Center for Medicare Advocacy

ALS - MAP

Medicare Access Project For People Living with ALS

Medicare Home Health Coverage And Case Studies

ALS-MAP@MedicareAdvocacy.org

Center for Medicare Advocacy

- CMA has been a Medicare leader since 1986.
- A national, non-profit, non-partisan law organization providing education, advocacy and assistance to help people with disabilities and older people obtain fair access to Medicare and quality health care.
- Headquartered in DC & CT
  - With additional attorneys in MA, NJ, CA

- This webinar is sponsored and made possible by the ALS Association.
- Webinar Agenda:
  - Summary of Medicare Home Health Coverage
  - Two Case Studies
  - Questions & Answers

Re-Cap:
Medicare Home Health Coverage

Basic Criteria For Medicare Home Health Coverage

- Services must be ordered by a physician
  - Under a written Plan of Care
  - After a "Face to Face" meeting with the physician or his/her nurse, Physician Assistant
    - (F2F form must completed and signed by physician)
- Beneficiary must be "confined to home" (Homebound)
- Care must be provided by, or under arrangements with, a Medicare-certified HH agency

Summary: Home Health Coverage

- To Qualify/Trigger Coverage
  - Need Intermittent Skilled Nursing, or PT or ST
  - If met then…
- Covered Services
  - Nurse, PT, SLP, OT, Home Health Aides…
- Can "Split Bill" (Medicare + another payment source)
- Restoration potential is not the deciding factor
- No duration of time limitation

Basic Coverage Criteria (Cont.)

- To trigger coverage, beneficiary must require a skilled service:
  - "Intermittent" nursing services; or
  - Skilled PT or SLP services
    - OT to continue but not to trigger coverage

Basic Coverage Criteria Confined To Home ("Homebound")

Intent: Provide home health care for people who lack an ordinary ability to leave home

- Individual must:
  - Require assistance of an individual or supportive device to leave home
  - Require "considerable and taxing effort" to leave home
  - Contraindicated to leave due to his or her medical conditions

42 USC § 1395f(a)(2)(C)

Homebound

- May leave home to receive health care treatment
  - Physician, medical needs, therapy not available at home
- Regular attendance at Adult Day-Care program = leaving for healthcare treatment if adult day program is therapeutic, psychosocial, or for medical treatment
  - ADC must be state licensed, certified, or accredited

Homebound

Other Absences From Home

- "…..occasional absences from home for non-medical purposes, e.g. an occasional trip to the barber, a walk around the block or a drive, attendance at a family reunion, funeral, graduation, or other infrequent or unique event would not necessitate a finding that the patient is not homebound…."

  Medicare Benefit Policy Manual (CMS Pub. 100-2), Ch. 7, Sec. 30.1.1 (6/27/2015)

- Attendance at religious services are OK – explicitly defined by law as infrequent or short duration

What Services Will "Trigger" Coverage? (Qualify an Ind. For Coverage)

42 CFR § 409.40 et seq

- To trigger coverage, beneficiary must require a skilled service:
  - Intermittent skilled nursing services; or
  - Skilled PT or ST services
    - OT to continue but not to trigger coverage

Intermittent Nurse Services (To Trigger/Qualify for Coverage)

Intermittent Skilled Nursing

- Intermittent means:
- Recurring - At least once every 60 days, but…
- Less than 7 days per week, except…
  - SN 7 days per week for 21 days or less, with extensions
    - If the need for daily care has an expected finite and predictable end point

Intermittent Nurse Services (To Trigger/Qualify for Coverage)

- Dr. can recertify if need for daily care doesn't end after 21 days as expected, but there must be an expectation that daily nursing need will end
  - Exception: Insulin injections when individual can not self-inject (Medicare Benefit Policy Manual Ch. 7, Sec. 40.1.2.4A2)

Intermittent Nurse Services (To Trigger /Qualify for Coverage)

Intermittent Skilled Nursing

- What if individual needs ongoing daily nursing?
  - If daily need is not expected to end:
    - See if another service can trigger coverage
      - Physical Therapy (PT), Speech Therapy (ST)?
- Reminder: Limit on daily nursing is to trigger coverage not for receipt of intermittent nursing once HH coverage is triggered

What Services Can Be Covered?
(Once Coverage is "Triggered")

- Skilled Nursing (SN)
- Physical Therapy (PT)
- Speech Language Pathology (SLP)
- Occupational Therapy (OT)
- Home Health Aides (Personal, hands-on care)
- Medical Social Services
- Medical Supplies (Related to the illness /injury)
  - Examples: catheters ostomy supplies
  - Not DME / Prosthetics & Orthotics → Covered under Part B

Covered Services (Cont.)

Skilled Services

- Skilled services (SN, PT, SLP, OT) must be medically reasonable and necessary
  - "Skilled" = Qualified professional is needed for the care to be safe & effective
    - To provide or supervise the care
  - Skilled Nursing / Therapy defined at 42 CFR §409.33
    - Same specific list of skilled nursing/therapy as for nursing home care 42 CFR § 409.42

What if the Home Health Agency Says Medicare Won't Cover?

- Tell the agency to submit a "Demand Bill" to Medicare for all the coverable services on the plan of care
  - Up to 35 hrs. / wk. of home health aide and nursing combined and PT, SLP, OT, other "dependent services"
  - Home Health Agency should use "Code 20" on the claim form so a medical review is done

Summary: Home Health Coverage

- Basic Criteria to Qualify for Coverage
  - Homebound
  - Need Intermittent Skilled Nursing, or PT or SLP
- Covered Services
  - Nurse, PT, SLP, OT, Home Health Aides…
- Can "Split Bill"
- Restoration potential not the deciding factor
- No duration of time limitation

Case Study #1

- It is February 1, 2016. Mr. Gehrig has ALS. He has traditional Medicare coverage in addition to health insurance through his wife's small business. His wife, Eleanor, is his caregiver. His neighbor comes by the house a few hours daily to keep him company. Mr. Gehrig currently uses a cane to help steady him as his balance is worsening. He now needs assistance 24 hours a day, 7 days a week.

Case Study #1

- Although it takes Mr. Gehrig hours to groom and dress, and his stamina is quickly depleted, he is able to leave the house for health care appointments (including at an ALSA Certified Center multidisciplinary clinic), church services, weekly support group meetings, brief errands, occasional special celebrations, and daily short outings in his neighborhood park.

Case Study #1

- Mr. Gehrig requires PT - for ROM to help slow progression and maintain his current functioning as long as possible, and to receive respiratory therapy treatments; SLP - for an SGD assessment and training; OT - to develop feeding and other ADL strategies for his changing needs; occasional SN - to routinely assess his overall treatment plan relative to his condition; daily SN - to observe Mr. Gehrig's new gastrostomy site for 10-14 days until healed and to train about tube feedings; medical social services - to help Mr. and Mrs. Gehrig adjust to their changing lives; and, an aide - to care for his personal needs when Mrs. Gehrig is working in her home office or meeting clients - about 30 hours a week, or running errands - about 15 hours a week. Three nights a week, 8 hours each night, Mr. Gehrig needs an aide to assist him when he awakens.

Case Study #1

- Mr. Gehrig contacts his doctor for an appointment to discuss home health services. They meet and plan for services to begin on March 1, 2016.

Case Study #1

Overview of Qualifications for Coverage

- Mr. Gehrig's Home Health Services Are Reasonable and Necessary
- There is No Willing and Able Caregiver Available During Some Periods of Time
- Mr. Gehrig is Homebound
- Physician Duties Include the Following:
  - Certification (With a Face-To-Face Encounter)
  - Plan of Care, Which Includes the Following –
    - All Pertinent Diagnoses
    - Identification of the Course of Treatment
    - An Order for Home Health Care Services
    - Justification of Home Health Aide & Skilled Nursing hours Beyond 28/Week
- Finding a Medicare Certified Home Health Agency
- Services Provided Under Arrangement By the HHA
- Recertification for Subsequent Episodes of 60 Days
- Payment for Non-Medicare Covered Services

Case Study #1

Services Are Medically Reasonable and Necessary

- Objective clinical evidence regarding Mr. Gehrig's need for skilled care must be documented. (20.1.2)
- The need for skilled care is based on information reflected in the home health plan of care, the OASIS (home health assessment needs tool), or a medical record of Mr. Gehrig. (20.1.2)
- When a family member or other person is, or will be, providing services that adequately meet Mr. Gehrig's needs, it would not be reasonable and necessary for HHA personnel to furnish such services. It is presumed there is no able and willing person unless Mr. or Mrs. Gehrig indicates otherwise or the HHA has first-hand knowledge to the contrary. (20.2)

Case Study #1

There is No Willing/Able Caregiver, Unless Indicated

- Mr. Gehrig's wife is unable to care for his some of his skilled needs (such as evaluating SGD needs, developing OT strategies, and assessing the overall treatment plan).
- Mrs. Gehrig has indicated that she is willing and able to care for her husband's personal needs except during her 30 scheduled weekly work hours, her 15 hours a week she does errands, and 3 nights a week when he needs care if he awakens. (see 40.1.1, Example 5).
- Mr. Gehrig's neighbor is unwilling to care for his personal needs at any time.

Case Study #1

Mr. Gehrig is Homebound/Confined to Home

- Because of ALS, Mr. Gehrig is unable to ambulate safely without the use of an assistive device (his cane). He is normally unable to leave his home because of the considerable and taxing preparation involved to groom and dress and because of his diminished stamina. When he does leave home, it is either for brief periods or infrequently. (See 30.1.1)

Case Study #1
Duties of Mr. Gehrig's Physician

- Mr. Gehrig must be under the care of a physician who is qualified to sign the physician certification and the plan of care. 42 C.F.R. 424.22; (30.3)

Case Study #1
Physician Certification

- A "certification" is considered to be anytime that a Start of Care OASIS assessment is completed to initiate care. (30.5.1)
- A physician must certify that:
  - Home health services are needed because Mr. Gehrig is confined to home,
  - Mr. Gehrig needs intermittent skilled nursing, physical therapy, or speech language pathology (note: only skilled services MUST be certified),
  - A plan of care has been established and is reviewed periodically,
  - Services will be furnished under the care of a physician, **and**
  - Mr. Gehrig's face-to-face encounter with his physician must be documented.

Case Study #1
Physician Certification

- The face-to-face encounter must be as follows:
  - Mr. Gehrig's face-to-face meeting with his physician occurred no more than 90 days prior to, or within 30 days after the start of, home health care (between January 1, 2016 and March 30, 2016),
  - It was related to the primary reason Mr. Gehrig requires home health services, his ALS diagnosis,
  - It was performed by an allowed provider type (in Mr. Gehrig's case, his certifying physician), **and**
  - The certifying physician must also document the date of the encounter. (30.5.1-30.5.1.1)

Case Study #1
Plan of Care Overview

- The plan of care must contain all **pertinent diagnoses** and include a **course of treatment** for therapy services. (30.2.1)
- The **orders** on the plan of care must indicate: 1. The nature of the service(s); 2. The type of professional who will provide the service(s); and 3. The frequency of the service(s). (30.2.2)
- The plan of care must be reviewed and signed by the physician who established the plan of care, in consultation with the HHA [note: and hopefully the patient and family] at least every 60 days. Each review must contain the signature of the physician and the date of review. (30.2.6).
- Must reflect the physician ordered services that the HHA provides either directly or under arrangement – HHA is responsible for payment under arrangement. (10.11.C.; 10.11.E.)

Case Study #1

Plan of Care – Pertinent Diagnoses

- The plan of care must contain all the pertinent diagnoses, including:
  - Mr. Gehrig's mental status; types of services, supplies and equipment required; 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; and, any additional items the HHA or physician chooses to include. (30.2.1)

Case Study #1

Plan of Care – Course of Therapy Treatment

- The course of Mr. Gehrig's therapy treatment must be established by his physician (after any needed consultation with the qualified therapist),
- The plan must include the following:
  - Measurable therapy goals which pertain directly to Mr. Gehrig's illness,
  - Expected duration of therapy services, and
  - A description of a course of treatment consistent with the qualified therapist's assessment of Mr. Gehrig's function. (30.2.1)

Case Study #1
Example of Physician Orders (Skilled)

- **SN x 7/wk x 14 days; 1/wk x 8 wk** (Skilled nursing visits 7 times per week for 14 days; 1 times per week for 8 weeks); daily for skilled observation and evaluation of the gastrostomy site healing process and infection checks and trainings on tube feedings [detail]; weekly for overall plan of care assessment and management.
- **PT x 2/wk x 8 weeks** (Physical therapy visits 2 times per week for 8 weeks); for skilled range of motion extremity exercises to minimize pain, maintain functioning or slow progression of loss of function, physiotherapy and lung capacity measurements; seating clinic at New Rochelle Hospital outpatient clinic and wheelchair adjustments prn.
- **SLP x 10/8 weeks** (Speech language pathology visits 10 times over 8 weeks); arrangements to be made with the HHA to have an SLP at the ALSA Certified Center at Columbia University evaluate and train for appropriate SGD selection and use.

Case Study #1
Example of Physician Orders (Unskilled)

- MSS x 1/wk x 8 weeks (medical social service visits 1 time per week for 8 weeks for Mr. Gehrig and assistance with community resources)
- MSS x 1/wk x 4 weeks (medical social service visits 1 time per week for 4 weeks for Mr. and Mrs. Gehrig to help develop communication and coping skills)
- HHA x 5/wk x 8 wk (home health aide 9 hours/day, 5 days a week) visits for toileting, dressing, bathing, feeding, light meals, laundering of personal items and bedding, other personal care services prn
- HHA x 3/wk x 8 wk (home health aide 8 hours/night, 3 nights a week) to assist with Mr. Gehrig's needs upon awaking

Case Study #1

Justification of Aide/SN Hours Beyond 28

- Mr. Gehrig has no willing and able caregiver 66 hours each week during the day, yet he needs constant assistance 24 hours a day, 7 days a week, for his own safety.
- Mr. Gehrig is not able to perform any self-care tasks without the potential to harm himself.
- Note: Medicare may only cover up to a combined 35 hours per week of skilled nursing and aide services, but Mr. Gehrig's secondary insurance will pay for the remaining 31 hours of care each week. Medicare allows this type of split billing. (50.7.1)

Case Study #1

Where to Find a Medicare Certified Home Health Agency

- Medicare Home Health Compare by Zip Code in New Rochelle, NY (10804): **https://www.medicare.gov/homehealthcompare/results.html#loc=10804&lat=40.9492193&lng=-73.7889689**
- Clinician referrals
- ALS Association referrals
- Support group referrals

Case Study #1

How Services Are Provided By Arrangement With The HHA

- Once Mr. Gehrig chooses a HHA, his HHA must provide all the covered home health services (except DME) either directly or under arrangement, and must bill for such covered home health services. (10.11; 10.11.E.)
- Home health services provided under arrangement at hospitals, SNFs, or rehabilitation centers when they involve equipment too cumbersome to bring to the home, or are furnished while the patient is at the facility to receive such services, are included in the HHA base payment rates.
- A HHA would not be responsible for payment in the situation in which they have no prior knowledge (unaware of physician orders) of the services provided by an entity during an episode to Mr. Gehrig who is under their home health plan of care.

Case Study #1

Recertification for Subsequent 60 Day Episodes

- The initial episode of care was March 1, 2016 – April 29, 2016.
- Medicare Conditions of Participation require that the recertification assessment be done during the last 5 days of the previous episode (days 56-60). 42 C.F.R. 484.55(d)(1). The recertification assessment should be done between April 25th and the 29th. (10.4.B.)
- The 2nd 60 day episode will be from April 30, 2016 through June 28. The recertification assessment for the 3rd 60 day episode should be done between June 24th and the 28th.

Case Study #1

Payment for Non-Medicare Covered Services

- Mr. Gehrig has secondary health insurance through his wife. Since her business has less than 100 employees, Medicare is the primary insurance.
- Medicare will cover up to 35 hours per week of combined skilled nursing and home health aide services.
- Mr. Gehrig's additional 31 hours per week of home health aide services may be covered by his secondary health insurance.

Case Study #2

- Mrs. Adams was diagnosed with ALS 2 years ago. She is a widow and lives alone. Her two adult daughters and their families live about an hour away from her.
- Mrs. Adams is enrolled in a Medicare Advantage (MA) plan. She has been receiving home health coverage for PT 1x/wk, OT 1x/wk, nursing 2x/wk, and home health aides 2x/day Mon – Fri.
- Mrs. Adams was told her home health coverage was ending because she was "stable in her disease state".
- She called the Center for help.

Case Study #2

- Can the HH agency be persuaded to continue care – as ordered by the physician?
- Did Mrs. Adams get a written denial notice?
  - If so, get a copy
- Did the Dr. who ordered HH care discharge her HH care?
- Will the Dr. support continued HH care?
  - If so, obtain Dr's active support
  - If possible in writing
- Try to speak to nurse, PT and OT re the care they've been providing and the continued need for that care

Case Study #2

- Goal: Keep care in place
- Call HH agency to try to keep care in place
- After learning the facts
- After speaking to Dr. and HH nurse, therapists
- If HH agency can't be convinced to continue care, appeal the denial
  - Be certain deadline for doing so is met
  - Get written support from Dr. to include with appeal

Case Study #2

- **Issues Presented**
  - Medicare when condition is "stable"/ not improving
  - Amount of coverable care/services
  - Length of time Medicare HH coverage can continue
  - Responsibility/ability of family to provide care
  - Medicare Advantage v. traditional Medicare
    - Application of Medicare law
    - Ability to advocate with HH agency

Case Study 2 Issues: Coverage When Condition Is Stable Or Not Improving

- **Restoration potential <u>is not</u> a basis for denial of coverage**
  - "Even if full recovery is not possible, a patient may need skilled services to prevent further deterioration or preserve current capabilities" (42 CFR § 409.32)
- **Improvement is not required for a service to be skilled – and covered**
  - *Jimmo v. Sebelius* Settlement

Case Study 2 Issues: Coverage When Condition Is Stable Or Not Improving

- "…There must be an expectation that the beneficiary's condition will improve materially in a reasonable (and generally predictable) period of time …**OR** the skills of a therapist must be necessary to perform a safe and effective maintenance program."

42 CFR § 409.44(c)(2)(iii)

Case Study 2 Issues: How Much and How Long Can Care Be Covered?

- Up to 28 to 35 hours per week combined of nursing and home health aide services (Medicare Act: 42 USC 1395x(m))
  - In practice, difficult to find an agency to provide
- And PT, ST, OT as medically necessary and reasonable
  - Note: OT can qualify as the skilled service to continue coverage, but not to trigger it
- **No duration of time limit**. Coverage is available so long as skilled care required.

Medicare Benefit Policy Manual, Chap. 7, §40.1.1

Case Study 2 Issues: Impact of Family or Caregivers on Coverage

- HH agency should not presume care is actually available
- Or refuse Medicare coverage on grounds it is or should be when it is not
- Is there actually an able and available caregiver who can provide the needed care safely and effectively?

Medicare Policy Manual, Chap. 7 §20.2

Case Study 2 Issues: Medicare Advantage Concerns

- Supposed to provide at least as much coverage as traditional Medicare
  - Same coverage rules apply
  - In practice…
- Harder to work directly with HH agency to continue care

Case Study #2

Resolution

Practical Issues

- Obtaining the full array of needed services
- Obtaining legally allowed 28-35 hours HH aide/nurse
- Maintaining services over the long-term
  - If seek additional care → losing what was provided
  - Being told "not safe," agency doesn't have the staffing,
- Obtaining services from another provider "under arrangements with" the home health agency (PT, ST, OT, HH aides
- Obtaining DME and supplies
- Appealing denials

Questions?

Please send further questions or comments to:
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More information is available at
www.Medicare Advocacy.org

Thank You

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