Medicare Home Health Services – ALS Patients

2016

Medicare coverage for Home Health Services is required to be provided

- BY LAW -

to all Medicare patients who meet the Home Health Services coverage criteria.

What Home Health Services (HHS) does Medicare cover?

All persons eligible for Medicare who meet Medicare home health services coverage criteria are eligible to receive a combined total of up to **35 hours** maximum per week in the six home health services disciplines, including up to 28 hours per week of home health aide services. The problem encountered, however, is the Medicare-Certified Home Health Agencies do not have to accept a patient and are unlikely to do so if the patient initially requests more than 2-3 hours per week of home health aide services. It's not profitable for them. It is, therefore, recommended a patient initially requests a minimal number of home health aide hours to ensure they are accepted. Once in the system, it is much easier to steadily increase the hours per week received during the recertification process, as it becomes more difficult for the Medicare-Certified Home Health Agency to deny coverage.

Home health services are available under Medicare for both Traditional/Original Medicare and Medicare Advantage plans and are provided to the patient in 60-day episodes. They are considered part-time and intermittent. The law requires each 60-day episode to provide and cover all six home health services, including medical supplies, which are paid on a reasonable cost basis. This includes costs incurred in the six home health services disciplines, which are:

1. Skilled nursing
2. Home health aide
3. Physical therapy
4. Speech-language pathology
5. Occupational therapy
6. Medical social services

What eligibility criteria must an ALS patient meet?

An ALS patient will be eligible for coverage for Medicare home health services if the following two criteria are met:

1. The patient is confined to home. (Confined to home does not mean a patient is bedridden.)
2. The patient requires ongoing, intermittent, medically-necessary skilled services in any one of the following areas: skilled nursing, physical therapy, speech-language pathology or occupational therapy.

This document was created on March 29, 2016.
It is not intended to resolve the systemic issues and coverage improvements needed within the Medicare system. It is intended to act as a guide for ALS patients to immediately access existing Medicare benefits.

Confined to Home

A physician must certify the patient is confined to his/her home. For purposes of the statute, an individual shall be considered confined to the home (homebound) when the following two criteria are met:

Criterion One:
The patient must either:

- Due to illness or injury, need the aid of supportive devices (such as crutches, cane, wheelchair, or walker), the use of special transportation or the assistance of another person.
  - OR -
- Have a condition which makes leaving his or her home medically contraindicated.

If the patient meets either one of the Criteria One conditions, then the patient MUST ALSO meet the two additional requirements defined in Criteria Two below.

Criterion Two:

- There must exist a normal inability to leave home.
  - AND -
- Leaving the home requires a considerable and taxing effort.

Medically-Necessary Skilled Services

Skilled Nursing – Qualifying factors which necessitate the need for skilled nursing include: 1) PEG/feeding tube maintenance and feedings (inspection of the stoma site, assessment of tube functionality, checking and measuring residuals and providing feedings based on a patient's schedule. Regardless of whether a family member or other 'non-skilled' person performs the tube feedings, the skillset remains that of a skilled nurse); 2) management and evaluation of the patient's Plan of Care to ensure the complexity of all necessary home health services are effective, and 3) other skilled nursing needs, as defined by Medicare home health services coverage.

Physical Therapy - For an ALS patient, physical therapy is not to be limited to or viewed only as rehabilitation, muscle strengthening type of therapy. Rather, physical therapy is also applicable and necessary to maintain the patient's current condition or to prevent or slow further deterioration and limit the impact immobility has on major organs and body system functions. Immobility, even in the earliest stages, can negatively impact the system functions of: circulatory, muscular, endocrine, nervous, gastrointestinal, respiratory, genitourinary and skeletal. It can also cause integumentary pain. Physical therapy also includes therapeutic exercises, gait training, range of motion and maintenance therapy. For supporting information, please reference:
http://www.hcpro.com/LTC-286850-10704/Complications-from-immobility-by-body-system.html

Speech-Language Pathology – Speech-language pathology is covered when a skilled service requirement can only be provided by a speech-language pathologist and where it is reasonably

This document was created on March 29, 2016.
It is not intended to resolve the systemic issues and coverage improvements needed within the Medicare system. It is intended to act as a guide for ALS patients to immediately access existing Medicare benefits.

expected the skilled service will improve, maintain, prevent or slow further deterioration in the patient's ability to carry out communication or feeding activities. It also allows for the speech-language pathologist to train the patient, family or other caregivers to augment the speech-language communication, treatments and maintenance program.

Occupational Therapy – Coverage of occupational therapy services is not determined solely on the presence or absence of a beneficiary's potential for improvement from the therapy, but rather on the beneficiary's need for skilled care. Occupational therapy services are covered when the individualized assessment of the patient's clinical condition demonstrates the need for specialized judgment, knowledge and skills.

Home Health Aide - Home health aide hours are covered by Medicare when provided in support of skilled nursing, physical therapy, speech-language pathology or occupational therapy services. Coverage in this category includes: bathing, dressing, grooming, caring for hair, nail and oral hygiene (which are needed to facilitate treatment or to prevent deterioration of the patient's health), changing the bed linens of an incontinent patient, shaving, deodorant application, skin care with lotions and/or powder, foot care, and ear care; feeding, assistance with elimination (including enemas unless the skills of a licensed nurse are required due to the patient's condition, routine catheter care and routine colostomy care), assistance with ambulation, changing position in bed and assistance with transfers. Home health aides also provide support of skilled services, which are directly supportive of skilled therapy services but do not require the skills of a therapist to be safely and effectively performed (such as routine maintenance exercises and repetitive practice of functional communication skills).

Medical Social Services - Medical social services that are provided by a qualified medical social worker or a social work assistant under the supervision of a qualified medical social worker may be covered as home health services where the beneficiary meets the qualifying criteria and: 1)The services of these professionals are necessary to resolve social or emotional problems that are or are expected to be an impediment to the effective treatment of the patient's medical condition or rate of recovery; and 2.The plan of care indicates how the services which are required necessitate the skills of a qualified social worker or a social work assistant under the supervision of a qualified medical social worker to be performed safely and effectively. Where both of these requirements for coverage are met, services of these professionals which may be covered include, but are not limited to: 1) Assessment of the social and emotional factors related to the patient's illness, need for care, response to treatment and adjustment to care; 2) Assessment of the relationship of the patient's medical and nursing requirements to the patient's home situation, financial resources and availability of community resources; 3) Appropriate action to obtain available community resources to assist in resolving the patient's problem (NOTE: Medicare does not cover the services of a medical social worker to complete or assist in the completion of an application for Medicaid because Federal regulations require the State to provide assistance in completing the application to anyone who chooses to apply for Medicaid.); 4) Counseling services that are required by the patient; and

This document was created on March 29, 2016.
It is not intended to resolve the systemic issues and coverage improvements needed within the Medicare system. It is intended to act as a guide for ALS patients to immediately access existing Medicare benefits.

5) Medical social services furnished to the patient's family member or caregiver on a short-term basis when the HHA can demonstrate that a brief intervention (that is, two or three visits) by a medical social worker is necessary to remove a clear and direct impediment to the effective treatment of the patient's medical condition or to the patient's rate of recovery. To be considered "clear and direct," the behavior or actions of the family member or caregiver must plainly obstruct, contravene, or prevent the patient's medical treatment or rate of recovery. Medical social services to address general problems that do not clearly and directly impede treatment or recovery as well as long-term social services furnished to family members, such as ongoing alcohol counseling, are not covered.

General Principles Governing Reasonable and Necessary Physical Therapy, Speech-Language Pathology Services, and Occupational Therapy – The service of a physical therapist, speech-language pathologist, or occupational therapist is a skilled therapy service if the inherent complexity of the service is such that it can be performed safely and/or effectively only by or under the general supervision of a skilled therapist. To be covered, assuming all other eligibility and coverage criteria have been met, the skilled services must also be reasonable and necessary to the treatment of the patient's illness or injury or to the restoration or maintenance of function affected by the patient's illness or injury. It is necessary to determine whether individual therapy services are skilled and whether, in view of the patient's overall condition, skilled management of the services provided is needed.

What steps must be taken to receive Medicare covered home health services?

1. **Patient has a face-to-face visit with the physician.**

   A face-to-face encounter with the physician must occur no more than 90 days prior to, or within 30 days after, the planned start of the home health services care. The primary reason of the visit is to establish the patient's need for home health services, and the physician must be an allowed provider type. The certifying physician must document the date of the encounter.

   If the patient is starting home health services directly after discharge from an acute/post-acute care setting where the physician, with privileges, that cared for the patient in that setting is certifying the patient's eligibility for the home health benefit, but will not be following the patient after discharge, then the certifying physician must identify the community physician who will be following the patient after discharge.

2. **Physician establishes a Plan of Care for home health services.**

   The orders should state the required skilled services and specifically indicate the frequency of the home health aide services required by the patient. Frequency for home health aide should stipulate any needs for multiple visits within a single day (i.e. morning/evening). One of the criteria that must be met for a patient to be considered eligible for the home health benefit is to

This document was created on March 29, 2016.
It is not intended to resolve the systemic issues and coverage improvements needed within the Medicare system. It is intended to act as a guide for ALS patients to immediately access existing Medicare benefits.

be under the care of a physician. Otherwise, the certification is not valid. The certification must be completed prior to the Home Health Agency bills Medicare for reimbursement; however, physicians should complete the certification when the Plan of Care is established, or as soon as possible thereafter.

If the plan of care includes a course of treatment for therapy services:

- The course of therapy treatment must be established by the physician after any needed consultation with the qualified therapist;
- The plan must include measurable therapy treatment goals which pertain directly to the patient's illness or injury, and the patient's resultant impairments;
- The plan must include the expected duration of therapy services; and
- The plan must describe a course of treatment which is consistent with the qualified therapist's assessment of the patient's function.

3. **The Physician's office is required to fax the orders to the Home Health Agency (HHA) being referred to provide the home health services.**

The fax is typically sent within 24-36 hours from commencement of doctor orders.

- Home Health Agencies for Original/Traditional Medicare must be Medicare-Certified.
- Home Health Agencies for Medicare Advantage (MA) Plans must follow the specific requirements of the MA plan.
- The Home Health Agency (HHA) must be acting upon a physician Plan of Care that meets the requirements for HHA services to be covered.

4. **The Home Health Agency (HHA) will schedule to meet with the patient/family to perform an evaluation/intake assessment.**

The meeting is typically conducted within 36-72 hours of receipt of referral. The evaluation/intake assessment meeting gathers information which contributes to the Plan of Care for medically necessary skilled services and home health aide services. A combination of the doctor orders and the evaluations by Home Health Agency skilled staff determines the specificity of the Plan of Care. The orders on the Plan of Care must indicate the type of services to be provided to the patient, both with respect to the professional who will provide them and the nature of the individual services, as well as the frequency of the services.

Depending on the skillsets being ordered for the patient, the Home Health Agency will advise whether additional evaluation meetings with the patient are necessary.

5. **Home Health Agency (HHA) informs patient/family if they are able to provide all the required home health services as defined in the doctor orders**

This document was created on March 29, 2016.
It is not intended to resolve the systemic issues and coverage improvements needed within the Medicare system. It is intended to act as a guide for ALS patients to immediately access existing Medicare benefits.

6. **If Home Health Agency (HHA) accepts the patient for services, the 60-day episode commences.**

7. **During the 60-day episode, skilled services are to conduct the 30-day assessment.**

8. **Approximately day 55 of the 60-day episode, either recertification is initiated or the patient is discharged from the Home Health Agency (HHA).**

   Note: No changes are to be made to the Plan of Care, nor should discharge commence, without physician approval. While others from the Home Health Agency (HHA) contribute to the Plan of Care, the physician has overall accountability for the Plan of Care and is required to be the approving signature. If the estimate is for greater than 60 days, the physician should state "likely into the foreseeable future but a minimum of 60 days, subject to re-review at recertification".

The Home Health Agency (HHA) as an Obstacle

Often, Home Health Agencies attempt to reduce the home health aide services for an ALS patient to 1-3 bath hour visits per week and refuse to allow the patient to receive services with their Home Health Agency (HHA) when doctor orders require home health aide hours in excess of 3 bath hours per week. There is a higher frequency of HHAs claiming staffing issues and refuse to mitigate staffing requirements "by arrangement" (a Medicare procedure that allows for staffing through another Medicare certified agency). HHAs also will cite Medicare does not pay for home health aides. This refusal from HHAs to provide all home health services is not acceptable for an ALS patient who is confined to the home. It is important to be able to educate Home Health Agencies of the medical necessity of the patients' needs for all disciplines, including home health aide services for personal care and in support of skilled services.

It is important to understand and help a family member be comfortable with not being able or willing to do baths and various exercises in support of skilled services with the patient. There are many reasons why a family member or other non-skilled person may not be able or willing to assume such tasks. No person should feel "guilty" or coerced into providing services which Medicare considers as reasonable and necessary covered services provided by a home health aide. Per Medicare: "Ordinarily it can be presumed that there is no able and willing person in the home to provide the services being rendered by the HHA unless the patient or family indicates otherwise and objects to the provision of the services by the HHA, or unless the HHA has firsthand knowledge to the contrary."

The example Medicare provides is classic for an ALS patient requirements for reasonable and necessary home health aide services for both personal care and in support of skilled services:

EXAMPLE 1:
A patient who lives with an adult daughter and otherwise qualifies for Medicare coverage of home health services, requires the assistance of a home health aide for bathing and assistance with an

This document was created on March 29, 2016.
It is not intended to resolve the systemic issues and coverage improvements needed within the Medicare system. It is intended to act as a guide for ALS patients to immediately access existing Medicare benefits.

exercise program to improve endurance. The daughter is unwilling to bathe her elderly father and assist him with the exercise program. Home health aide services would be reasonable and necessary.

Why should A PATIENT ADVOCATE be present during the assessment?

The importance of a Home Health Agency assessment/intake meeting with patient/family must be articulated to those in attendance for such a meeting. It is highly recommended to have an "impartial" **patient advocate** participate in the HHA Evaluation/Intake Assessment meeting. How the intake assessment is conducted and medical necessity is communicated in great detail is critical to achieving the highest quality and quantity of medically-necessary home health services allowed by Medicare policy and regulations in accordance with supporting doctor orders. The importance of a patient advocate being available and present for these intake assessments with the patient/family will contribute significantly to assist the intake person in achieving a greater depth in understanding the patient's medical needs beyond what may be written in doctor orders or visually perceived during the intake assessment meeting.

What if home health aide services are inaccurately deemed unnecessary?

When a patient/family communicates a need for home health aide services or caregiver help, it must not be immediately discredited as custodial and non-covered. An ALS patient who meets the criteria of confined to home will most definitely have needs for medically-necessary skilled services, including home health aide services both for personal care and in support of skilled services. It is important to listen with empathy and understand that the 'conversational request' is based on frame of reference and typically with no knowledge of how to correctly word/phrase requests.

Why are Medicare Home Health Services defined as part-time or intermittent?

The term "part-time or intermittent" for purposes of coverage under §1861(m) of the Act means skilled nursing and home health aide services furnished any number of days per week as long as they are furnished (combined) less than 8 hours each day and 28 or fewer hours each week (or, subject to review on a case-by-case basis as to the need for care, less than 8 hours each day and 35 or fewer hours per week).

- Medicare Home Health Services *permits continuous episode recertifications* for patients who continue to be eligible for the home health benefit.
- Medicare *does not limit* the number of continuous episode recertifications for beneficiaries who continue to be eligible for the home health benefit.
- Skilled care may be necessary to improve a patient's current condition, *to maintain the patient's current condition, to prevent or slow further deterioration of the patient's condition.*

This document was created on March 29, 2016.
It is not intended to resolve the systemic issues and coverage improvements needed within the Medicare system. It is intended to act as a guide for ALS patients to immediately access existing Medicare benefits.

What if the patient requires more hours than allowed by Medicare?

If a patient's personal circumstances requires more hours than what Medicare Home Health Services covers, this DOES NOT eliminate the patient from Medicare Home Health Services eligibility. It simply means the patient/family will have a multi-layer support system solution to meet the patient needs. Medicare only covers up to a maximum of 35 hours per week.

What should be expected during the Home Health Agency (HHA) evaluation/intake assessment meeting?

The information listed below is a helpful guide for patient/family to expect as part of the information gathering and exchange during the HHA evaluation/intake assessment meeting. The plan of care must contain all pertinent diagnoses, including:

- The patient's mental status
- The types of services, supplies, and equipment required
- The frequency of the visits to be made
- Prognosis
- Rehabilitation potential
- Functional limitations
- Activities permitted
- Nutritional requirements
- All medications and treatments
- Safety measures to protect against injury
- Instructions for timely discharge or referral
- Any additional items the HHA or physician chooses to include

What is the frequency of assessments during a 60-day episode?

At least once every 30 days, for each therapy discipline for which services are provided, a qualified therapist (instead of an assistant) must provide the ordered therapy service, functionally reassess the patient, and compare the resultant measurement to prior assessment measurements. The 30-day clock begins with the first therapy service (of that discipline) and the clock resets with each therapist's visit/assessment/measurement/documentation (of that discipline).

What if the patient is denied of coverage or refused to Home Health Services (HHS)?

Anytime a verbal denial for coverage is discussed whether it is by the medical staff, the home health agency staff, equipment providers, insurance providers - ALWAYS ask for the denial in writing AND a copy of the actual documentation the person is using to support their claims of a denial. Too often,

This document was created on March 29, 2016.
It is not intended to resolve the systemic issues and coverage improvements needed within the Medicare system. It is intended to act as a guide for ALS patients to immediately access existing Medicare benefits.

misinterpretations of coverage (or rumors) are passed around from various sources. Verbal denials of coverage have no weight/value when needed to file an appeal for denial of coverage.

Denials must always be in writing if a patient is to appeal a denied claim. If someone refuses to provide a written denial, follow up with the person in email to convey your understanding of the denial and ask for an exact copy of the document source to support their denial claim.
If a Home Health Agency refuses to provide services altogether, be sure to ask the reasons why. Ask for it in writing. Follow up with an email or other form of written communication to confirm your understanding of their refusal to provide services. It is always important to create an audit trail.

Where do I go for more information?

For supporting data on Medicare Home Health Services coverage, please reference:

Center for Medicare Advocacy:
http://www.medicareadvocacy.org/medicare-info/home-health-care/

Chapter 7 Medicare Home Health Services Benefits Manual
(detailed information about coverage)
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c07.pdf

Medicare Certified Home Health Agencies by Zip Code
(Be sure to select Home Health Agencies which provide services in all disciplines. A 'red X' will indicate which skilled services an agency may not provide.):
https://www.medicare.gov/homehealthcompare/

Source:

This document has been created utilizing readily available, public documents, including:
Chapter 7 Medicare Home Health Services Benefits Manual
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c07.pdf

This document was created on March 29, 2016.
It is not intended to resolve the systemic issues and coverage improvements needed within the Medicare system. It is intended to act as a guide for ALS patients to immediately access existing Medicare benefits.