PERSPECTIVES

# Eligibility for Home Care Certification

## What Clinicians Should Know

*Tom J. Wachtel, MD, David R. Gifford, MD, MPH*

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.[1] 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.[2] 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.[1] By signing a standard authorization form approved for home care services by HCFA,[4] 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.[3,16] 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

*Received from the Division of Geriatrics, Rhode Island Hospital, Providence (TJW, DRG).*

*Address correspondence and reprint requests to Dr. Wachtel: Division of Geriatrics, Rhode Island Hospital, 593 Eddy St., Providence, RI 02903.*

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.[1] 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.[10] 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, cannot have more than 5 absences from home per month, cannot leave home for more than 3 hours at a time on average, and medical absences are limited to treatments that cannot be provided in the home (Zaldivar RA. *Providence Journal-Bulletin*. May 16, 1997:1). According to HCFA officials, these proposed rules are not intended to restrict coverage, but rather to simply spell out the meaning of the current criteria for eligibility. To date, HCFA has not instituted these new criteria, and indeed they may never be implemented; nor has HCFA addressed how existing criteria might be verified and monitored in the field.

A frail person who is homebound is not considered eligible for home care unless criteria for intermittent skilled care are also met.[1] The criteria for skilled care are even more ambiguous than those for home confinement. Skilled care is care that must be provided by a registered nurse, physical, occupational, or speech therapist. 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," and the service must meet "accepted standards of medical and nursing practice."[1] 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.[1] 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.[1] 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,[6] physicians may be driven away from ordering 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[18–20] (also see Dugan IJ. *Business Week*. Sept. 22, 1997:71–4). Many physicians, presumed

**Table 1. Examples of Homebound Cases According to Medicare Criteria***

1. Restricted mobility from disease process such as unsteady gait, draining wounds, or pain.
2. Poor cardiac reserve, shortness of breath, or activity intolerance as a result of unstable or exacerbated disease process.
3. Bed or wheelchair-bound patients who require physical assistance to move any distance.
4. Patients who require caregiver help with assistive devices such as a cane, walker, wheelchair, or other special device to leave home.
5. A tracheostomy, abdominal drains, Foley catheter, or nasogastric tube that restricts ambulation.
6. Home ventilator dependence or a patient who is unable to ambulate with portable oxygen.
7. Psychotic ideation, confusion, or impaired mental status that restricts functional abilities outside the home.
8. A new colostomy or ileostomy that complicates ambulation.
9. Fluctuating blood pressures or blood sugar levels that predispose patients to syncope.
10. Patients who cannot ambulate stairs or uneven surfaces without assistance of caregiver.
11. Five days or less after eye surgery where the physician has restricted patient activity.
12. Patients who are legally blind or cannot drive.
13. Natural disasters or geographic barriers such as dirt roads or islands that restrict patient mobility or make it a taxing effort for the patient.

**Adapted, with permission, from Rice.*[17]

"guilty of fraud" until proven innocent,[21] are convinced that HCFA is serious about enforcing its regulations. Thus, some frail, elderly persons may be denied needed home care services,[22] and forced to move into nursing homes.[6] The $16.2 billion cut in home care services covered by Medicare enacted by the 1997 Balanced Budget Act and implemented in January 1998 will only make this concern more likely to materialize (Gentry C. *Wall Street Journal*. Jan. 7, 1998: NE1). In this context, what should physicians do?

Without first-hand knowledge of the patient's homebound status, physicians should not certify the patient in a perfunctory manner as confined to home. Physicians should take the time to assess the patient's functional status and need for skilled services before prescribing home care services. In some cases, the physician who prescribes home care has no doubt that the patient meets the Medicare criteria for home confinement. Examples include a patient with a dense hemiparesis, a patient with advanced dementia, or a patient who recently underwent major surgery. These patients are incapable of leaving their home independently or have a medical contraindication to do so; if they have a need for intermittent skilled care, they meet the Medicare criteria for in-home care.

For many patients, however, physicians may not know whether they are eligible to be certified for home care. For example, a diabetic patient with a foot ulcer who is capable of driving her car may benefit greatly from home care for wound management and diabetic teaching by a visiting nurse, but her physician knows or should know that she is able to drive to her doctor's office to receive the wound care and teaching. She is not eligible for home care services. Patients who need physical therapy or daily monitoring of vital signs following hospital discharge may not meet the eligibility criteria for home confinement if they can travel independently to their doctor's office or to a rehabilitation facility. Yet, physicians prescribe home care in such situations without much afterthought because wound care, diabetic teaching, gait training, and blood pressure checks are performed by nurses, physical, or occupational therapists. In each of these cases, in order for the patient to receive outpatient nursing care, usually available only through home care agencies, the office-based primary care physician who does not employ a nurse must prescribe home care and must certify that patient as home confined, which may be a misrepresentation of the patient's status.

Thus, physicians are sometimes placed in conflicting roles as advocates for their patients and as gatekeeper for HCFA eligibility criteria for home care. This conflict is even more pronounced when patients have chronic conditions such as congestive heart failure or chronic obstructive pulmonary disease and only meet criteria for skilled services during episodes of exacerbation. Yet, in-home services for those conditions have been shown to reduce exacerbations and hospitalizations.[23] Table 2 illustrates how some clinical vignettes match up with Medicare eligibility criteria for home care.

The medical literature provides physicians with tools that identify valid correlates of home confinement.[24] In a cohort study of 1,625 community-dwelling elderly persons, positive answers to questions about their functional status such as ability to walk a half mile without help, climb a flight of stairs, or perform heavy work around the house were associated with nonrecipient status of in-home services in the last 12 months with a specificity of 98% to 99%. Negative answers to these questions were associated with in-home services use in the last 12 months with a sensitivity of 60%. Inability to carry out activities of daily life, cognitive impairment, and urinary incontinence also correlated with the use of in-home services. Given that an assessment of functional status is a recommended component of geriatric care, the medical record can and should contain up-to-date functional assessments that can be used to justify patients' home confinement and need for skilled services.

Physicians should always pay sufficient attention to home care certification and plan-of-care forms completed by home care agency staff and mailed to physicians for signature. Physicians should not rely solely on the recertification

**Table 2. Clinical Vignettes Related to Medicare Home Care Eligibility Criteria**

| Vignette | Home Confined | Skilled Care Need | Meets Medicare Eligibility Criteria* |
|---|---|---|---|
| Patient with unsteady gait who requires caregiver assistance for ambulation and whose blood pressure is 190/110. | Yes | Yes | Yes |
| Patient with a dense hemiparesis who is bed or chair bound and who has a pressure ulcer. | Yes | Yes | Yes |
| Patient with severe peripheral neuropathy and blind who is wheelchair dependent for mobility and whose diabetes is well controlled with insulin. | Yes | No | No |
| Patient with advanced Alzheimer's dementia, incontinent of urine, and living in his daughter's home. No other medical problem. | Yes | No | No |
| Patient with a draining venous ulcer who is able to walk and drive her car independently. | No | Yes | No |
| Patient with severe emphysema and cor pulmonale who is ambulatory and stable on home oxygen therapy and medication. | No | No | No |

**Patients must both meet the home confinement definition and require intermittent skilled care to be eligible for home care covered by Medicare.*

**Table 3. Resources and Information Concerning Home Care**

| Agency | Publications |
|---|---|
| The American Academy of Home Care Physicians<br>P.O. Box 1037<br>Edgewood, MD 21040-1037<br>Tel: 410-676-7966 | *Making Home Care Work in Your Practice* (Oct 1997) |
| The National Association of Home Care<br>228 Seventh St. SE<br>Washington, DC 20003<br>Tel: 202-547-7424 | *How to Choose a Home Care Provider* (Nov 1997)<br>*Basic Statistics About Home Care* (Nov 1997) |
| The American Medical Association<br>Department of Geriatric Health<br>515 North State St.<br>Chicago, IL 60601<br>Tel: 312-464-5085 | *Guidelines for the Medical Management of the Home Care Patient* (1992) |

plan-of-care forms sent to them as the forms may not contain adequate information about the patient's functional status and condition. Physicians should demand that these forms document not only patients' current needs for skilled care, but also the reasons for their homebound status. Copies of these forms should be entered into the medical record and used to justify the in-home skilled services provided. Physicians also should not allow long periods of time to go by (e.g., 6 months for a stable patient) without seeing patients who receive home care services; this may require house calls for some patients. Patients whose chronic diseases are unstable (e.g., those with cardiopulmonary conditions) may require more frequent updates, not only to provide good care, but also to verify that they remain eligible for needed home care services.

Resources are available for physicians who want to learn more about home care: The American Academy of Home Care Physicians is an organization dedicated to promoting the art, science, and practice of medicine in the home. The National Association for Home Care serves as the home care industry's watchdog on Capitol Hill, in the regulatory agencies, the courts, and the media. These two organizations and the American Medical Association are listed in Table 3 with some useful publications.

What else can physicians do? First, beyond improving their awareness of HCFA home care eligibility criteria, individual physicians and organized medicine should also lobby to decriminalize incorrect certification of home confinement by physicians. Indeed, most physicians have no financial investment in home care agencies, profit in no way whatsoever when they prescribe home care services, and therefore have no motive to defraud the government. Special regulations should be formulated for physicians involved in self-referral schemes with home care agencies. Second, home care agencies, rather than physicians, should have the authority and the responsibility to certify home confinement and skilled service needs in certain situations such as when the patient has not seen a physician for 6 months or longer. Their staff is more likely to have current information necessary to pass judgment about the home-confinement status of such patients. The home care agency should then be the party at risk for denial of payment or other penalties. Third, HCFA should develop explicit functional criteria that can be measured to establish home confinement so all parties (physicians, home care agencies, and patients) clearly understand when a patient is eligible for home care services. Fourth, if necessary services are denied, physicians should encourage patient activism (e.g., letters to their representatives in Congress) to put pressure on the government and HCFA to modify regulations that do not serve them well. Physicians should also encourage patients to appeal denials for home care when both patient and physician believe that needed services meet Medicare eligibility criteria. A recent report found that most denials for home care services are overturned on appeal (Pear R. *New York Times*. Feb. 15, 1998:1). Finally, physicians and organized medicine should advocate in favor of a broader range of clinical circumstances that the Medicare program would cover for community-residing elderly persons with stable chronic conditions to avert preventable exacerbations or relapses.

As the elderly population continues to expand and acute care hospitalizations decrease, use of home care services will continue to grow. Physicians need to be aware of the current eligibility criteria for those services and should become involved in lobbying for expanded criteria that would allow patients to receive needed services unavailable under existing Medicare regulations.

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