*Helping Older Persons With Legal & Long-Term Care Problems*

# Medicare Coverage of Home Health Care

## 1. When Will Medicare Pay For Home Health Care?

Medicare will pay if

(a) your care requires intermittent or part-time skilled nursing care, physical therapy or speech therapy;
(b) you are confined to your home; and
(c) your doctor determines that you need home health care.

Medicare will pay all costs of part-time or intermittent skilled and home health aide services, medical supplies and medical social services. Medicare will also pay 80% of the approved costs of any durable medical equipment you need (such as a hospital bed or walker) that is provided by a home health agency.

## 2. Is There A Three-Day Hospitalization Requirement For Medicare Coverage Of Home Health Services?

In 1997, Congress substantially restructured the Medicare home health benefits available under the Part A and Part B Medicare programs. For the first time, the Part A program requires a beneficiary to be hospitalized for three days and also imposes a 100 visit limitation per benefit period. If the beneficiary exhausts his/her 100-visit limit or does not meet the three-day hospitalization requirement, but meets all other criteria for home health services, the home health services will be covered by the Part B Medicare program.

## 3. Were There Other Significant Changes In The Medicare Home Health Benefit?

Congress required in the Balanced Budget Act of 1997 (BBA'97), the establishment of per visit limitations on reimbursement for home health services. The BBA of '97 also required the establishment of a Prospective Payment System for home health services by October 1, 1999. This system is based on the establishment of a prospective payment amount (a predetermined amount of reimbursement for a particular diagnosis) regardless of the cost to a home health agency of providing the actual care needed by an individual patient.

## *4. How Does Medicare Define "Homebound Or Confined To The Home?"*

You are considered to be homebound when, because of an illness or injury, you are unable to leave your home unless someone helps you, or you use a supportive device like crutches or a wheelchair.

You are also homebound if your physical condition makes it medically unwise to leave home. You do not need to be bedridden, but should normally be unable to go out, except for brief or occasional trips, or for medical treatment.

## *5. What Is Considered Intermittent Or Part-Time Care?*

Medicare defines part-time or intermittent home health care, as care where services are provided for fewer than 7 days a week. Part-time care means occurring fewer than 8 hours in each of those days. Intermittent care is care for

(a) up to 28 hours a week of combined skilled nursing and home health aide services, as long as you do not receive these services every day;
(b) up to 35 hours a week of combined skilled nursing and home health aide services, if the need is documented, and you do not receive the services daily; or
(c) up to 7 days a week of combined services if you receive them temporarily (usually up to 21 days unless there is a documented need for more).

## *6. What Determines Whether A Service Is Skilled?*

The service must be so complex that it can only be performed by, or under the general supervision of, professionals. A condition that does not ordinarily require skilled services may require them because of special medical complications involved in a patient's care. The development, management and evaluation of a patient care plan can be considered a skilled service when those activities must be performed by professionals. Patient education services are also skilled services if professionals are needed to teach a patient how to take care of him or herself.

## *7. What Determines Whether Physical Therapy Is A Skilled Service?*

To be a skilled service, physical therapy must be

(a) specifically related to a physician's active treatment plan;
(b) be complicated enough or involve a condition that requires a physical therapist;
(c) necessary to establish a safe maintenance program; or
(d) designed to prevent further deterioration.

Physical therapy services are most commonly used for heart and stroke conditions, arthritis, rheumatism and back and spine problems.

## *8. What Home Health Aide Services Are Paid For By Medicare?*

Medicare will pay for

(a) household services that are essential to your health care at home, such as changing bedding for an incontinent patient;
(b) help with medications that you could ordinarily take yourself;
(c) simple procedures that let you practice what you learned during therapy, such as practicing with your walker, or moving from your bed to a wheelchair and back again; and
(d) help with your personal care and daily activities, including bathing, getting in and out of bed, caring for your hair and teeth, exercising, and teaching you how to take care of yourself.

## *9. What Speech Therapy Services Are Covered By Medicare?*

Speech pathology services are covered if they are needed to diagnose and treat speech and language disorders that make it difficult for you to communicate. The services must be prescribed by a physician in a written treatment plan and be necessary to treat your illness or injury.

## *10. Must I Pay For Home Health Care I Did Not Know Medicare Would Deny?*

Informal Medicare home health coverage determinations are made initially by the agency that provides the care. If care was provided before you were notified in writing that Medicare would not pay, then the agency cannot charge you for these services.

## *11. Is A Medicare Denial Final?*

No. The initial Medicare denial that you receive is often based on the policy of an insurance company or a Medicare administrative agency that is too strict. Many of these initial denials are reversed on appeal, and Medicare ends up paying the claim.

Unfortunately, some home health care providers only receive Medicare benefits training from an insurance company or the agency that administers Medicare. This means that many patients accept an incorrect claim denial because they assume these decisions are correct.

## *12. What Can I Do?*

Request a written Medicare denial from the home health agency. If the agency has not submitted a claim to Medicare, ask that they do so as a Medicare claim that the patient insisted be submitted. Once the Medicare intermediary has made a decision, you can appeal it within 4 months. You can appeal a reconsideration denial by the intermediary by requesting a hearing before an Administrative Law Judge (ALJ) within 60 days. If you receive a negative ALJ decision, you can ask the Medicare Departmental Appeals Board to review the decision within 60 days of receiving the decision. If the bill is at least $1,460, you can appeal an adverse Appeals Board's decision to a federal court.

## *13. Can I Get Free Legal Help?*

Yes. Residents of Butler, Clermont, Clinton, Hamilton and Warren counties can contact **Pro Seniors (513) 345-4160 or 1-800-488-6070** for help with appealing Medicare denials.

Pro Seniors also has a free legal advice and referral Hotline for anyone, age 60 or older, who is a resident of Ohio.



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Pro Seniors' Legal Hotline for Older Ohioans provides free legal information and advice by toll-free telephone to all residents of Ohio age 60 or older. If you have a concern that cannot be resolved over the phone, then the hotline will try to match you with an attorney who will handle your problem at a fee you can afford.

In southwest Ohio, Pro Seniors' staff attorneys and long-term care ombudsmen handle matters that private attorneys do not, such as nursing facility, adult care facility, home care, Medicare, Medicaid, Social Security, protective services, insurance and landlord/tenant problems.

This pamphlet provides general information and not legal advice. The law is complex and changes frequently. Before you apply this information to a particular situation, call Pro Seniors' free Legal Hotline or consult an attorney in elder law.

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