Home Health Care: When Will Medicare Pay?

There are very specific criteria for when Medicare will cover home health care (HHC) services. It’s important to understand these criteria so you can help explain it to your clients when they are denied coverage AND so you can help your clients when they meet the criteria and are wrongfully denied the benefit.

What are the criteria for the home health care (HHC) benefit?

Medicare will cover the home health care benefit when a doctor certifies:

- **The person is confined to the home ("homebound").** What exactly does “homebound” mean? The Centers for Medicare & Medicaid Services (CMS) has outlined its definition of “homebound” status for home health care coverage to require a person to meet at least one of Criteria 1 and both of Criteria 2:

  **Criteria 1 (person must meet one):**
  - A person, because of illness or injury, cannot leave home without the assistance of another person, use of special transportation, or supportive device (e.g., wheelchair, cane), OR
  - The person has a condition such that leaving home is medically contraindicated (i.e., medically advised against).

  **Criteria 2 (in addition to meeting one of the above, the person must also meet both of these):**
  - There must exist a normal inability to leave the home, AND
  - It must require a considerable and taxing effort to leave home.

This “homebound” definition can result in people being denied, sometimes improperly, the home health benefit. Individuals can still meet the definition of homebound even if they leave the home occasionally and for short periods of time, such as to go to church or for an occasional haircut, or to receive ongoing, outpatient kidney dialysis. Conversely, the definition of homebound does not allow for people who do not require a supportive device, use of special transportation, or the assistance of another person to leave the home to be considered homebound.

- **Is under the care of a doctor.** Medicare will only cover home health care services when a doctor has determined that the person needs skilled nursing or rehabilitation therapy at home, and orders and signs an order for that care.

  Additionally, a doctor (or a non-physician practitioner working with the doctor) must complete and document a face-to-face visit (in some instances, a face-to-face meeting can be done through
telehealth) with the beneficiary no more than 90 days prior to the start of home health care or within 30 days after the home health care benefit has begun. This is to help ensure that the doctor (or NPP) has met with the beneficiary, and can attest that the beneficiary is indeed homebound and in need of skilled services.

- **Needs skilled care and on a part-time or intermittent basis.** Skilled care could be from a registered nurse, licensed nurse practitioner, or a skilled physical, occupational, or speech and language therapist.

Medicare defines “part-time” as less than 8 hours each day up to 28 hours per week (or, subject to review on a case-by-case basis, less than 8 hours each day and 35 or fewer hours each week) of combined skilled nursing and home health aide services. “Intermittent” generally means from once daily, for periods up to 21 days if there is a predictable end to the daily care, to once every 60 days. There may be exceptions for unusual circumstances, such as the need for sterile wound care when the wound does not heal in 21 days.

- **Gets skilled care from a Medicare-approved home health care agency.** Medicare will only cover the home health care benefit if the home health agency (HHA) providing care is a Medicare-approved (certified) agency. You can help your clients find a Medicare-approved HHA in their area with Medicare’s Home Health Care online tool.

Your clients can choose the HHA from which they receive their care. HHA staff will work with your client and the doctor to create a plan of care, which includes the types of care and equipment needed; how often care is needed; which health care professionals or providers should give this care; and what the doctor expects from the treatment. The first order should allow for up to 60 days of home health care services. After that, if your client needs additional care, they will need their doctor to renew the order.

**What does the home health care benefit cost?**

If your client qualifies for Medicare home health care coverage, they generally do not pay anything under Original Medicare. Unlike inpatient hospitalizations and skilled nursing facility stays, Medicare does not charge deductibles or coinsurance for the home health care services. The only exception is for durable medical equipment (DME). Your client would be responsible for 20% coinsurance for any equipment ordered as part of the care plan.

If your client receives Medicare through a private health plan (Medicare Advantage), she should check with the plan to find out the different costs and plan rules for getting Medicare-covered home health benefits (e.g., the plan may require her to use certain home health care agencies in order to get coverage).
**How long does Medicare home health last?**

There is no limit on how long a person can receive the benefit as long as the qualifying criteria above are met, they can continue to receive home health benefit services.

**Note:** CMS has revised its coverage manuals to clarify that a person’s condition does not need to improve in order for a person to get continued skilled care coverage. Prior to this revision, there had been a longstanding misconception about Medicare’s requirement for HHC coverage that led to people being denied home health care coverage because their condition had “plateaued,” that is, they were not improving. However, this practice was against the law (also known as the “improvement standard”). Following a nationwide class-action lawsuit, *Jimmo vs. Sebelius* (January 24, 2013), CMS agreed to revise its manuals and conduct an educational campaign to help ensure Medicare beneficiaries are not wrongly denied this benefit.

**What should my client do if the HHA is terminating services?**

At some time, the Home Health Agency (HHA) may decide that a person is no longer homebound, or meet the need of skilled nursing or rehabilitative care.

If a home health agency is ending care, it must issue an *Advance Beneficiary Notice (ABN) of Medicare Provider Non-Coverage* no later than two days before services will be ended. The notice explains the beneficiary’s appeal rights and provides contact information for the Quality Improvement Organization (QIO), which will review an appeal of the home health agency decision, if requested.

If your client appeals the HHA decision, the HHA must issue a *Detailed Explanation of Non-Coverage*, which explains why the HHA believes services should end. The QIO will review the case. If the QIO disagrees with the HHA, your client will continue to receive home health care services. If the QIO agrees with the HHA decision, your client can move to the next level of appeal.

**References and Additional Resources**

Get the statute, or legal citations, pertaining to the home health care benefit criterion for coverage:

- [42 CFR 409.42](#) - Beneficiary qualifications for coverage of services
- [42 CFR 409.44](#) - Skilled services requirements
- [42 CFR §409.44(b)(3)(iii)](#) – No legal limit for home health benefit duration

See the Centers for Medicare & Medicaid Services (CMS) Medicare Benefit Policy Manual, [Chapter 7 – Home Health Services](#), Section 30.1 for guidance on the home health benefit criteria. See section 30.5.1.1 for specific guidance on the face-to-face requirement in the home health benefit.
For more information about Medicare’s HHC benefit, read the official Medicare publication, Medicare and Home Health Care, at: [http://www.medicare.gov/Pubs/pdf/10969.pdf](http://www.medicare.gov/Pubs/pdf/10969.pdf)

Center for Medicare Advocacy, *Self-Help Packet for Home Health Care Appeals Including “Improvement Standard” Denials*

See the Centers for Medicare & Medicaid Services (CMS) [manual updates](http://www.medicare.gov) which clarify coverage pursuant to *Jimmo vs. Sebelius*.

See the January 2014, Medicare Learning Network (MLN) Matters [revised publication](http://www.medicare.gov) from the Centers for Medicare & Medicaid Services (CMS) to help inform and educate providers regarding the skilled care coverage manual updates.