request for anticipated payment (RAP) for the initial percentage payment. The initial payment is 60% of the total PPS amount for new patients and 50% for on-going patients. At the end of the episode the HHA submits a request for the residual final payment, and is paid the remaining amount.

The initial request for payment does not constitute a Medicare claim. Medicare will only pay for home health services if there is a signed doctor's certificate. Under the final PPS rules, the RAP may be submitted without a care plan signed by a doctor. The request for payment may be based on a signed doctor's referral prescribing detailed orders or on verbal doctor's orders that are: recorded in the plan of care; that include a description of the patient's condition and services to be provided; that are attested to by the nurse or therapist responsible for the care; and that are included in a plan of care that is submitted immediately to the doctor. The care plan must be signed and dated by the doctor before the claim for each episode is submitted for the final percentage PPS payment.

#### F. Changes to the Initial Payment

1. Changes based on services provided: The regulations authorize CMS to change the initial payment percentage or to change the PPS amount assigned to the episode in several situations. CMS may reduce or disapprove requests for anticipated payments when protecting Medicare program integrity warrants this action. Since the request for anticipated payment is not a claim, the regulations say the request will be canceled and recovered unless the claim is submitted within the greater of 60 days from the end of the episode or 60 days from the issuance of the request for anticipated payment.

2. Low utilization payment adjustment: If, at the end of an episode, CMS determines the HHA furnished only a minimal services to a beneficiary, it will make a low-utilization payment adjustment (LUPA) to the PPS amount. A LUPA will occur where there have been four or fewer services. The HHA will be compensated based on a per visit amount that differs depending on the service. A home health agency that anticipates providing four or fewer services to a beneficiary may do so without filing a RAP, hence the term no-RAP LUPA.

3. Partial episode payment adjustment: Payments will also be reduced where an intervening event warrants a new 60-day episode payment. This is referred to as a partial episode payment adjustment (PEP). Intervening events are defined as a beneficiary electing transfer to another HHA, or a beneficiary being discharged and then returning to the same HHA during the 60-day period. A beneficiary transfer to a different agency must occur at the initiation of the beneficiary, and is not available if the beneficiary transfers to a HHA that is under common ownership with the original HHA. A discharge and return to the same HHA only occurs when the beneficiary reaches the goals in the original plan of care and the original plan of care is terminated with no anticipation of the need for additional care. Thus, a HHA can't get a PEP for a beneficiary who has a hospital stay and wants to return to the same HHA during a 60-day period.

If there is an intervening event that warrants a new episode, the HHA must obtain a new physician certification for a new plan of care. The amount paid to the HHA for the initial period is determined by the length of time the patient remained under its care under the original care plan. The ratio of the actual days served to 60 is multiplied by the initial HHRG payment amount

4. Significant change in condition adjustment: A HHA may be entitled to an increase in the PPS amount if the beneficiary has a significant change in condition (SCIC) that was not envisioned in the original care plan. To get an increased payment, the HHA has to justify the change in HHRG by doing another OASIS assessment and getting the doctor to sign the change in services ordered. The SCIC adjustment is calculated by first determining the span of days (first billable service date through the last billable service date) before the change in condition as a proportion of 60. This amount is multiplied by the original episode payment. Next the span of service days after the SCIC is determined as a proportion of 60 and multiplied by the new episode payment. The HHA is entitled to the sum of the two amounts.

5. Outlier payments: One of the problems with the interim payment system was that it did not provide for any additional payment if a patient required an unusually high amount of care. Under PPS, the HHA can get an outlier payment in addition to the PPS amount if the imputed cost of the 60-day episode exceeds a certain amount. The outlier threshold is the total payment amount plus a fixed dollar loss amount that is the same for all case-mix groups. The outlier payment will be 80% of the costs exceeding the threshold, which is currently set at 113% of the payment amount.

Congress restricted the amount of PPS funding that could be designated for outlier payments. The total amount for outlier payments cannot exceed five percent of all payments under PPS. Calculating whether a HHA has exceeded the threshold for the outlier payment, and then calculating the amount of the outlier payment is so timely that the small additional payment from the outlier may not be worth the effort. The limitations in receiving outlier payments raise concerns that the disincentive to serving heavy care patients still remains.

#### G. Care Plan Changes and New Assessments:

Care plans must be reviewed by the doctor in consultation with agency professional personnel at least every 60 days. The care plan needs to be reviewed more frequently if the beneficiary decides to change to another agency, there is a significant change in condition which would result in a change to the case-mix adjustment, or the beneficiary is discharged and returns to the same HHA within the 60-day episode. Any care plan change must be signed and dated by a doctor.

The OASIS assessment must also be updated. The update is to occur in the last five days of every 60 day episode beginning with the start-of-care date. An update will occur more frequently in the circumstances listed above.

PPS permits continuous episode recertifications for Medicare eligible beneficiaries. No limit is placed on the number of 60-day episode recertifications permitted in a given fiscal year, assuming the beneficiary remains eligible for home health benefits. The first day of the initial episode of care generally corresponds to the first billable visit. The first

day of a subsequent episode is day 61, regardless of whether it corresponds to a billable service date.

#### H. Appeals

All appeals from denials of home health coverage, either under Part A or Part B, are handled under the [Part A appeals system](#).

Unfortunately, Medicare beneficiaries must overcome several hurdles before they can even get into the appeals system, including the fact that HHAs fail to provide beneficiaries with adequate notice of denials, reductions, or terminations of care. Another hurdle arises when HHAs that believe Medicare coverage will be denied or that are unsure whether coverage will be granted avoid submitting a claim in order to escape any possible financial penalty. The beneficiary has a right to insist that a claim, referred to as a "demand bill", be submitted in these circumstances. If a demand bill is not submitted, beneficiaries have no Medicare denial from which they may appeal. If the demand bill is denied, then the beneficiary may proceed through the Part A appeal process. Of course, if the demand bill is granted Medicare will pay for the services.

#### I. Effect of PPS On Home Health Care

PPS has had an effect on access to home health services and the quality of care provided. Based on conversations with CMS, home health providers and beneficiaries, problems have occurred in the delivery of home health services due to the effects of PPS. The following is a partial list.

- Beneficiaries have been turned down by HHAs because their HHRG does not pay as adequately as the HHA would like. People with dementia and mental illnesses are particularly vulnerable in this regard.
- CMS has admitted publicly that PPS creates an incentive to under serve beneficiaries. Advocates, as well as CMS, need to work to ensure that beneficiaries receive medically necessary services as ordered by their doctors.
- A HHA that wants an increase in payment during an episode has to do a SCIC. Once submitted to the fiscal intermediary for payment, this HHRG may be "down coded," thus lowering the payment.
- The ability of the HHA to submit a RAP without a doctor's certificate encourages some HHAs to reduce services or change care plans without the treating doctor's concurrence. HHAs continue to discharge patients without securing physician's orders.
- A HHA that no longer wants to serve a costly or difficult patient may terminate care in the middle of the episode and claim non-coverage reasons for termination - insufficient staff, safety, etc. The agency may try to claim that the termination is at the beneficiary's election. Some agencies strongly encourage patients to select the "no bill" option on the request for demand bill.
- Advocacy is still needed to assure that beneficiaries with chronic health problems can receive Medicare home health benefits for as long as they need the services?

Please click here to view a [Notice From CMS Center For Beneficiary Services Regarding Home Health PPS](#)

\* Footnotes available upon request. Please [click here](#) to request.

#### HOME HEALTH ARTICLES AND UPDATES

- [OLDER ARTICLES](#)