



## **How do I handle a “Reconsideration” of my Home Health Aide case?**

After you file an appeal challenging the change in your home health aide hours, the Office of Administrative Hearings (OAH) will schedule a “status conference.”

**You must go to that status conference or your case will be dismissed.**

→ If you can’t go in person, call OAH at **202-442-9094** and ask for permission to participate by phone. **If the clerk doesn’t confirm that you have this permission, you must go in person.**

At the status conference, the judge and/or a representative from the D.C. Department of Healthcare Finance (DHCF) (the Medicaid agency) will ask if you want to participate in the DHCF “reconsideration” process.

A reconsideration means that DHCF will take a second look at their earlier decision to reduce or end the home health aide hours you receive. DHCF will then decide if they should change their earlier decision. **If you win the reconsideration, you do not have to have a hearing.**

Here are some tips for trying to get DHCF to change their earlier decision.

### **1) Meet deadlines for turning in all documents.**

If you decide to participate in the reconsideration process, the judge and/or DHCF will set a deadline for you to submit any documents supporting your request to get the same number of home health aide hours you were getting before. **You must meet this deadline.**

**2) Prove that your request for home health aide hours is “medically necessary.”**

**a) Submit a detailed letter from your doctor or primary care provider (PCP). (*Sample attached*)**

It is most important to get and submit a detailed statement from your doctor or primary care provider explaining:

- (i) Number of home health aide hours your PCP recommends you receive;
- (ii) Your medical conditions that cause you to need the recommended hours;
- (iii) Which of the following activities you need help with -- and why:

- **Activities of Daily Living (ADLs):**

- bathing;
- personal hygiene;
- dressing upper and lower body;
- walking;
- using the toilet (including moving on and off and cleaning yourself afterwards);
- moving on and off the bed;
- eating;

and

- **Instrumental Activities of Daily Living (IADLs):**

- preparing meals;
- doing housework;
- going up and down stairs;
- shopping;
- traveling outside the home;
- using the phone;
- managing medications;
- managing finances.

**b) Submit a detailed letter from you, your case manager, and/or a family member that explains the same things the above medical provider letter does. (*Sample attached*)**

**c) Submit medical records from any providers that prove your medical conditions and need for the home health aide hours you are requesting.** Medical records from the past year are most helpful.

**d) Request a re-assessment.** If your medical conditions have gotten worse since the last time DHCF assessed them, you can also ask DHCF to conduct another assessment. If this does not result in an increase in your home health aide hours, you can still continue your appeal through the Office of Administrative Hearings.

**3) If you disagree with the reconsideration decision, ask for an “evidentiary hearing.”**

After you submit your reconsideration documents to DHCF, it takes at least 45 to 60 days for the DHCF medical doctor to review everything and make another decision about your home health aide hours.

If you disagree with DHCF’s reconsideration decision, then tell the judge and DHCF that you want to have an evidentiary hearing. At that hearing, you can present evidence and witnesses in support of getting the number of home health aide hours you are requesting.

**4) If you tried to get legal help before and couldn’t, you can try asking for help again after you have asked for a hearing.**

**Sample Doctor/Primary Care Provider's ("PCP") Letter (which should be on letterhead)**

[DATE]

Re: [Patient Name and Date of Birth] Need for Home Health Assistance

To Whom It May Concern:

My name is [PCP Name]. I am a [PCP Title] at [Name of Office/Clinic] and [Patient Name]'s primary care provider [or other doctor]. I have been seeing [Patient Name] for [x period of time] and see [him/her/them] every [x months/weeks]. It is my opinion that based on [his/her/their] multiple medical problems, [his/her/their] health would be adversely affected if [his/her/their] home health assistance is [reduced/terminated]. This letter explains the basis of my opinion.

[Patient Name] suffers from the following medical conditions:  
[List of medical conditions/diagnoses].

[Patient Name] requires the assistance of a home health aide because [Description of how these medical conditions factor into the PCP's recommendation for the number of home health care hours requested].

The following is a description of the effect [Patient Name]'s medical conditions have on [his/her/their] ability to perform ADLs and IADLs:

- Eating: [Description of effects from medical condition, e.g. problems using utensils because of hand tremors or cognitive/mental impairments that prevent patient from concentrating or remembering to feed him/her/themselves]
- Preparing Food: [Description of effects from medical condition, e.g. problems standing for long periods of time due to arthritis or cognitive/mental impairments that prevent patient from concentrating on cooking]
- Toileting: [Description of effects from medical condition, e.g. incontinence, physical inability to get to toilet and/or clean him/her/themselves or cognitive/mental impairments that prevent patient from toileting]
- Etc. for other affected ADLs/IADLs

Given the medical conditions and needs described above, I recommend that [Patient Name] receive at least [Number of hrs recommended] of home health aide services, [Number of days] per week. Please contact me if you have any further questions at [PCP's phone number].

Sincerely,

[PCP Signature]

[PCP Name, Title]

## Sample Letter from You

**[DATE]**

I, **[Name of Beneficiary]**, disagree with the D.C. Department of Healthcare Finance's assessment of my home health needs.

I have the following medical conditions:  
**[List your medical conditions].**

Due to my medical conditions/disabilities, I need **[# of Home Health Aide hours you are requesting]** hours of home health aide services every day.

I need help with:  
**[Any applicable ADLs or IADLs listed on pg. 2 of this packet].**

I cannot do things by myself due to my medical conditions.  
**[Detailed explanation of why you need assistance with each ADL or IADL you list. Example: I need help putting on pants and shoes because my back pain makes it very hard for me to bend over].**

If my hours are reduced, I feel that I will be at risk.  
**[List any specific safety concerns that you have].**

Please provide me with **[# of Home Health Aide hours you are requesting]** hours of home health aide services per day so that I can remain safe in my home.

Thank you,

**[Beneficiary's Signature]**

**[Beneficiary's Name]**

**Sample Letter from your Case Manager (“CM”) (which should be on letterhead)**

[Date]

RE: [Beneficiary’s Name]

To Whom It May Concern:

I am a case manager at [Name of Agency], and I have been working with [Beneficiary Name] since [Date]. [He/She/They is/are] enrolled in the EPD Waiver Program.

[Beneficiary Name] is an [Beneficiary’s Age] year old who resides in [x-bedroom apartment or house] with [his/her/their] [any other people in home and relationship to beneficiary, e.g. minor grandchild].

[Beneficiary Name] is medically diagnosed with [List of beneficiary’s medical conditions/diagnoses]. [He/She/They] requires assistance with [List of any applicable ADLs and IADLs]. [His/Her/Their] diagnosis will not allow [him/her/them] to complete any of these daily activities on [his/her/their] own.

I wanted to correct areas of the Assessment that are not accurate based on my own experience in caring for [Beneficiary’s Name]:

**Bathing:** [Level of assistance case mgr thinks actually needs and reason for this opinion, e.g. Mr. X is totally dependent on others for his bathing needs. He cannot get in and out of a tub or shower on their own.]

**[Repeat above example for any ADL or IADL Case Manager thinks was inaccurately assessed]**

In order for [Beneficiary Name] to continue [his/her/their] current well-being, [he/she/they] needs to have [# of home health aide hours requesting] hours x 7 days of home health aide hours.

If you have any questions, please call me at [CM Phone Number].

Sincerely,

[CM Signature]

[CM Name]

[CM’s phone number and/or email address]