

**Medicare Home Health Coverage
For People with Long-Term
And Chronic Conditions**

ACL Under 65 Project

July 27, 2016

CENTER FOR MEDICARE ADVOCACY

- National, non-profit, non-partisan law organization providing education, advocacy and assistance to help older people & people with disabilities obtain fair access to Medicare and quality health care.
 - Established in 1986
 - Headquartered in DC & CT, with additional attorneys in CA, MA, NJ
- ACL Project – Focusing on the needs of Medicare beneficiaries who are under 65

Agenda

- Medicare Home Health Coverage
 - Criteria for coverage
 - Qualifying for coverage
 - Continuing coverage
 - Emphasis on issues for people with disabilities and long-term conditions
- Review of *Jimmo* case and its impact on home health care

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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)

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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

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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

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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

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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

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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

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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...
 - Can be 7 days per week for 21 days or less,
 - Extensions beyond 21 days if the need for daily care has an expected finite and predictable end point

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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 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

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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

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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

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 (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 (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 (Cont.)

- A patient’s overall medical condition, without regard to whether the illness or injury is acute, chronic, terminal, or expected to extend over a long period of time, should be considered in deciding whether skilled services are needed. A patient’s diagnosis should never be the sole factor in deciding that a service the patient needs is either skilled or not skilled. Skilled care may, depending on the unique condition of the patient, continue to be necessary for patients whose condition is stable.
- MBPM, Chap. 7, §40.1.1 (2014)

Skilled Nursing (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 (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 (Cont.)

42 CFR § 409.33(b)

- **Skilled nursing services defined**
 - **Examples:**
 - Intravenous or intramuscular injections
 - Intravenous & enteral feedings
 - Insertion and sterile irrigation of supra pubic catheters

Skilled Nursing (Cont.)

Specific Nursing Services Defined (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 (Cont.)

- **Restoration potential is not 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

- “...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)

Skilled Therapy (Cont.)

- Maintenance 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...”

42 CFR § 409.33(c)(5)

Skilled Therapy (Cont.)

- **Maintenance Therapy** – Where services that are required to maintain the patient’s 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 procedure safely and effectively, the services would be covered... .”

MBPM, Chap. 7, §0.2.2.E

Skilled Therapy (Cont.)

- 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.

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

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

Other “Dependent Services”

Additional Services

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

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

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



Questions?

***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

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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**
 - Including Nursing and Therapy
 - Services can be skilled and covered when:
 - Skilled professional is needed to ensure services are safe and effective
 - To maintain, prevent, or slow decline

MBPM, Chap.7, §20.1.2

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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)
 - See also 42 CFR §409.44(a)

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.”

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**



Questions?



Next Webinar:

*Transitions Onto (and Off Of) Medicare for
Individuals Under Age 65*

**September 15, 2016
2:00–3:00 PM EDT**

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