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MEDICARE

Home Health Care Coverage Under Medicare

With no limits on the duration of services, home care appears a surprisingly expansive source of long-term care under Medicare.

With few limits on the quantity of care available each day, and no deductible or copayment is required, why do services fall so far short of need?

By Edward M. Dale and Cheryl diane Feuerman

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Home health care issues can be divided into two categories: (1) whether the patient meets the threshold criteria required in order to be eligible for *any* home health care services and (2) whether medically necessary and reasonable services are available once all the threshold criteria are met.

Threshold Criteria for Home Care

There are several prerequisites to Medicare coverage of home health care. As with all services under Medicare, the patient's physician must certify that home care is necessary,¹ and a Medicare-certified provider² must dispense the services or supplies. The patient must be confined to the home.³ Additionally, the doctor must certify that the patient needs intermittent skilled care: either nursing care, physical therapy services, or speech-language pathology.⁴ The requirement that the patient need skilled care may also be met if the patient has a continuing need for occupational therapy services

after intermittent skilled nursing, or speech or physical therapy, is no longer necessary.⁵

Homebound Status

A common reason for the denial of coverage is an alleged lack of "homebound" status. The applicable standard is established by two carefully crafted sentences in the law:

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 contraindicated. While the 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 considerable and tax-

ing effort by the individual, and the absences of the individual from the home are infrequent or of relatively short duration, or are attributable to the need to receive medical treatment.⁶

Note that the standard set forth in the first sentence is mandatory, while the standard described in the second provides guidance rather than firm limits. The first sentence contains several conditions, drafted in the disjunctive. Thus an individual must be considered homebound if they need assistance *or* the aid of a supportive device (wheelchair, crutches, braces, cane) to leave the home, *or* if leaving the home is medically contraindicated. For example, a dementia patient who is not physically impaired might be considered homebound because the patient requires supervision when outside the home. The second sentence indicates that absences are allowed, without jeopardizing coverage, if leaving is difficult, so long as the absences are infrequent, of short duration, or required for medical needs. Therefore absences for medical treatment should never be considered in determining a patient's eligibility for home health care benefits, regardless of their frequency or duration, and occasional long trips and numerous short ones for nonmedical purposes should not disqualify the patient. In determining homebound status, the question should be "Can the patient leave the home on a routine basis without assistance and without risk?"

The courts have generally supported a broad construction of

the "confined to the home" standard.⁷ The Health Care Financing Administration's (HCFA) internal policy is also reasonably accommodating.⁸

The Need for Skilled Care

Another common basis for denial of home care coverage is the requirement that the patient be in need of intermittent skilled nursing care, or physical, speech, or occupational therapy.⁹ Receipt of skilled care as infrequently as once every sixty days is generally sufficient to meet this requirement.¹⁰ For example, a patient who needs a catheter changed every other month would be eligible for home care coverage, triggering coverage for the rare and brief nursing visits as well as up to almost thirty-five hours per week of aide services. With regard to skilled nursing, but not therapy services, Medicare law includes an upper limit, disqualifying patients who require skilled nursing care more than six days per week or for eight or more hours per day. However, Medicare covers care at these levels if it is required for twenty-one days or less. Coverage may extend beyond the twenty-one-day period in "exceptional circumstances when the need for additional care is finite and predictable."¹¹

It is noteworthy that this standard merely requires the "need" for skilled care without regard to whether this care is provided in the home. Many individuals who need nonskilled home care services, including home health aide or medical social services, will be receiving skilled care outside the home. This includes those who simply choose to receive therapy ser-

vices from a source other than a Medicare-certified home care provider. For example, Medicare will cover physical therapy services provided by an independent therapist or a hospital on an outpatient basis.¹² Medicare beneficiaries are free to choose to receive services from any health care provider participating in the Medicare program.¹³ Therefore, any patient receiving skilled care (nursing or therapy services) outside of the home would meet this threshold criterion, and home care coverage should be available even if the patient receives only nonskilled care from a home care provider. Since Medicare administration is disjointed by design, that is, the HCFA contractor processing home care claims will have no knowledge or documentation as to health care received from other providers, claims for home health aide or social services will be routinely denied, and will have to be appealed.

The distinction Medicare draws between "skilled" and "custodial" care is central to qualifying for home care services. Skilled care requires professional personnel to perform medical tasks that are so inherently complex that they can only be safely and effectively performed directly by or under the supervision of such personnel.¹⁴ Medicare regulations delineate types of skilled care, providing many examples and clarifying that the patient's restoration potential is not the deciding factor in determining whether skilled services are required.¹⁵ The regulations also contain some useful examples of skilled nursing and therapy services.¹⁶

Medicare provides coverage for services that are generally considered nonskilled if they must be performed by skilled nursing or rehabilitation personnel because of medical complications.¹⁷ In addition to more demonstrable forms of skilled care, such as injections, skilled services may include patient education, observation and assessment, or overall management and evaluation of the care plan.¹⁸ Skilled management, for example, may be necessary simply to ensure ongoing delivery of non-skilled care from several sources.

In contrast, "custodial" care performed by nurses or therapists will not satisfy this threshold criterion. Custodial care is defined by regulation as any care that does not meet the requirements for coverage as post-hospital skilled nursing facility care.¹⁹ Courts have defined custodial care as that which could be administered by a layperson, without any possible harm to the health of the patient.²⁰ Courts have held that whether care is custodial care should be based on a review of the patient's "total condition" and care needs.²¹

Physician Certification

Medicare may also scrutinize home care claims for compliance with the physician certification requirements. Given that the home care providers themselves typically assess the need for home care, prepare a written plan of treatment, and then seek the doctor's signature, problems do arise in this area. Doctors are prohibited from ordering services from any home care agency in which they have a financial

interest.²² The plan of care must not be for more than two months and must be recertified every two months with the certification signed by the doctor when the care is established or as soon thereafter as possible.²³

Covered Home Care Services

Once the preceding criteria have all been met, Medicare home care coverage can be very expansive with coverage for up to thirty-five hours per week of combined skilled nursing care and home health aide services; physical, speech, and occupational therapy; medical social services; medical supplies; medical equipment; and services at hospitals, skilled nursing facilities, or rehabilitation centers when they involve equipment that is too difficult to bring to the home.²⁴

Unlike other areas of coverage, there is no duration limit on home care. Some beneficiaries will receive covered services for life, except that nursing care is not covered if required seven days per week or eight or more hours per day for longer than twenty-one days. Extensions beyond the twenty-one-day limit are permitted if additional care is for a finite and predictable period.²⁵ Cases involving long-term care are often won or lost based on medical documentation. A doctor's order noting that the patient needs daily injections for a six-month period would meet the "finite and predictable" requirement, while a more open-ended order would result in a coverage denial. Notably, the need for care "must be based solely on the beneficiary's unique condition and indi-

vidual needs, without regard to whether the illness or injury is acute, chronic, terminal, or expected to last a long time."²⁶ There are no limits on the frequency or duration of therapist care visits.

In determining whether nursing services are covered, "consideration must be given to the inherent complexity of the service, the condition of the beneficiary, and accepted standards of medical and nursing practice."²⁷ Care is not considered skilled if it could be safely and effectively performed by a layperson without professional supervision. Even if particular skilled services could be taught to the patient or other caregiver, the service is considered skilled and therefore covered.²⁸

Therapy services (physical, occupational, or speech) are covered if they have therapeutic value,²⁹ but activities or exercise to foster the general physical welfare are not covered.³⁰ Services are covered only if they are expected to result in significant improvement in the beneficiary's condition in a reasonable time or if necessary to establish or reevaluate a maintenance therapy program that may include instruction of the patient, family, or home health aides.³¹ Some denials are based on judgments and cost-benefit analysis that can be successfully challenged through the appeal process. For example, Medicare may view very slow improvements in mobility or speech in a traumatic brain injury client as insignificant, while the patient and an administrative law judge may take a contrary position. Similarly, physical therapy services that safely alleviate

pulmonary congestion may only provide short-term rather than permanent relief, the same way that aspirin will cure one headache, but not preclude future headaches. Long-term improvement is not required so long as there is meaningful therapeutic value.

While the need for the "custodial" services that home health aides provide is insufficient to establish eligibility for coverage, once the patient meets all the threshold criteria, including the need for some skilled care, extensive aide services can be covered. Only the following aide services are eligible for coverage: personal care of the patient, including hygiene, dressing, assistance in ambulating and transferring, exercise, nonskilled medical care, and incidental services such as meal preparation and laundry.³² Coverage for aide services may be denied if there is an alternative, able-and-willing caregiver.³³ However, family members are under no obligation to provide this care, and the patient is free to reject a potential caregiver without jeopardizing entitlement to a Medicare-covered aide.

Medical social services, provided by a social worker or social work assistant, are covered when necessary to resolve social or emotional problems that might impede effective treatment of the patient.³⁴ These may include short-term social services for family members or caregivers, or assistance in obtaining other sources of medical coverage, for example, help in completing a Medicaid application.

Other covered home care services include care by intern and

resident doctors under a teaching program;³⁵ and medical supplies that are essential to the provision of the home care services.³⁶

Home Care Under Medicare Managed Care

Those enrolled in any Medicare Managed Care program (Medicare+Choice), including health maintenance organizations, preferred provider organizations, and provider-sponsored organizations, must be provided with the same benefits available to those covered under Medicare Parts A and B.³⁷ Managed care providers are not permitted to impose any additional limitations or restrictions on services, but may offer additional coverage.

Notice of Noncoverage and Appeals

If the home care agency or managed care organization denies coverage, a written denial must be provided. Similarly, if the agency determines that Medicare coverage is no longer available for all or part of continuing services, advance written notice must be provided which details the basis for the denial, the beneficiary's right to obtain those services despite the denial, and the procedures for having a Medicare claim submitted.³⁸ The patient can then opt to obtain the home care, seek a Medicare determination as to coverage,³⁹ and appeal any denial of coverage.⁴⁰ Appeals can be taken only as to services that have already been provided, that is, the only remedy is retroactive payment or reimbursement. Since the beneficiary must accept personal liabil-

ity for the care in this situation, provider denials are often unchallenged. The exception to this rule is Medicare managed care, where an appeal can be taken as soon as the denial is issued seeking an order to have services provided. Unfortunately the appeal process is slow.

Recent Developments

Previously, Medicare paid home health agencies under a cost-based, fee-for-service basis, with a predetermined fee paid for each visit by each staff member. As the number of visits increased, so did the amount of payment to the home care agency. Changes in the reimbursement system, prompted by rapid increases in Medicare's home care expenditures, are now effectively decreasing access to home care.

The annual costs of providing home care have risen sharply over the last three decades for several reasons.⁴¹ Our elderly population is living longer and has greater medical needs. Medical innovations have made home care a feasible alternative to care that had previously been available only in a nursing home setting. Access was expanded by the growth of the home care industry, particularly the establishment of for-profit and hospital-sponsored home care agencies. Medicare's financial pressure on hospitals resulted in patients being discharged while they still needed significant skilled and custodial care. The landmark home care case of *Duggan v. Bowen*⁴² resulted in increased availability of Medicare coverage for home care services. In that case, the

plaintiff successfully challenged a restrictive interpretation of "intermittent" that resulted in denial of coverage for those who required part-time home care more than four days per week. Medicare's expenditures for home care rose thirty-eight percent per year following that decision.

To stem this trend, Congress has changed the reimbursement system. Benefit payments are currently determined under an "interim payment system" that imposes maximum charges on a provider's aggregated home care claims. The current system has significantly decreased payments to home care providers, resulting in widespread closings of home care agencies and effectively reducing the availability of home care services to Medicare beneficiaries, particularly for those needing long-term and/or extensive services. By October 1, 2000, the current system will be replaced by a "prospective payment system" under which the fees paid to a home care provider will be set on a per beneficiary basis with the amounts of payment and care determined by several factors, including patient diagnosis.⁴³ This new system is similar to the prospective payment system recently established for nursing home care.⁴⁴

While the reimbursement structure has been radically altered, basic eligibility criteria and the scope of services covered remains intact. The resulting systems pit patients against those who provide home care for them. Under the prior per-visit payment structure, home care agencies had a vested interest in ensuring that patients received

all the care they needed. Even when coverage was denied, if the patient's appeal was successful, more visits would be covered and an additional payment made to the provider. Under the new systems, agencies will be financially motivated to decline patients who need costly care and to end care sooner. If a Medicare coverage denial is successfully appealed, a patient might be awarded coverage for months of additional care, but the provider would generally receive no additional payment. This encourages providers to reject new patients or to limit care for those whose needs are great but for whom payment levels are comparatively low.

To counter this *de facto* evisceration of the home care benefit, beneficiaries and their advocates will have to use Medicare's appeal process. As noted, however, this will generally require that they be able and willing to accept personal financial liability for services provided following a Medicare denial, in the hopes of obtaining reimbursement through the appeal process.

The changes in the reimbursement structure hurt those most in need of care, for example, those who need extensive and expensive care. Faced with the loss of coverage for services required by those in need, advocates have developed innovative approaches. Two federal cases have been initially successful in suits against home care providers, challenging the termination of services provided by a federal benefits program brought under the Rehabilitation Act of 1973.⁴⁵

In *Morris v. North Hawaii*

Community Hospital,⁴⁶ the court issued an injunction under the Rehabilitation Act to prevent the suspension of services that Medicare might cover. The injunction was issued based on the allegation that the plaintiff would otherwise be denied benefits of a federally funded program due to his disability and need for extensive home care services.

*Winkler v. Interim Services, Inc.*⁴⁷ was a class-action suit brought on behalf of Medicare beneficiaries who were being "dumped" by providers because the reimbursement changes made the beneficiaries fiscally unattractive to providers. In ruling on motions to dismiss and for a preliminary injunction, the court found the plaintiff class had presented a valid claim under the Rehabilitation Act by showing "(1) that they are 'handicapped persons' under the Act; (2) that they are 'otherwise qualified' for participation in the program; (3) that they were excluded from participation in, denied the benefits of, or subjected to discrimination under the program solely by reason of their handicaps; and (4) the program in question [Medicare] received federal financial assistance."⁴⁸ This case was subsequently settled with the defendant's agreement not to discriminate against Medicare beneficiaries or to discontinue services because of financial considerations.

Both *Winkler* and *Morris* included allegations, which have not yet been ruled on, that the termination of services violated state contract, consumer, and public health laws. Significantly,

neither suit alleged violation of Medicare laws. By accepting the risk of personal liability and continuing the care, patients can pursue Medicare claims and appeals and, if triumphant, will not have to pay for this care. Such an outcome will be financially problematic for providers, who may receive the same total payment regardless of the length of the period found to be Medicare covered.

Patients and advocates bringing suits under Medicare law have not, to date, been able to prevent terminations of ongoing home care services. In *Healey v. Shalala*,⁴⁹ the plaintiff class sought injunctive relief against the federal government to prevent suspension of care. The court denied the plaintiff's request for summary judgment as to this injunctive relief and was unwilling to require continuation of services and Medicare coverage, though it did grant partial summary judgment as to claims that the notices of the reduction or termination of Medicare-covered home care services were inadequate. Work on the revisions of Medicare notices relating to home care began in 1999.⁵⁰

While all three of these cases are still pending, it is apparent that advocates must follow a two pronged approach to preserving the Medicare home care benefit: (1) litigation against providers who would deny access to care; and (2) legislative advocacy to ensure that providers are fairly compensated.

Endnotes

1. See 42 U.S.C. § 1395f(a); 42 C.F.R. §§ 409.43(b), 424.10–424.27; HEALTH CARE FINANCING ADMINISTRATION, PUB. NO. 11, HOME HEALTH AGENCY MANUAL § 204.2 (2000) [hereinafter HHAM].
2. See 42 U.S.C. § 1395cc. To be Medicare certified, a home health care provider must meet Medicare's conditions of participation. See 42 U.S.C. §§ 1395f(a)(2)(C), 1395n(a)(2)(A); 42 C.F.R. Parts 484 and 489.
3. See 42 U.S.C. §§ 1395f(a), 1395n(a); 42 C.F.R. §§ 409.42(a), 424.22(a)(1)(ii); HHAM § 204.1.
4. See 42 C.F.R. § 409.42(c).
5. See 42 C.F.R. § 409.42(c)(4).
6. 42 U.S.C. §§ 1395f(a), 1395n(a) (emphasis added).
7. See *Morris v. North Haw. Community Hosp.*, 37 F. Supp. 2d 1181 (D. Haw. 1999) (determining that quadriplegic plaintiff unable to leave his bed without the assistance and unable to leave his house without the aid of another individual and a powered wheelchair and with considerable and taxing effort is homebound especially where plaintiff's absences from home appear to be infrequent or of relatively short duration); *Richardson v. Shalala*, No. 2:93-CV-387, 1995 WL 441956 (D. Vt. Jan. 27, 1995) (finding that plaintiff's regular attended adult day care is not for medical care and thus denial of coverage was proper); *Pope v Secretary of Health and Human Services*, No. CIV.89-256, 1991 WL 236173 (D. Vt. Aug. 18, 1991)

(finding that plaintiff who could ambulate without taxing effort and was absent from the home for up to four hours at least once per week for non-medical reasons was not homebound); *Labossiere v. Secretary of Health and Human Services*, No. 90-150, 1991 WL 531922 (D. Vt. July 24, 1991) (finding that plaintiff who left the home nearly daily and for extended periods each day was not homebound); *Dennis v. Shalala*, No. 5:92-CV-210, 1994 WL 708166 (D. Vt. March 4, 1994) (finding that plaintiff who left home for groceries and adult day care 16 times over seven months, used a walker or wheelchair, and needed the assistance of another outside her home was homebound because the plaintiff's "excursions from the home were neither so numerous nor so lengthy as to disqualify her from homebound status"); *Burgess v. Shalala*, No. 5:92-CV-158, 1993 WL 327764 (D. Vt. June 10, 1993) (awarding coverage to patient who allegedly left the home regularly, and used an assistive device (a cane), because leaving the home required considerable and taxing efforts and "[t]he obvious thrust is that a definition of 'confined to the home' should not serve to imprison the elderly by creating the penalty of a loss of Medicare benefits for heroic attempts to live a normal life"); see also H.R. REP. NO. 100-391(I), at 409 (1987), reprinted in, 1987 U.S.C.C.A.N. 2313-1, 2313-229 ("confined to home" includes those who "could . . . leave home for such non-medical purposes as an infrequent family dinner, an occasional drive or walk around the block, or a church service . . .").

8. An individual does not have to be bedridden to be considered confined to the home. However, the patient's condition should be such that there exists a normal inability to leave home and, consequently, leaving home would require a considerable and taxing effort. If the patient does, in fact, leave the home, he or she may nevertheless be considered homebound if the absences from the home are infrequent, for periods of relatively short duration, or to receive medical treatment. HHAM § 204.1. This section also lists several examples of the circumstances which would render a patient homebound for purposes of coverage.
9. 42 C.F.R. § 409.42; *see also* 42 C.F.R. § 424.22(a)(1)(i); HHAM §§ 204.4, 206.1.
10. *See* HHAM § 205.1.
11. 42 U.S.C. § 1395x(m).
12. *See* 42 U.S.C. § 1395x(p).
13. *See* 42 U.S.C. § 1395a.
14. *See* 42 C.F.R. §§ 409.31, 409.32(a).
15. *See* 42 C.F.R. § 409.32.
16. *See* 42 C.F.R. § 409.33.
17. *See* 42 C.F.R. § 409.32(b).
18. *See* 64 Fed. Reg. 41,643, 41,684 (1999).
19. *See* 42 C.F.R. § 411.15(g).
20. *See* *Sawyer v. Sullivan*, 1991 WL 350049 (D. Vt. Apr. 17, 1991); *Hurley v. Bowen*, 857 F.2d 907 (2nd Cir. 1988); *Samuel v. Weinberger*, 379 F. Supp. 120 (S.D. Ohio 1973).
21. *Freidman v. Secretary of Dep't of Health & Human Servs.*, 819 F.2d 42 (2nd Cir. 1987).
22. *See* 42 C.F.R. § 424.22.
23. *See* 42 C.F.R. § 424.22; HHAM § 204.5.
24. *See* 42 U.S.C. § 1395x(m).
25. *See id.*
26. 42 C.F.R. § 409.44(b)(3)(iii). Under Medicare policy, "the determination of whether a beneficiary needs skilled nursing care should 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 extend over a long period of time. In addition, skilled care may, dependent upon the unique condition of the beneficiary, continue to be necessary for beneficiaries whose condition is stable." HEALTH CARE FINANCING ADMINISTRATION, PUB. NO. 13-3, MEDICARE INTERMEDIARY MANUAL § 3118.1.A.4 (May 1996).
27. 42 C.F.R. § 409.44(b)(i).
28. *See* 42 C.F.R. §§ 409.44(b)(ii), (iii).
29. *See* 42 U.S.C. § 1395x(m)(2).
30. *See* 42 C.F.R. § 409.44(c)(1); HHAM § 205.2(A)(5)(c).
31. *See* 42 C.F.R. § 409.44(c)(2)(iii).
32. *See* 42 U.S.C. §§ 1395x(m)(4), 409.45(b); HHAM § 206.
33. *See* 42 C.F.R. § 409.45(b)(3).
34. *See* 42 U.S.C. § 1395x(m)(3); 42 C.F.R. § 409.45(c); HHAM § 206.3.
35. *See* 42 U.S.C. § 1395x(m)(6); 42 C.F.R. § 409.45(g).
36. *See* 42 C.F.R. § 409.45(f); HHAM § 206.4.
37. *See* 42 U.S.C. §§ 1395w-22(a), 1395w-23(h); 42 C.F.R. § 422.10(a).
38. *See* 42 C.F.R. §§ 411.404(b), 411.408.
39. *See* 42 C.F.R. §§ 411.404, 411.408.
40. *See* 42 U.S.C. § 1395pp.
41. *See generally Reforming Medicare's Home Health Benefit: testimony by Health Care Financing Administrator, Bruce Vladeck, Before the House Commerce Committee Subcommittee of Health and Environment*, 150th Cong. (1997); Cynthia C. Scalzi et al., *Growth and Decline in the Supply of Providers of Medicare Covered Home Health Care Services in the 80's: National and Regional Experience*, 15 HOME HEALTH SERVICES Q. 3 (1994).
42. 691 F. Supp. 1487 (D.D.C. 1988).
43. Omnibus Consolidated and Emergency Supplemental Appropriations Act for Fiscal Year 1999, Pub. Law No. 105-227, § 5101(c); amending § 4603 of the Balanced Budget Act of 1997 (Public Law 105-33); 64 Fed. Reg. 58,134 (1999) (proposed implementing regulations).
44. *See generally* Edward M. Dale & Cheryl Diane Feuerman, *Nursing Facility Coverage Under the Medicare Program*, ELDER'S ADVISOR J., Summer 2000, at 74.

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45. *See* 29 U.S.C. § 794.
46. 37 F. Supp. 2d 1181 (D. Haw. 1999).
47. 36 F. Supp. 2d 1026 (M.D. Tenn. 1999).
48. *Id.* at 1029
49. 2000 WL 303439 (D. Conn. Feb. 11, 2000).
50. *See* 64 Fed. Reg. 24,217–18 (2000).