Welcome to MAP – ALS

Medicare Access Project For People Living with ALS

Medicare Overview - With an Emphasis on the Home Health Care Benefit

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- CMA has been a Medicare leader for 30 years.
- 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 staff nationwide

- This webinar is sponsored and made possible by the ALS Association.
- In today's program CMA will:
  - Introduce Medicare (30 minutes)
  - Discuss the Home Health Benefit (1 hour)
  - Open the discussion for questions and answers (30 minutes)

Medicare For Individuals Living with ALS: An Introduction

Part 1: When Do I Qualify for Medicare?

Part 2: How Do I Enroll in Medicare?

Part 3: What Coverage Does Medicare Offer?

Part 4: What Should I Ask Before I Choose a Medicare Plan?

Part 5: When Am I Allowed to Change Medicare Enrollment?

Part 6: How Does Medicare Coordinate With My Other Coverage Sources?

Center for Medicare Advocacy

Part 1:
When Do I Qualify For Medicare?

Qualifying For Medicare With a Diagnosis of ALS

1. You have been determined, under the Social Security or Railroad Retirement Acts, to meet the criteria for Social Security Disability Insurance (SSDI) or Railroad Disability Benefits (RRDB) based on your own work record, AND
2. You have fulfilled a 5 month waiting period (not including a partial month) beginning from the SSA criteria determined onset date of the disability.

Qualifying for Medicare with a Diagnosis of ALS - Example:

- Mr. Hall was diagnosed with ALS. After he stopped working, he applied for SSDI. SSA criteria determined that the onset date of his disability (the date he became unable to perform substantial gainful work activity) was June 10, 2014.
- Mr. Hall's waiting period for SSA benefit entitlement and Medicare is five months after the 1st of the month in which he was found to be disabled (Jul-Aug-Sep-Oct-Nov) = Dec. 1, 2014.

Qualifying For Medicare With a Diagnosis of ALS

- If you were a government worker who is not insured for disability benefits through SSDI or RRDB:
  - You paid Medicare taxes through your job, but not Social Security taxes, AND
  - You have earned 40 Medicare quarters of coverage, you are eligible for premium-free Part A Medicare.

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Part 2:
How Do I Enroll In Medicare?

Enrolling in Medicare

- You will be contacted by Medicare before you become eligible for Medicare.
- You will be automatically enrolled in Medicare Parts A and B (with the option of turning down Part B, since you must pay a Part B premium if you want Part B or Part C coverage).
- Check to see if you may benefit from using the "Life-Changing Event" Form to save money on Part B premiums. https://www.ssa.gov/forms/ssa-44.pdf
- Late enrollment penalties may apply if Part B is turned down at initial enrollment.

Enrolling in Part B

- Timely enrollment periods:
  - Initial Enrollment Period (IEP)
    - The 7th month period surrounding the SSA notice of disability, or
  - Special Enrollment Period (SEP)
    - Up to 8 months following separation from health insurance coverage based on current employment or spouse's employment

Enrolling in Part B (Cont.)

- Failure to enroll on time may result in a Part B late enrollment penalty
  - 10% for every 12 months not enrolled
- A late enrollment may be allowed during the General Enrollment Period (GEP)
  - Jan 1 – Mar 31. Coverage begins July 1 of that year
  - But individual still may be subject to a late enrollment penalty
- If a late penalty is incurred under age 65, it will end when the individual turns 65 and he/she will receive a new IEP
- If individual was misled by Social Security and in some other circumstances, there can be "good cause" to waive the penalty

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Part 3:
What Coverage Does Medicare Offer?

An Overview of Medicare Coverage: Parts A, B, C and D

- The Medicare Program has **4 Defined Parts**:
- **Part A and Part B** is Traditional (or Original) Medicare
- **Part C** (an alternative to Parts A and B) is Medicare Advantage or Managed Care Medicare
- **Part D** Medicare is for Prescription Drugs

An Overview of Medicare Coverage: Parts A, B, C and D

- **Traditional Medicare:**
  - **Part A** – Inpatient Hospital Care, Skilled Nursing Care, Hospice, Home Health Care
  - **Part B** – Physician Services, Outpatient Hospital Care, Lab Work, Diagnostic Tests, Therapy, Supplies, Equipment, Ambulance, Home Health Care
  - NOTE: Many who opt for Parts A and B also get a Medigap Plan to help cover cost sharing and a Part D Plan.

An Overview of Medicare Coverage: Parts A, B, C, and D

- **Medicare Advantage/Managed Care Medicare:**
  - **Part C** (created in 1997) – An alternative way to receive Parts A and B
  - HMO & PPO networks limit providers
  - Many MA Plans include Part D coverage
  - MA Plans are administered by private insurance companies under contract with CMS
  - MA Plans must follow rules set by CMS

An Overview of Medicare Coverage: Parts A, B, C, and D

- **Prescription Drug Coverage:**
  - **Part D** – Administered by private insurance companies
  - May be a stand-alone prescription plan (PDP)

  Or
  - May be included in a Part C Medicare Advantage Part (MA-PD)

Part 4:
What Should I Ask
Before I Choose A Medicare Plan?

Questions to Ask to Determine the Best Coverage For You

- What coverage options do I have?
  - If I Choose Part A and B Traditional Medicare:
    - What are my Medigap (payments for deductibles, coinsurance, and copays) options?
      - https://www.medicare.gov/supplement-other-insurance/compare-medigap/compare-medigap.html
    - What are my Part D Prescription Drug options?
      - https://www.medicare.gov/part-d/
      - https://www.medicare.gov/find-a-plan/questions/home.aspx

Questions to Ask to Determine the Best Coverage For You

- What coverage options do I have?
  - If I Choose a Part C Medicare Advantage Plan?
    - What MA Plans are available in my service area?
      - https://www.medicare.gov/sign-up-change-plans/medicare-health-plans/medicare-advantage-plans/medicare-advantage-plans.html
    - What available MA Plans include my providers, suppliers, and clinics in their networks?

Choosing the Best Coverage For You

- Major considerations in choosing between Part A and B Medicare or Part C Medicare – Coverage and Cost
  - Coverage:
    - Do your providers/suppliers/clinics accept Medicare?
    - Are your providers/suppliers/clinics "in-network" for the Part C Medicare Advantage Plans you are considering?
    - How important is it for your own providers to co-ordinate your care with you?
    - How important is it that you have less restricted coverage access?

Choosing the Best Coverage For You

- Major considerations in choosing between Part A and B Medicare or Part C Medicare – Coverage and Cost
  - Cost:
    - Are Medigap plans (to pay cost-sharing for Parts A and B) available in your state?
    - Do you qualify for any Medicare Savings Programs?
    - How important is an annual out-of-pocket-maximum?

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Part 5:

When Am I Allowed To Change My Medicare Enrollment?

Changing Medicare Enrollment

- The Annual Co-ordinated Election Period (ACEP) is every October 15-December 7
- You may change from traditional Medicare to an MA Plan OR change from one MA Plan to another OR change from an MA Plan to traditional Medicare.
- Enrollment is effective on the first date of the next calendar year.

Part 6:
How Does Medicare Co-ordinate With My Other Coverage Sources?

Ensure The Proper Order of Payment by Medicare and Other Coverage Sources

1. Provide all types of coverage information on your Initial Enrollment Questionnaire (IEQ)
2. If health coverage changes thereafter, tell Medicare and all your providers and suppliers
3. Confirm this information with the Benefits Coordination and Recovery Center (BCRC) at:
   1-855-798-2627 (TTY 1-855-797-2627)

Who Pays First?

- If you are entitled to Medicare and Medicaid?
  - Medicare pays first, Medicaid second
- If you are under age 65 and covered by a Large Group Health Plan (LGHP = 100+ employees), or you are age 65 or older and covered by a Group Health Plan (GHP = 20+ employees), based on current employment of a spouse?
  - LGHP or GHP pays first, Medicare second
- If you are a Veteran with Veteran's benefits?
  - VA "authorized coverage" coordinates with Medicare coverage, neither pays twice
- If you are covered by COBRA?
  - Medicare pays first, COBRA pays second

A Note of Caution About COBRA

- When you lose employer coverage and have Medicare, you should be aware of the timeframes of the following:
  - The COBRA Election Period,
  - The Part B Enrollment Period, and
  - The Medigap Open Enrollment Period
- These may all have different deadlines that overlap
- What you decide about one type of coverage (COBRA, Part B, Medigap) might cause you to lose rights under other types of coverage.

State Health Insurance Assistance Programs (SHIPS)

Do your own research. Speak with your providers, suppliers, and clinics about what coverage they accept. Then call your state SHIP to confirm your coverage choices and to let you know if you qualify for any Medicare Savings Programs before you make your coverage elections. (Note: In many states SHIPs are called by a different name.)

Find your SHIP here:

https://www.shiptacenter.org/

Medicare For Individuals Living with ALS: An Introduction

- In this section, we discussed:
  - Qualifying for Medicare
  - Enrolling in Medicare
  - Medicare Coverage Overview
  - How to Choose the Medicare Options that Are Right For You, and
  - Co-ordination of Other Benefits with Medicare

Center for Medicare Advocacy

Part 7:
What is Medicare Home Health Coverage?

Basic Criteria For Medicare Home Health Coverage

42 CFR § 409.40 et seq

- Services must be ordered by a physician
  - Under a written Plan of Care
  - After a "Face to Face" meeting
- Beneficiary must be "confined to home" (Homebound)

Basic Coverage Criteria (Cont.)

42 CFR § 409.40 et seq

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

Basic Coverage Criteria (Cont.)

42 CFR § 409.40 et seq

Services must:

- Be medically reasonable and necessary
- Be provided by, or under arrangements with, a Medicare certified home health agency

Basic Coverage Criteria
Confined To Home ("Homebound")

42 USC § 1395f(a)(2)(C)

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

Homebound (Cont.)

Individual must:

1. Have a normal inability to leave home; and
2. Leaving home requires a considerable and taxing effort.

42 USC §1395f(a)(8) – Part A
42 USC §1395n(a)(2)(A)(i) – Part B

Homebound (Cont.)

- May leave home to receive healthcare 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 (Cont.)

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

Homebound (Cont.)

Absences from Home

- Examples
  - A patient paralyzed [from a stroke] who is confined to a wheelchair or requires the aid of crutches in order to walk
  - A beneficiary who has lost the use of his or her upper extremities and, therefore, is unable to open doors, use handrails on stairways. etc., and therefore requires the assistance of another individual on leaving his or her place of residence
  - A patient in the late stages of ALS or a neurodegenerative disability

Medicare Benefit Policy Manual, Ch. 7, Sec. 30.1.1

Homebound (Cont.)
Questions To Ask About Absences

- Wheelchair other assistive devices needed?
- Special transportation arrangements? Needs equipment?
- If electric w/c or scooter: Can't transfer self? Can't dress self? Look for issues like poor grip, upper body paralysis, incontinence, poor vision, mental status, requires escort/another person's assist.
- Evidence of "taxing effort"
- If no physical limitations – Does patient require supervision for safety's sake (Some people with dementia or psychiatric issues)?
- "Patient drives" – Does not always mean not homebound
- Adult Day Care v. Senior Center?
- **Look at individual's overall condition & experience, rather than isolated period(s). MBPM §30.1.1**

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 cover not for receipt of nursing once HH coverage is triggered

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

- Skilled Nursing (SN)
- Physical Therapy (PT)
- Speech Therapy (ST)
- 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.)

How Much and How Long?

- Up to 28 to 35 hours per week combined of nursing and home health aide services
- 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

Covered Services (Cont.)

Skilled Services

- Skilled services (SN, PT, ST, 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

Skilled Nursing Criteria

42 CFR § 409.33(a)

- Observation and Assessment of Changing Condition
  - Management of overall care plan
  - Patient education services
  - Plus other specific services (like intermuscular injections, irrigation of catheter…)

Skilled Nursing Criteria (Cont.)

Observation and Assessment of Changing Condition

- The likelihood of change in a patient's condition requires skilled nursing to identify and evaluate the patient's need for possible modification of treatment, or
- Skilled nursing initiation of additional medical procedures until the medical regimen is essentially stabilized
- Information from the patient's medical history may support the likelihood of a future complication or acute episode and may justify the need for continued skilled observation and assessment beyond a 3 week period

Medicare Benefit Policy Manual (CMS Pub. 100-2), Ch. 7, Sec. 40.1.2.1

Skilled Nursing Criteria, (Cont.)

"Where a patient was admitted to home health care for skilled observation because there was a reasonable potential of a complication or further acute episode, but did not develop a further acute episode or complication, the skilled observation services are still covered for three weeks or so long as there remains a reasonable potential for such a change, complication or further acute episode."

Medicare Benefit Policy Manual, Chapter 7, §40.1.2.1

McDonald v. Shalala
855 F.Supp.658 (D.VT.,1994)

- **"[T]he fact that [the beneficiary] did not experience the complications sought to be avoided by the type of care described in [42 CFR]409.33(a)(1)–(2) does not mean that those services were not reasonably expected to be appropriate treatment** throughout the certification period, and thus reasonable and necessary. To hold otherwise would be illogical.
- The **fact that skilled care has stabilized a claimant's health does not render that level of care unnecessary**: an elderly claimant need not risk a deterioration of his fragile health to validate the continuing requirement for skilled care."

Skilled Nursing Criteria (Cont.)

42 CFR § 409.33(b)

- List of specific services
  - Examples:
    - Intravenous or intramuscular injections
    - Intravenous & enteral feedings
    - Insertion and sterile irrigation of supra pubic catheters

Skilled Nursing Criteria (Cont.)

Examples of Specific Services (Cont.)

- Application of dressing involving prescription medications and aseptic techniques
- Treatment of extensive decubitus ulcers and other widespread skin disorders
- Nasopharyngeal / tracheostomy aspirations

Skilled Nursing Criteria (Cont.)

Overall Management of Care Plan

- When patient requires nurse to manage a combination of non-skilled services
  - Considered reasonable & necessary "when underlying conditions or complications are such that only a registered nurse can ensure that essential non-skilled care is achieving its purpose".
    42 CFR Sec. 409.42(c)(1)i)
  - And a requirement for payment for these services is that in the patient's care plan "the physician includes a brief narrative describing the clinical justification for this need".
    42 CFR Sec. 424.22(a)(1).

Skilled Nursing Criteria (Cont.)

Overall Management of Care Plan

"[We] are not excluding beneficiaries in advanced stages of chronic illness from qualifying for this service. When a chronically ill patient with an underlying condition or complication requires skilled nursing personnel to manage the plan of care then this service is indeed indicated until the treatment regimen has essentially stabilized. If the combination of the patient's underlying condition, age and immobility creates a high potential for serious complications which require that only a registered nurse can ensure that essential nonskilled care is achieving its purpose then the patient is indeed eligible for this service."

Preamble Fed. Regs:

Skilled Nursing Criteria (Cont.)

Patient Education Services 42 CFR § 409.33(a)

We believe it inappropriate to assign specific timeframes for patient education services because the length of time a patient or family or caregiver needs should be determined by assessing each patient's individual condition and other pertinent factors such as the skill required to teach the activity and the unique abilities of the patient. It is important to know that teaching activities must be related to the patient's functional loss, illness, or injury."

74 Fed. Reg. 58115 (Nov. 10, 2009)

Skilled Nursing Criteria (Cont.)

- **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.**

Skilled Therapy
42 CFR § 409.44(c)(2)(iii)

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

Skilled Therapy
42 CFR § 409.33(c)(5)

- **Maintenance rehabilitation therapy is a covered service**
  - **"…when the specialized knowledge of a qualified therapist is required to design and establish a maintenance program based on an initial evaluation and periodic assessment of a patient's needs…"**

Skilled Therapy

- Occupational Therapy (OT) can constitute the triggering skilled service when:
  - OT is ordered in conjunction with some other skilled services (Example: Nursing, PT, or ST) and
  - The other skilled service(s) are discontinued but the OT remains in place

Home Health Therapy v. Outpatient Therapy

HH Therapy

- Part A (and/or Part B)
- PT, ST, OT as ordered and medically necessary & reasonable
- No $ Cap on Coverage
- No duration of time limit
- Paid as part of bundled payment to HH agency

Out Patient Therapy

- Part B
- PT /ST combined and OT
  - $1,940 / Yr. Cap
  - Unless appeal & get an "Exception" and
  - Medical Review after $3,700/Yr.

Jimmo v. Sebelius, No. 5:11-CV-17 (D. VT., Settlement Approved Jan. 24, 2013)

- Federal class action to eliminate improvement standard in skilled nursing facilities (SNFs), home health (HH), outpatient therapy (OPT).
- Filed Jan. 18, 2011; Settled October 2012 (Court approved 1/2013); Back to Court for further implementation: 3/1/2016
- Plaintiffs: 5 individuals and 6 organizations
  1. National MS Society
  2. Alzheimer's Association
  3. National Committee to Preserve Social Security & Medicare
  4. Paralyzed Veterans of America
  5. Parkinson's Action Network
  6. United Cerebral Palsy

What *Jimmo* Means

- CMS revised Medicare policy manuals, guidelines, instructions to "clarify":
  - Coverage does not turn on the presence or absence of potential for improvement but rather on the need for **skilled care**.
  - Services can be skilled and covered when:
    - Needed to maintain, prevent, or slow decline or deterioration; or
    - Skilled professional is needed to ensure services are safe and effective.

Nursing to Maintain Function or Slow Deterioration

- Maintenance nursing services are Medicare-coverable when skilled nursing is necessary to maintain current condition or prevent or slow deterioration so long as the skills of a nurse are required to ensure the services are safe and effective
  - MBPM Ch. 7, 40.1.1
- Decision regarding coverage should turn on whether skill nursing is needed, not whether individual is expected to improve.
  - MBPM Ch. 7, 20.1.2 (Home Health)

Therapy to Maintain Function or Slow Deterioration

"Maintenance Therapy – Where services that are required to maintain current function or to prevent or slow further deterioration are of such complexity and sophistication that the skills of a qualified therapist are required to perform the procedures safely and effectively, the services would be covered physical therapy services."

Medicare Benefit Policy Manual, Chapter 7, §40.2.2.E
(Home Health Care)

Individualized Assessment

- Medicare should not use "rules of thumb"
- Rather, "Determination of whether skilled nursing care is reasonable and necessary must be based solely upon the beneficiary's unique condition and individual needs, without regard to whether the illness or injury is acute, chronic, terminal, or expected to last a long time."
  - Home Health Regs. 42 CFR §409.44(b)(3)(iii)

Jimmo Summary

Questions to Ask:

- Is a skilled professional needed to ensure nursing or therapy is safe and effective? Yes - Medicare covers.
- Is a qualified nurse or therapist needed to provide or supervise the care? Yes - Medicare coverable

Regardless of whether the skilled care is needed to improve, or maintain, or slow deterioration of the condition. Or if condition is "chronic" or "stable" or has "plateaued."

Other "Dependent Services"

- If beneficiary receiving intermittent skilled nursing or PT, ST or continuing OT, then
- Then coverage is also available for "Dependent Services"

Other "Dependent Services"

Home Health Aides

- Remember, 28-35 hour per week limit is in combination with skilled nursing services
  - HH Aides must be providing personal, hands-on-care
  - Homemaker services alone are *not* covered
    - Only allowed if incident to personal hands-on care

Other "Dependent Services"

Home Health Aides

- "Custodial" Care
  - Medicare Act specifically establishes home health aide services as a covered service under the Medicare benefit

42 U.S.C. Sec. 1395x(m); 42 C.F.R. Sec. 409.45

Is Coverage Available If Caregivers Are At Home?

- A patient is entitled to have the costs of reasonable and necessary services reimbursed by Medicare without regard to whether there is someone available to furnish the services…
- Ordinarily it can be presumed that there is no able & willing person at home to provide services rendered by HH aide.
- MBPM Chap. 7 §20.2

Other "Dependent Services"

Additional Services

- Medical social work services
- Occupational therapy (when not a "continuing skilled service")

Summary: Important Coverage Concerns

- Individualized assessment regarding eligibility for coverage is required
- Restoration potential is not the deciding factor
- Medicare should not be denied at any care level because the beneficiary has a chronic condition or needs services to maintain his/her condition
- Skilled therapy and other services may be covered to:
  - Prevent further deterioration
  - Preserve current capabilities
- Home Care can be long term as long as qualifying criteria met

Advance Beneficiary Notices (ABNs)

- New notice approved January 2006
  - Generally must be delivered when agency believes they are about to deliver items and services which do not meet Medicare's coverage criteria at any of three points ("triggering events"):
    - Initiation of services
    - Reduction in services
    - Termination of services (when non-covered care will continue after termination of covered care, along with generic expedited determination notice)
    - Medicare Claims Processing Manual, CMS Pub. 100-04, Ch.60

ABNs and Non-English Proficient Beneficiaries

- Medicare Claims Processing Manual, Chapter 30, states that:
  - An ABN must be written in lay language [Sec.40.3.1.2]
  - An ABN will not be valid if the beneficiary or authorized representative "is incapable of understanding the notice due to particular circumstances (even if others may understand) [Sec. 40.3.1.3]
  - Proper delivery of an ABN occurs when the notice is received and the beneficiary can "comprehend its contents" [Sec. 40.3.4.1]
  - "A person who does not read the language in which the notice is written…is a person for whom receipt of the usual written notice in English may not constitute having received notice at all" [Sec. 40.3.4.3]

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 aid and nursing combined and PT, ST, OT, other "dependent services"
  - Home Health Agency should use "Code 20" on the claim form so a medical review is done

Face to Face Requirements for Certification At Start of Care

- A face-to-face encounter must have "occurred no more than 90 days prior to the home health start of care date or within 30 days of the start of the home health care by including the date of the encounter." The certification of the need for home health care must include an explanation as to why the physician's clinical findings support the need for home health care, including that the patient is homebound and the need for either intermittent skilled nursing services or therapy services as defined in 42 C.F.R. §409.42(a) and (c). The regulations provide that a face-to-face encounter can be by tele-health as provided in §1834(m) of the Social Security Act.

Face to Face Requirements for Certification At Start of Care

- The regulations require that the face-to-face encounter be performed by the certifying physician or by a nurse practitioner, a clinical nurse specialist who is working in collaboration with the physician or a physician assistant under the supervision of the physician. The documentation of the face-to face patient encounter must be a separate and distinct section of, or an addendum to, the certification, and must be clearly titled, dated and signed by the certifying physician. When the face-to-face encounter is performed by a non-physician, he or she must document the clinical findings of the face-to-face encounter and communicate those findings to the certifying physician.
- The Centers for Medicare & Medicaid Services (CMS) has decided to delay implementation of the face-to-face requirement in the home health and hospice settings until the second quarter of Calendar Year (CY) 2011.

Face to Face Requirements for Certification At Start of Care

- Recertification of the need for home health care must be provided at least every 60 days, with a preference for the recertification to occur at the time that the plan of care is revised. The recertification must be signed and dated by the physician who reviewed the plan of care. According to CMS, *recertification does not require Face-to-Face*.

Summary: Home Health Coverage

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

Thank You

This webinar was provided with support from the ALS Association

Please join us for the next half hour to ask questions.

Following the Q&A session.

If you have further questions or comments, please send them to:

ALS-MAP@MedicareAdvocacy.org

We will post responses on the ALS-MAP Web-page at www.MedicareAdvocacy.org.