



*Helping Older Persons With
Legal & Long-Term Care
Problems*

Medicare Home Health Services:

How To Identify Wrongful Denials

1. Does Medicare cover home health care?

Medicare will cover home health care if

- (a) your care requires intermittent or part-time skilled services, physical therapy or speech therapy;
- (b) you are confined to your home and;
- (c) your doctor says you need home health care.

Once it has been determined that you are eligible for home health coverage, you can begin to receive home health aide services in addition to skilled care. These include

- (a) household services essential to your health care at home;
- (b) help with medications that you would normally take yourself;
- (c) simple procedures that are an extension of therapy services; and
- (d) personal care including help with daily activities.

2. What is a wrongful denial?

Medicare beneficiaries often suffer wrongful denials of coverage when Medicare law is interpreted too strictly. There are certain reasons for denial that are frequently used by home health agencies and Medicare, which are not in accord with the law.

It pays to be aware of these common denials. Once you understand which areas of Medicare law are likely to be interpreted too strictly, you can take steps to protect yourself against wrongful denials.

3. What should I look for if I am denied Medicare?

If your Medicare coverage is restricted incorrectly, you risk losing your home health care completely, or receiving less care than you actually need. If you are denied coverage for any of these reasons, be suspicious and challenge the denial:

(a) Duration denials: There are no time limits on how long you can receive home health services. If you have a chronic condition, you have a good chance of getting the coverage you need. As long as you need skilled care at least once every 2 months, you are entitled to home health care coverage.

During this time, you are not required to improve or reach certain goals established by your plan of care. It is enough if your care prevents or slows your health from getting worse, or helps you stay at your current level of functioning. This is particularly important if you are receiving skilled rehabilitation.

(b) "Not medically reasonable" denials: Medicare intermediaries often use their own judgment to decide if certain skilled care is medically reasonable. Your own doctor, and not an insurance company, should decide what care you need.

The Medicare evaluator or "intermediary" should not substitute its judgment for your doctor's in determining what care is needed. Medicare highly values and will usually accept the opinion of the treating physician in determining the reasonableness and need for the health services furnished by providers.

(c) "Not homebound" denials: Medicare sometimes improperly denies coverage to individuals who are homebound and unable to leave home to obtain necessary care. If you cannot leave your home without help from an individual or supportive device (such as crutches or a wheelchair), you are considered homebound.

This is also true if it is not medically advisable for you to leave your home without assistance. You do not need to be bedridden, but should be normally unable to leave home. In certain circumstances, you can still be considered homebound even if you attend an adult day care program outside your home.

(d) "Family members can provide the needed care" denials: Your family is under no obligation to give you the kind of care provided by home health agencies. Likewise, you do not have to accept the services of a family member. In some cases, having a family member provide the care you need is not only inappropriate but also dangerous.

(e) "No improvement" denials: Medicare coverage is available even if you are not going to improve medically and you need skilled care to prevent or delay further deterioration or preserve your current capabilities.

To get coverage for care that maintains your current capabilities, it should be described in terms of reaching a goal, such as the goal of maintaining or preventing further deterioration.

(f) Supervision by a skilled practitioner: To qualify for Medicare coverage based on supervision by a skilled practitioner, all that is required is that a registered nurse, licensed practical nurse, physical or occupational therapist, speech pathologist or audiologist generally supervise skilled nursing and rehabilitation services.

A supervisor does not have to be physically present or on the premises when services are performed.

(g) Coordinating a plan of care: Medicare regulations say that your overall condition must be considered and that skilled personnel may be necessary to perform and coordinate a series of tasks that, taken individually, would not require a skilled professional.

(h) Observation and assessment as a skilled service: Observation and assessment are considered to be skilled services when the skills of a technical or professional person are required to identify and evaluate your need for additional medical procedures.

For example, a patient with congestive heart failure may need continuous close observation to detect signs of deterioration, abnormal fluid balance or a bad reaction to medications.

Likewise, patients discharged from a hospital while in a complicated and unstable condition after surgery may need continued skilled monitoring to watch for post-operative complications.

(i) Management and evaluation of care plan: Management and evaluation is a skilled service when the skills of a technician or professional are periodically required to evaluate and manage the home health aide services you receive. In other words, the skilled professional oversees the unskilled services to make sure that they are effective.

For example, a nurse's management and evaluation skills would be needed to monitor the diet, fluid intake and other health-related needs of an Alzheimer's patient. The services could be provided by unskilled home health aides with the skilled nurse managing the services and periodically evaluating the patient.

4. If my Medicare claim is refused, where can I get help?

If you feel you have been unfairly turned down, call **Pro Seniors' Legal Hotline at (513) 345-4160 or 1-800-488-6070**. If you are having trouble getting Medicare to pay your claims, the Pro Seniors' Health Care Consumer Rights Project will work with you to decide what steps to take.

Pro Seniors provides free legal assistance with Medicare problems to Ohio residents of Butler, Clermont, Clinton, Hamilton and Warren counties.

Pro Seniors' Health Care Consumer Rights Project will (a) investigate and appeal questionable coverage denials made by intermediaries; (b) monitor Medicare trends as well as changes in Medicare law and policy that may affect Medicare coverage decisions; and (c) provide free pamphlets that explain Medicare laws and how they work.

5. How do I appeal a denial?

If you have been denied coverage for home health care, ask the home health agency for a written Medicare denial. If the agency has not submitted a claim to the Medicare intermediary, request that they do so.

If a home health care agency turns down your claim, you should appeal. It's easy and costs you nothing. Remember that wrongful denials are common. They can usually be overturned if you appeal.

If the Medicare intermediary rules against you, you can appeal the decision within 4 months. Ask for a reconsideration of the decision from the **Ohio Medicare Intermediary; Palmetto GBA,**

Medicare Part A Intermediary, P.O. Box 7004, Camden, South Carolina 29010-7004. You must make this request in writing.

If coverage is denied, request a hearing before an Administrative Law Judge (ALJ) within 60 days after you receive the denial if the bill is more than \$100. If the ALJ rules against you, you can appeal the decision to the Medicare Departmental Appeals Board within 60 days of the decision. If the bill is at least \$1,000, you can appeal the Appeals Board's decision to a federal court.

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Pro Seniors' Legal Hotline for Older Ohioans provides free legal information and advice by toll-free telephone to all residents of Ohio age 60 or older. If you have a concern that cannot be resolved over the phone, then the hotline will try to match you with an attorney who will handle your problem at a fee you can afford.

In southwest Ohio, Pro Seniors' staff attorneys and long-term care ombudsmen handle matters that private attorneys do not, such as nursing facility, adult care facility, home care, Medicare, Medicaid, Social Security, protective services, insurance and landlord/tenant problems.

This pamphlet provides general information and not legal advice. The law is complex and changes frequently. Before you apply this information to a particular situation, call Pro Seniors' free Legal Hotline or consult an attorney in elder law.

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Pro Seniors, Inc.
7162 Reading Rd.
Suite 1150
Cincinnati, Ohio 45237

Switchboard: 513.345.4160
Clients Toll-free: 800.488.6070
Fax: 513.621.5613
TDD: 513.345.4160

E-mail: proseniors@proseniors.org

Web Site: www.proseniors.org