Eligibility for Home Care Certification

What Clinicians Should Know

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In order for patients to receive home care that is reimbursable by Medicare, the Health Care Financing Administration (HCFA) has ruled that a physician must certify the need for services at home and establish the plan of care. This gate-keeping role may be appropriate for primary care physicians in many cases. However, nurses, therapists, or social workers may sometimes be better suited to determine home care eligibility because of the nature of the patient's condition or because, unlike physicians, they routinely make house calls. Before 1989, coverage of home care services by Medicare was intended exclusively to provide short-term care after an acute illness or medical event. Since 1989, as a result of a lawsuit brought against the federal government by the National Association of Home Care on behalf of a patient (Duggan v Bowen), Medicare beneficiaries can receive in-home, long-term care so long as eligibility criteria continue to be met.1,3

Nonetheless, the eligibility criteria for home care remain stringent because the intent of the Medicare program is still generally to cover acute care rather than long-term care or preventive care. In addition, the clinical reality for many patients is that their chronic conditions exacerbate and improve over time, causing them to shift in and out of home care eligibility. These transitions further complicate the physician’s role in determining patients’ eligibility for home care services covered by Medicare. The purpose of this article is to discuss the role of the physician in authorizing and monitoring home care services given existing HCFA regulations.

When physicians prescribe home care services for Medicare beneficiaries, they must certify that the patient (1) is homebound, (2) is in need of intermittent skilled nursing care, or physical, speech, or occupational therapy, and (3) is under the physician’s ongoing care. By signing a standard authorization form approved for home care services by HCFA, the physician certifies that the patient meets these three eligibility criteria and that the physician will review the home care plan periodically but no less than every 2 months.1 Even though physicians may not have first-hand knowledge that the home care services they prescribe are appropriate and necessary,5-7 the federal government’s position is that “when a physician signs a Medicare certification form, there is an implied representation that all the rules are complied with.”8 In fact, the official form for the home care plan contains a statement that “misrepresentation, falsification or information concealment may be subject to fine, imprisonment or civil penalty.”4

The report by Welch, Wennberg, and Welch of a geographic variation by state of more than threefold in the rates of home health care visit claims per Medicare enrollee,9 and similar findings by Kennedy and Dubay,10 suggest that physicians do not know the Medicare rules for home health care eligibility or vary in their interpretation of those rules. The doubling of homebound patients to 3.5 million, the quadrupling of home care costs to $14.5 billion between 1989 and 1994,6,11 the doubling of Medicare-certified home health care agencies from 2,935 to 5,836 between 1979 and 1990,12 along with the finding that proprietary home care agencies provide twice the number of weekly visits per patient, three times the total visits per patient, and four times the total charges per patient compared with public home care agencies,13 all make home care a prime target for investigation of “fraud” to help contain the Medicare budget.14,15 Recently, HCFA implemented a demonstration project, Operation Restorative Trust, in five states. This project focuses on reducing fraud and abuse in home care.15 The Health and Human Services Office believes this program has been highly successful in recovering “improper Medicare payouts,” and plans to expand the program to all 50 states.15 As HCFA broadens its investigation of home care fraud and abuse, physicians must familiarize themselves with the eligibility criteria for home care services and comply with them in order to maximize patient access to the needed services to which they are entitled.

If the federal Medicare program defined home confinement literally, patients who visit doctors in their offices while receiving home care would not be, strictly speaking, confined to their home. Fortunately, HCFA does not define home confinement literally.5,16 Currently, patients need not be bedridden, but “there should exist a normal inability to leave home and consequently leaving their homes would require a considerable and taxing effort.”3,16 For practical purposes, Medicare considers patients as homebound if
they lack the ability to leave independently their place of residence; however, such patients may leave their home with the aid of supportive devices (i.e., canes, crutches, walkers, or wheelchairs), special transportation (e.g., ambulance or van), or another person (e.g., family member). Still, not all patients who use canes are eligible for home care. Medicare also expects that absences from the home be infrequent or relatively short in duration (e.g., a trip to the hairdresser or to church), and that in most instances absences from the home be for the purpose of medical treatment. Patients may also be considered homebound if leaving the home is medically contraindicated.

The criteria for home confinement are rather subjective. Therefore, how physicians, home care agencies, patients, and HCFA define home confinement may differ. For example, in a review of claims for home care in New York and Texas, HCFA found that 40% of the claims were improperly billed, with the majority of improper billings resulting from patients failing to meet home confinement criteria. Table 1 lists clinical situations that would qualify patients for meeting the Medicare criteria for home confinement.

The Clinton administration has proposed a more specific definition of a home-confined patient. Under this proposal, a homebound patient cannot leave home for nonmedical reasons for more than 16 hours per month on average, and medical absences are limited to treat more than 5 absences from home per month. However, because a service is provided by one of these health professionals does not necessarily mean the service is a skilled service. To be considered skilled service, a nurse must be required to provide it because of "the inherent complexity of the service," and "the condition of the patient." A diagnosis alone is rarely adequate documentation of the need for skilled services. Rather, the relation between a patient's diagnosis, symptoms, and functional status must justify the complexity of services.

In addition, the need for skilled services must be intermittent, meaning that the services are required less frequently than 7 days per week, but at least once every 60 days; HCFA provides a list of examples that do and do not meet this requirement. The documentation in the medical record should describe the patient's condition and the complexity of required services, and also include an assessment of the risk of complications or deterioration should such skilled services become unavailable. These same principles of medical documentation apply for physical, occupational, and speech therapy.

As Congress and HCFA struggle to preserve the Medicare program for future generations, changes to the program and to these definitions are inevitable. Even though some believe that Medicare makes skilled home care benefits available because patients fear nursing homes and want professional help at home, physicians may be driven away from offering home care services by the vague and complicated criteria defining home confinement and skilled care, linked with the current climate of investigating home care services for fraud and abuse. The investigations of hospital-based academic physicians for fraud and abuse of the Medicare program are ongoing (also see Dugan IJ. Business Week. Sept. 22, 1997:71–4). Many physicians, presumed