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MEDICARE HOME HEALTH COVERAGE

Se habla español

Produced under a grant from the
Connecticut State Department on Aging
in conjunction with the CHOICES Program

WHAT IS NEEDED TO QUALIFY FOR MEDICARE HOME HEALTH COVERAGE?

- The patient is homebound. (This does not mean the patient can never leave home. For example, patients can leave home occasionally, go to adult day care, religious services, medical appointments);

- The patient needs skilled nursing on an intermittent basis (from once a day for finite, recurring periods of 21 days at a time, to once every 60 days), or physical therapy, speech therapy, occupational therapy or to continue care,;

- A physician must order the care and sign a "plan of care;"

- A physician or appropriate non-physician health care professional must have seen the patient face-to-face prior to certifying the need for home health services;

- Documentation regarding the face-to-face meeting is present on the home health care certification; and

- The care is provided by, or under arrangements with, a Medicare-certified home health agency.

WHAT SERVICES WILL MEDICARE COVER?

- Part-time and intermittent nursing care provided by or under the supervision of a registered nurse;
- Physical, occupational, and speech therapy;
- Home health aides, to provide hands-on personal care services
- Medical social services provided under the direction of a physician and;

THE PATIENT DOES NOT HAVE TO IMPROVE TO QUALIFY FOR MEDICARE COVERAGE

- Medicare coverage for skilled services does not turn on the presence or absence of a beneficiary's potential for improvement, but rather on the need for skilled care.
- It is not necessary for the patient to improve in order to qualify for Medicare coverage. The patient can have a chronic or long-term condition.
- Skilled nursing and therapy to maintain a patient's condition, or to slow decline, can be covered by Medicare.

UNFAIR DENIALS OF MEDICARE OCCUR WITH SURPRISING FREQUENCY

Because Medicare administrators sometimes use rules and procedures which may improperly restrict coverage and payment, patients are sometimes denied coverage and required to pay for care which should be covered by Medicare.

WHAT TO DO IF MEDICARE COVERAGE IS ENDING OR DENIED

- If the home health agency issues a notice that states services will be ending, the patient has a right to an expedited appeal when "a physician certifies that failure to continue the provision of such services is likely to place [the patient's] health at significant risk."

- Ask the patient's doctor to instruct the home health agency to continue to provide necessary services. Home health care should not be ended or reduced unless the change has been ordered by the doctor.

- The home health agency must give at least two days advanced notice before ending services. A request for an expedited review, orally or in writing, must be made by noon of the next calendar day to preserve expedited appeal rights.

- If the patient receives a written denial from the home health agency, ask the agency, in writing, to submit the claim to Medicare for a coverage determination from the Medicare "Contractor." Sometimes coverage will be granted. If not, further appeal is then possible.

IMPORTANT ADVOCACY TIPS

- There is no legal limit to the duration of the Medicare home health benefit. Medicare coverage is available for necessary home health care even if it is to extend over a long period of time.

- Do not accept arbitrary caps on coverage. For example, don't accept assertions that home health aide services in excess of one visit per day cannot be covered.

- In order to be able to appeal a Medicare denial, the home health agency must file a Medicare claim for the patient's care. If the patient wants to pursue coverage, he/she should tell the home health agency to file a Medicare claim, even if the agency thinks Medicare coverage is not available.

- The doctor is the patient's most important ally. If it appears that Medicare coverage will be denied, ask the doctor who ordered the care to help.

RESTORATION POTENTIAL IS NOT REQUIRED TO OBTAIN MEDICARE COVERAGE.

MEDICARE IS AVAILABLE IF A SKILLED PROFESSIONAL IS NEEDED TO MAINTAIN CURRENT CAPABILITIES OR PREVENT FURTHER DETERIORATION.

MEDICARE COVERAGE SHOULD NOT BE DENIED SIMPLY BECAUSE THE INDIVIDUAL'S CONDITION IS CHRONIC OR EXPECTED TO LAST A LONG TIME.

Need help?

Contact your State's Health Insurance Assistance Program (SHIP)

In Connecticut, this is CHOICES, (800) 994-9422.

There is also a great deal of information and Self-help packets on the Center for Medicare Advocacy's website:
www.MedicareAdvocacy.org

HELP US KEEP THIS INFORMATION AVAILABLE!

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CENTER FOR MEDICARE ADVOCACY, INC.

The Center for Medicare Advocacy, founded in 1986, is a national non-profit law organization that works to ensure fair access to Medicare and quality health care. The Center is based in Connecticut and Washington, DC, with offices around the country.

Based on our work with real people, the Center advocates for policies and systemic change that will benefit all those in need of health care coverage and services.

Staffed by attorneys, legal assistants, nurses, and information management experts, the organization represents thousands of individuals in appeals of Medicare denials. The work of the Center also includes responding to over 7,000 calls and emails annually from older adults, people with disabilities, and their families, and partnering with CHOICES, the Connecticut State health insurance program (SHIP).

Only through advocacy and education can older people and people with disabilities be assured that Medicare and health care are provided fairly:

• We offer education and consulting services to help others advance the rights of older and disabled people and to provide quality health care.

• We draw upon our direct experience with thousands of Medicare beneficiaries to educate policy-makers about how their decisions play out in the lives of real people.

The Center for Medicare Advocacy is the most experienced organization for Medicare beneficiaries and their families.

Visit our website:
www.MedicareAdvocacy.org

Rev. 4/2016