



An Important Message from Medicare:

You're getting this letter to let you know about a new demonstration you may see if you get home health care services now or in the future.

Medicare will begin a new Pre-Claim Review Demonstration for Home Health Services in Illinois on August 1, 2016. **This new demonstration doesn't change your Medicare home health benefit and coverage requirements.**

During this demonstration, if you get home health services beginning August 1, 2016 in Illinois, your home health agency will start a process called "pre-claim review." A pre-claim review means that your home health agency will send information to Medicare. Medicare will review the information to make sure that you meet the eligibility requirements and that the services you get meet the coverage requirements for home health benefits. The pre-claim review shouldn't cause any delays in your home health services and **you can start getting services before the review occurs.**

What do I need to do?

You don't need to take any action. In most cases, the home health agency providing your care will submit a pre-claim review request and all documentation to Medicare on your behalf. You can choose to submit the request yourself if you get the required documents from your home health agency and doctor.

How will I know if my request was affirmed (meaning approved) or non-affirmed (meaning not approved)?

Medicare will send a letter letting you know if the pre-claim review request is affirmed (meaning approved) or non-affirmed (meaning not approved). If the request is affirmed you'll continue to get home health services.

If the request is non-affirmed the first time it's reviewed, and there's additional information that supports your need for home health services, either you or your home health agency may submit another pre-claim review request to Medicare with the additional information. Medicare will re-review information as many times as needed. **You can continue to get services while this review occurs.**

More details about the program are in the fact sheet below.

If you have additional questions or want to report possible fraud, visit Medicare.gov or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

FACT SHEET

1. Your home health benefits will remain the same. To qualify for home health benefits under either Medicare Part A or Part B, you must :
 - Be confined to the home at the time of services;

Medicare considers you confined to the home (i.e., “homebound”) if:
 - 1) There exist a normal inability to leave the home, and
 - 2) Leaving home requires a considerable and taxing effort.
 - Additionally, one of the following must also be true:
 - 1) Because of illness or injury, you need the aid of supportive devices (such as a crutch, cane, wheelchair, or walker); the use of special transportation; or the assistance of another person in order to leave your home; or
 - 2) You have a condition such that leaving your home is medically contraindicated.
 - Be under the care of a physician;
 - Receive services under a plan of care established and periodically reviewed by a physician;
 - Need skilled services, which are services that only a skilled nurse or therapist can safely and effectively provide;
 - Have a face-to-face encounter (or visit) with a doctor or practitioner no more than 90 days before you start home health care or within 30 days after you start home health,
2. The home health pre-claim review process does not require additional documentation other than what is normally required to demonstrate you are eligible for the Medicare home health benefit and that the services you receive are covered under the Medicare home health benefit. Your home health agency is responsible for making sure they have all required documentation.
3. Medicare will send a decision letter to the home health agency and to the beneficiary after the first pre-claim review request has been submitted. Medicare will also send decision letters for re-submitted requests.
4. In some cases, if your pre-claim review request is non-affirmed by Medicare, and you continue to receive home health services, you will not have to pay for a denied claim. However, a home health agency may give you an Advance Beneficiary Notice of Non-coverage (ABN) to tell you the services you are going to receive may not be covered by Medicare. If you agree to receive the services and agree to pay if Medicare does not pay, the home health agency may bill you for all denied charges. You can contact Medicare to check whether you have to pay even if you received an ABN. You or the home health agency may appeal any denied claims.