

CENTERS for MEDICARE & MEDICAID SERVICES

Medicare & Home Health Care

This **official** government booklet tells you:

- **Who's eligible**
- **What services are covered**
- **How to find and compare home health agencies**
- **Your Medicare rights**

Paid for by the Department of Health & Human Services.

The information in this booklet was correct when it was printed. Changes may occur after printing. Visit [Medicare.gov](https://www.Medicare.gov), or call 1-800-MEDICARE (1-800-633-4227) to get the most current information. TTY users can call 1-877-486-2048.

“Medicare and Home Health Care” isn’t a legal document. Official Medicare Program legal guidance is contained in the relevant statutes, regulations, and rulings.

Table of Contents

Home health care.....	4
Section 1: Medicare Coverage of Home Health Care.....	5
Who's eligible?	5
Eligibility is also based on the amount of services you need	6
How Medicare pays for home health care.....	7
What Medicare covers	8
What isn't covered?	10
What you have to pay	10
Advance Beneficiary Notice of Noncoverage (ABN)	11
Your right to a fast appeal	12
Section 2: Choosing a Home Health Agency	15
Finding a Medicare-certified home health agency	15
Comparing home health agencies.....	15
Comparing quality	16
Home Health Agency Checklist	17
Special rules for home health care	18
Find out more about home health agencies	18
Section 3: Getting Home Health Care	19
Your plan of care	19
Your rights getting home health care	20
Where to file a complaint about the quality of your home health care.....	21
Home Health Care Checklist.....	22
Section 4: Getting the Help You Need	23
Help with questions about home health coverage	23
What you need to know about fraud	24
Definitions	27
Notice of Availability of Auxiliary Aids & Services	29
Nondiscrimination Notice	30

Home health care

Many health care treatments that were once offered only in a hospital or a doctor's office can now be done in your home. Home health care is usually less expensive, more convenient, and just as effective as care you get in a hospital or skilled nursing facility. In general, the goal of home health care is to provide treatment for an illness or injury.

Where possible, home health care helps you get better, regain your independence, and become as self-sufficient as possible. Medicare home health coverage is also, and equally, available to help people maintain their condition or level of function, or to slow decline.

Medicare pays for you to get health care services in your home if you meet certain eligibility criteria and if the services are considered reasonable and necessary for the treatment of your illness or injury.

If you get your Medicare benefits through a **Medicare health plan** (not **Original Medicare**) check your plan's membership materials, and contact the plan for details about how the plan provides your Medicare-covered home health benefits. The coverage rules discussed here also apply to Medicare Advantage and there may be additional benefits available.

Commented [MK1]: This statement is not accurate. Medicare home health coverage is also, and equally, available to help people maintain their condition or level of function, or to slow decline. This statement must accurately reflect the more comprehensive purpose of home health care. (42 CFR 409.32(c); *Jimmo v. Sebelius*)

**Section 1:
Medicare Coverage of Home Health Care
Who's eligible?**

If you have Medicare, you can use your home health benefits if:

1. You're under the care of a doctor, and you're getting services under a plan of care established and reviewed regularly by a doctor.
2. You need, and a doctor certifies that you need, one or more of these:
 - Intermittent skilled nursing care
 - Physical therapy
 - Speech-language pathology services
 - Continued occupational therapy

See pages 8–9 for more details on these services.

3. The home health agency caring for you is approved by Medicare (Medicare-certified).
4. You're **homebound**, and a doctor certifies that you're homebound. Homebound does not mean bedbound or that you can never leave home. To be homebound means:
 - You have trouble leaving your home without help (like using a cane, wheelchair, walker, or crutches; special transportation; or help from another person) because of an illness or injury, or
 - Leaving your home isn't recommended because of your condition, and you're normally unable to leave your home because it's a major effort

You may leave home for medical treatment or short, infrequent absences for non-medical reasons, like ~~attending religious services~~ 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. You can still get home health care if you attend adult day care or religious services.

Commented [MK2]: Medicare Benefit Policy Manual, Ch. 7, 30.1.1(2.)

5. As part of your certification of eligibility, a doctor, or certain health care professionals who work with a doctor (like a nurse practitioner), must document that they've had a face-to-face encounter meeting with you within required timeframes and that the findings of that encounter meeting support that you're homebound and need skilled care.

6. If you meet the conditions above, Medicare pays for your covered home health services for as long as you're eligible and your doctor certifies you need them.

Eligibility is also based on the amount of services you need. Beneficiaries requiring more than intermittent skilled nursing may not be eligible for home care

~~If you meet the conditions above, Medicare pays for your covered home health services for as long as you're eligible and your doctor certifies you need them. If you need more than part-time or "intermittent" skilled nursing care, you aren't eligible may not qualify for home health services. To decide if you're eligible for home health care based on nursing, Medicare defines part-time or "intermittent" as skilled nursing care that's needed or given on either fewer than 7 days each week for an undetermined amount of time or daily for less than 8 hours each day over for up to 21 days (or less) with some exceptions in special circumstances. Hour and day limits may be extended in exceptional circumstances when if your doctor can predict when your need for daily nursing care will end. After receiving daily skilled nursing, a beneficiary could continue with care if the subsequent nursing was needed and given fewer than 7 days a week, or the doctor again predicts daily nursing would only be necessary for up to 21 days.~~

Beneficiaries requiring other skilled services are eligible for nursing care

Intermittent or part-time nursing care may be covered if you also need physical therapy, speech-language pathology or occupational therapy.

Commented [MK3]: This section is incomplete; it sounds like home health coverage is limited to 21 days except in exceptional circumstances. This is not accurate. The 21-day-limit refers to the time during which an individual can receive daily nursing; it is not a general limit on home health care. In fact, the federal regulations note that coverage determinations should be made without regard to whether the illness or injury is acute, chronic, terminal, or expected to last a long time." 42 CFR 409.44(b)(3)(iii). [Emphasis added.] The 21-day-limit statement must be replaced with one that more accurately describes eligibility for home health benefits.

How Medicare pays for home health care

Medicare pays your Medicare-certified home health agency one payment for the covered services you get during a 60-day period. This 60-day period is called an “episode of care.” The payment is based on your condition and care needs. Getting treatment from a home health agency that’s Medicare-certified can reduce your out-of-pocket costs. A Medicare-certified home health agency agrees to:

- Be paid by Medicare
- Accept only the amount Medicare approves for their services

Note: If you get services from a home health agency in Illinois, Florida, Texas, Massachusetts, or Michigan, you may be affected by a Medicare demonstration program. Under this demonstration, your home health agency, or you, may submit a request for pre-claim review of coverage for home health services to Medicare, so you and the home health agency will know earlier in the process if Medicare is likely to cover the services. Medicare will review the information and cover the services if the services are medically necessary and meet Medicare requirements. Your Medicare home health benefits aren’t changing and your access to home health services shouldn’t be delayed by the pre-claim review process. For more information, call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

Medicare’s home health benefit only pays for services provided by the home health agency. Other medical services, like visits to your doctor or equipment, are generally still covered by your other Medicare benefits. Look in your copy of the “Medicare & You” handbook for information on how these services are covered under Medicare. To view or print this booklet, visit [Medicare.gov/publications](https://www.Medicare.gov/publications). You can also call 1-800-MEDICARE if you have questions about your Medicare benefits.

What Medicare covers

If you're eligible for Medicare-covered home health care (see page 5), Medicare covers these services if they're reasonable and necessary for the treatment of your illness or injury:

Skilled nursing care. Medicare covers skilled nursing services when they're given on a part-time or intermittent basis. For skilled nursing care to be covered by Medicare, your care must be necessary and ordered by your doctor for your specific condition. You must not need full-time nursing care indefinitely, and you must be homebound. See page 5.

A registered nurse (RN) or a licensed practical nurse (LPN) provides skilled nursing services. If you get services from a LPN, your care will be supervised by an RN. Home health nurses provide direct care and teach you and your caregivers about your care. They also manage, observe, and evaluate your care. Examples of skilled nursing care include: giving IV drugs, shots, or tube feedings; changing dressings; and teaching about prescription drugs or diabetes care. Any service that could be done safely by a non-medical person (or by yourself) without the supervision of a nurse **isn't** skilled nursing care.

~~Home health aide services may be covered when given on a part-time or intermittent basis if needed as support services for skilled care. Home health aide services must be part of the care for your illness or injury. Medicare doesn't cover home health aide services unless you're also getting skilled care like nursing care or other physical therapy, occupational therapy, or speech language pathology services from the home health agency.~~

Physical therapy, occupational therapy, and speech-language pathology services. Medicare uses these criteria to determine if these therapy services are reasonable and necessary in the home setting:

1. The therapy services must be a specific, safe, and effective treatment for your condition.

Formatted: Underline

Formatted: Font: Not Bold

Commented [MK4]: Home health aide coverage should not be buried in a paragraph that is entitled and describes skilled nursing care. Skilled nursing is not required to have a home health aide; skilled therapy will also trigger coverage for home health aides. While this point is included elsewhere in the text, it is confusing and will not be clear to those who aren't familiar with the home health benefit.

Commented [MK5]: Information about home health aides has been moved to page 9.

2. The therapy services must be complex such that your condition requires services that can only be safely and effectively performed by, or under the supervision of, qualified therapists.
3. Your condition must require one of these:
 - Therapy that's reasonable and necessary to restore function affected by your illness or injury.
 - A skilled therapist to safely and effectively establish a program and perform therapy to help you maintain your current condition or to prevent your condition from getting worse.
4. The amount, frequency, and duration of the services must be reasonable.

Home health aide services. Medicare will pay for part-time or intermittent home health aide services for personal care. ~~Home health aide services may be covered when given on a part-time or intermittent basis if needed as support services for skilled care. Part-time or intermittent services means home health aide services furnished any number of days per week as long as they are furnished less than 8 hours each day and 28 or fewer hours each week, or in certain situations, less than 8 hours each day and 35 or fewer hours per week.~~ Home health aide services must be part of the care plan for your illness or injury. Medicare doesn't cover home health aide services unless you're also getting skilled care, which includes like nursing care, ~~or other~~ physical therapy, ~~occupational therapy, or~~ speech-language pathology services and, continuing occupational therapy from the home health agency.

Commented [MK6]: Medicare Benefit Policy Manual, Ch. 7, 40.

Commented [MK7]: Moved from page 8.

Medical social services. Medicare covers these services when given under the direction of a doctor to help you with social and emotional concerns that may interfere with your treatment or how quickly you recover. This might include counseling or help finding resources in your community.

Medical supplies. Supplies, like wound dressings, are covered when your doctor orders them as part of your care.

Medicare pays separately for **durable medical equipment**. The equipment must meet certain criteria and be ordered by a doctor. Medicare usually pays 80% of the Medicare-approved amount for certain pieces of medical equipment, like a wheelchair or walker. If your home health agency doesn't supply durable medical equipment directly, the home health agency staff will usually arrange for a home equipment supplier to bring the items you need to your home.

Commented [MK8]: Formatted smaller only to preserve pagination.

Note: Before your home health care begins, the home health agency should tell you how much of your bill Medicare will pay. The agency should also tell you if any items or services they give you aren't covered by Medicare, and how much you'll have to pay for them. This should be explained by both talking with you and in writing.

Commented [MK9]: Formatted smaller only to preserve pagination.

The home health agency is responsible for meeting **all** of your medical, nursing, rehabilitative, social, and discharge planning needs, as noted in your home health plan of care. See page 19 for more information. Home health agencies are required to perform a comprehensive assessment of each of your care needs when you're admitted to the home health agency, and communicate those needs to the doctor responsible for the plan of care. After that, home health agencies are required to routinely assess your needs.

What isn't covered?

Here are some examples of what Medicare doesn't pay for:

- 24-hour-a-day care at home.
- Meals delivered to your home.
- Homemaker services, like shopping, cleaning, and laundry.

~~Personal care given by home health aides, like bathing, dressing, and using the bathroom, when this is the only care you need.~~

Talk to your doctor or the home health agency if you have questions about whether certain services are covered. You can also call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

Note: If you have a **Medigap** (Medicare Supplement Insurance) policy or other health coverage, be sure to tell your doctor or other health care provider so your bills get paid correctly.

What you have to pay

You may be billed for these:

- Services and supplies that are never paid for by Medicare, like routine foot care.
- Services and supplies that are usually paid for by Medicare but this time won't be paid for in this instance, when you've agreed to pay for them. The home health agency must give you a notice called the Advance Beneficiary Notice of Noncoverage (ABN) in these situations. See the next page.
- 20% of the Medicare-approved amount for Medicare-covered medical equipment, like wheelchairs, walkers, and oxygen equipment.

Commented [MK10]: While the sentence ends with "when this is the only care you need," the placement of home health aide care in the **Not Covered** section, and the explanation are highly confusing. Like Medical Social Services and Medical Supplies, Home Health Aide care is a "Dependent Service;" coverage for these services is dependent on the individual needing and receiving skilled nursing or therapy. See 42 CFR 409.45. Listing Personal Care home health aide care under "What **Isn't** Covered," while including Medical Social Services and Medical Supplies under "What **Is** Covered," is inaccurate and very confusing. Home Health Aide care is often the difference between an individual being able to stay at home or not. These services are covered and, like the other Dependent Services, must be included in a stand-alone section in the list of what **is** covered on pages 8-10.

Advance Beneficiary Notice of Noncoverage (ABN)

The home health agency must give you a written notice called an “Advance Beneficiary Notice of Noncoverage” (ABN) before giving you a home health service or supply that Medicare probably won’t pay for because of these:

- The care isn’t medically reasonable and necessary.
- The care is **only for** nonskilled, personal care, like help with bathing or dressing.
- You aren’t **homebound**.
- You don’t need skilled care on an intermittent basis.

When you get an ABN because Medicare isn’t expected to pay for a medical service or supply, the notice should describe the service and/or supply, and explain why Medicare probably won’t pay. The ABN gives clear directions for getting an official decision from Medicare about payment for home health services and supplies and for filing an **appeal** if Medicare won’t pay.

In general, to get an official decision on payment, you should do these:

- Keep getting the home health services and/or supplies if you think you need them. The home health agency must tell you how much they’ll cost. Talk to your doctor and family about this decision.
- Understand you may have to pay the home health agency for these services and/or supplies.
- Ask the home health agency to send your claim to Medicare so that Medicare will make a decision about payment. You have the right to have the home health agency bill Medicare for your care.

If **Original Medicare** pays for your care, you’ll get back all of your payments, except for any applicable coinsurance or deductibles, including any coinsurance payments you made for **durable medical equipment**.

The home health agency must also give you the ABN or a “Home Health Change of Care Notice” (HHCCN) when they reduce or stop providing home health services or supplies:

- for business-related reasons, or
- because your doctor has changed or hasn’t renewed your orders.

If a home health agency reduces or stops providing certain services or supplies, you may have the option to keep getting them. The ABN or HHCCN will explain what service or supply is going to be reduced or stopped and give you instructions on what you can do if you want to keep getting the service or supply.

Your right to a fast appeal

When all of your covered home health services are ending, you may have the right to a fast appeal if you think these services are ending too soon. During a fast **appeal**, an independent reviewer called a Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO) looks at your case and decides if you need your home health services to continue. The BFCC-QIO is a group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to people with Medicare.

Your home health agency will give you a written notice called the “Notice of Medicare Non-Coverage” (NOMNC) at least 2 days before all covered services end. If you don’t get this notice, ask for it. Read the notice carefully. It contains important information about the termination of services, including:

- The date all your covered services will end
- How to ask for a fast appeal
- Your right to get a detailed notice about why your services are ending
- Any other information required by Medicare

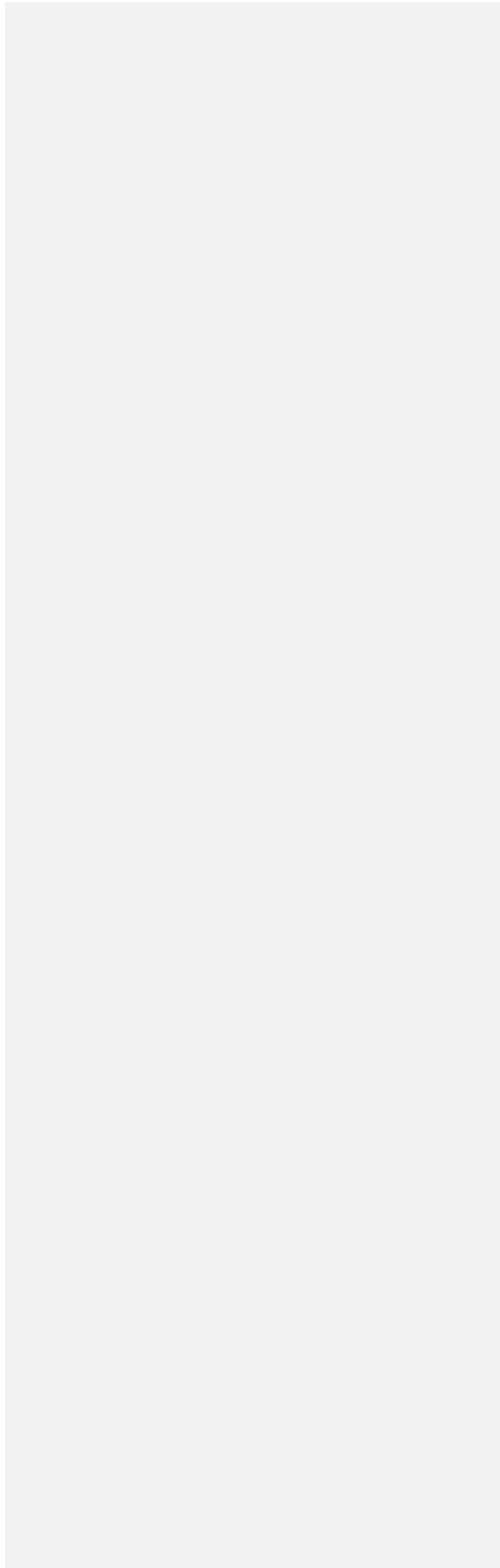
If you ask for a fast **appeal**, the BFCC-QIO will ask why you think coverage of your home health services should continue. The BFCC-QIO will also look at your medical information and talk to your doctor. The BFCC-QIO will notify you of its decision as soon as possible, generally no later than 3 days after the effective date of the NOMNC.

If the BFCC-QIO decides your home health services should continue, Medicare may continue to cover your home health care services, except for any applicable coinsurance or deductibles.

If the BFCC-QIO decides that your coverage should end, you'll have to pay for any services you got after the date on the NOMNC that says your covered services should end. Your home health agency must give you an ABN with an estimate of how much these services will cost.

You may stop getting services on or before the date given on the NOMNC and avoid paying for any further services. If you don't ask for a fast appeal and want to continue getting services after the date listed on the NOMNC, your home health agency must give you an ABN to let you know what you must pay.

For more information on your right to a fast appeal and other Medicare appeal rights, look at your "Medicare & You" handbook or visit [Medicare.gov/appeals](https://www.Medicare.gov/appeals). You can also call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.



Section 2:**Choosing a Home Health Agency****Finding a Medicare-certified home health agency**

If your doctor decides you need home health care, you may choose an agency from the participating Medicare-certified home health agencies that serve your area. Home health agencies are certified to make sure they meet certain federal health and safety requirements. Your choice should be honored by your doctor, hospital discharge planner, or other referring agency. You have a say in which agency you use, but your choices may be limited by agency availability, or by your insurance coverage.

(**Medicare Advantage Plans** or other **Medicare health plans** may require that you get home health services from agencies they contract with.)

Comparing home health agencies

Visit [Medicare.gov/homehealthcompare](https://www.medicare.gov/homehealthcompare) to compare home health agencies in your area. You can compare home health agencies by the types of services they offer and the quality of care they provide. Home Health Compare provides this information about home health agencies:

- Name, address, and phone number
- Services offered, like nursing care, physical therapy, occupational therapy, speech-language pathology services, medical/social services, and home health aide services
- Initial date of Medicare certification
- Type of ownership (For Profit, Government, Non-Profit)
- Information about the quality of care provided (quality measures)

Comparing quality

Some home health agencies do a better job of caring for their patients than others. Home health agencies give quality care when they give their patients care and treatment known to get the best results for each patient's condition. In some cases, the home health agency will help improve the patient's condition. In other situations, it will help maintain a patient's condition or slow his/her decline. Quality measures for "maintenance care" are not included on Home Health Compare. Visit Home Health Compare to see how well health agencies in your area care home for their patients. You can compare agencies based on various measures of quality and against state and national averages.

For patients who are expected to improve, Here's an example of the information you'll find on Home Health Compare:

Quality Measures	Percentage for XYZ Home Care Agency	State Average	National Average
------------------	-------------------------------------	---------------	------------------

Higher Percentages Are Better

Percentage of patients who get better at walking or moving around	71%	76%	82%
Percentage of patients who get better at getting in and out of bed	74%	72%	72%
Percentage of patients who have less pain when moving around	59%	80%	76%
Percentage of patients whose wounds improved or healed after an operation	77%	76%	80%

Home Health Agency Checklist

Use this checklist when choosing a home health agency.

Name of the home health agency:

Commented [MK11]: To leave number 6 in the checklist is to confuse beneficiaries about what they should be asking for when they choose a home health agency. This is a publication about Medicare, to include non-Medicare covered services sets up the beneficiary to think they have covered services when they generally do not, in the case of number 6.

Question	Yes	No	Comments
1. Medicare-certified?			
2. Medicaid-certified (if you have both Medicare and Medicaid)?			
3. Offers the specific health care services I need, like skilled nursing services or physical therapy?			
4. Meets my special needs, like language or cultural preferences?			
5. Offers the personal care services I need, like help bathing, dressing, and using the bathroom?			
6. Offers the support services I need, or can help me arrange for additional services, like a meal delivery service, that I may need? <i>(NOTE: These type of services are not generally covered by Medicare).</i>			
7. Has staff that can provide the type and hours of care my doctor ordered and start when I need them?			
8. Is recommended by my hospital discharge planner, doctor, or social worker?			
9. Has staff available at night and on weekends for emergencies?			
10. Explained what my insurance will cover and what I must pay out-of-pocket?			
11. Has letters from satisfied patients, family members, and doctors that testify to the home health agency providing good care?			

Special rules for home health care

In general, most Medicare-certified home health agencies will accept all Medicare patients. An agency isn't required to accept a patient if it can't meet the patient's medical needs. An agency shouldn't refuse to take a specific Medicare patient because of the patient's condition, unless the agency would also refuse to take other patients with the same condition.

Medicare will only pay for you to get care from one home health agency at a time. You may decide to end your relationship with one agency and choose another at any time. Contact your doctor to get a referral to a new agency. You should tell both the agency you're leaving and the new agency you choose that you're changing home health agencies.

Find out more about home health agencies

Your State Survey Agency, the agency that inspects and certifies home health agencies for Medicare, also has information about home health agencies. Ask them for the state survey report on the home health agency of interest to you. Visit [Medicare.gov/contacts](https://www.medicare.gov/contacts) to get your State Survey Agency's phone number. You can also call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

In some cases, your local long-term care ombudsman may have information on the home health agencies in your area. Visit [ltombudsman.org](https://www.ltombudsman.org). Visit [eldercare.gov](https://www.eldercare.gov), or call 1-800-677-1116. To find out more about home health agencies, you can do any of these:

- Ask your doctor, hospital discharge planner, or social worker. Or, ask friends or family about their home health care experiences.
- Use a senior community referral service, or other community agencies that help you with your health care.
- Look in your phone directory in the Yellow Pages under "home care" or "home health care."

Section 3: Getting Home Health Care

Usually, once your doctor refers you for home health services, staff from the home health agency will come to your home to talk to you about your needs and ask you some questions about your health. The home health agency will also talk to your doctor about your care and keep your doctor updated about your progress. Doctor's orders are needed to start and continue care.

Your plan of care

Your home health agency will work with you and your doctor to develop your plan of care. A plan of care lists what kind of services and care you should get for your health problem. You have the right to be involved in any decisions about your plan of care.

Your plan of care includes these:

- What services you need
- Which health care professionals should give these services
- Visit schedule
- How often you'll need the services
- The medical equipment you need
- What results your doctor expects from your treatment

Your home health agency must provide you with all of the home care listed in your plan of care, including services and medical supplies. The agency may do this through its own staff or through an arrangement with another agency. The agency could also hire nurses, therapists, home health aides, and medical social workers to meet your needs.

Your plan of care (continued)

Your doctor and home health team review your plan of care as often as necessary, but at least once every 60 days. If your health problems change, the home health team should tell your doctor right away. Your health care team will review your plan of care and make any necessary changes with the approval of your doctor. Your home health team should tell you about any changes in your plan of care. If you have a question about your care, or if you feel your needs aren't being met, talk to both your doctor and the home health team.

The home health team will teach you (and your family or friends who are helping you) to continue any care you may need, including wound care, therapy, and disease management. You should learn to recognize problems like infection or shortness of breath, and know what to do or whom to contact if they happen.

Your rights getting home health care

In general, as a person with Medicare getting home health care from a Medicare-certified home health agency, you're guaranteed certain rights, including these:

- To get a written notice of your rights before your care starts
- To have your home and property treated with respect
- To be told, in advance, what care you'll be getting and when your plan of care is going to change
- To participate in your care planning and treatment
- To get written information about your privacy rights and your **appeal** rights
- To have your personal information kept private
- To get written and verbal information about how much Medicare is expected to pay and how much you'll have to pay for services
- To make complaints about your care and have the home health agency follow up on them
- To know the phone number of the home health hotline in your state where you can call with complaints or questions about your care

Visit [Medicare.gov](https://www.Medicare.gov) to learn more about your rights and protections. You can also call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

Where to file a complaint about the quality of your home health care

If you have a complaint about the quality of care you're getting from a home health agency, you should call either of these organizations:

Your state home health hotline. Your home health agency should give you this number when you start getting home health services.

The Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO) in your state. To get the phone number for your BFCC-QIO, visit [Medicare.gov/contacts](https://www.Medicare.gov/contacts). You can also call 1-800-MEDICARE.

Home Health Care Checklist

This checklist can help you (and your family or friends who are helping you) monitor your home health care. Use this checklist to help make sure that you're getting good quality home health care.

When I get home health care

Yes No Comments

1. The staff is polite and treats me and my family with respect
2. The staff explains my plan of care to me and my family, lets us participate in creating the plan, and lets us know ahead of time of any changes.
3. The staff is properly trained and licensed to perform the type of health care I need.
4. The agency explains what to do if I have a problem with the staff or the care I'm getting.
5. The agency responds quickly to my requests.
6. The staff checks my physical and emotional condition at each visit.
7. The staff responds quickly to changes in my health or behavior.
8. The staff checks my home and suggests changes to meet my special needs and to ensure my safety.
9. The staff has told me what to do if I have an emergency.
10. The agency and its staff protect my privacy.

Section 4: Getting the Help You Need

Help with questions about home health coverage

If you have questions about your Medicare home health care benefits or coverage and you're in **Original Medicare**, call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048. If you get your Medicare benefits through a **Medicare health plan**, call your plan.

You may also call the **State Health Insurance Assistance Program (SHIP)**. SHIP counselors answer questions about Medicare's home health benefits and what Medicare, **Medicaid**, and other types of insurance pay for. In addition, these counselors help with these:

- Medicare payment questions.
- Questions about buying a **Medigap** (Medicare Supplement Insurance) policy or long-term care insurance.
- Concerns about payment denials and **appeals**.
- Medicare rights and protections.
- Complaints about your care or treatment.
- Choosing a Medicare health plan.

To get the phone number for your SHIP, visit shiptacenter.org or call 1-800-MEDICARE.

What you need to know about fraud

In general, most home health agencies are honest and use correct billing information. Unfortunately, there may be some who commit fraud. Fraud wastes Medicare dollars and takes money that could be used to pay claims. You play an important role in the fight to prevent Medicare fraud, waste, and abuse.

Look for these:

- Home health visits that your doctor ordered, but that you didn't get.
- Visits by home health staff that you didn't request and that you don't need.
- Bills for services and equipment you never got.
- Fake signatures (yours or your doctor's) on medical forms or equipment orders.
- Pressure to accept items and services that you don't need or that Medicare doesn't cover.
- Items listed on your "Medicare Summary Notice" that you don't think you got or used.
- Home health services your doctor didn't order. The doctor who approves home health services for you should know you, and should be involved in your care. If your plan of care changes, make sure that your doctor was involved in making those changes.
- A home health agency that offers you free goods or services in exchange for your Medicare number. Treat your Medicare card like a credit card or cash. Never give your Medicare or **Medicaid** number to people who tell you a service is free, and they need your number for their records.

The best way to protect your home health benefit is to know what Medicare covers and to know what your doctor has planned for you. If you don't understand something in your plan of care, ask questions.

Reporting fraud

If you suspect fraud, here's what you can do:

- Contact your home health agency to be sure the bill is correct.
- Call the Office of Inspector General Hotline:

Phone: 1-800-HHS-TIPS (1-800-447-8477)

Fax: 1-800-223-2164 (no more than 10 pages)

E-Mail: HHSTips@oig.hhs.gov

Mail: Office of the Inspector General

HHS TIPS Hotline

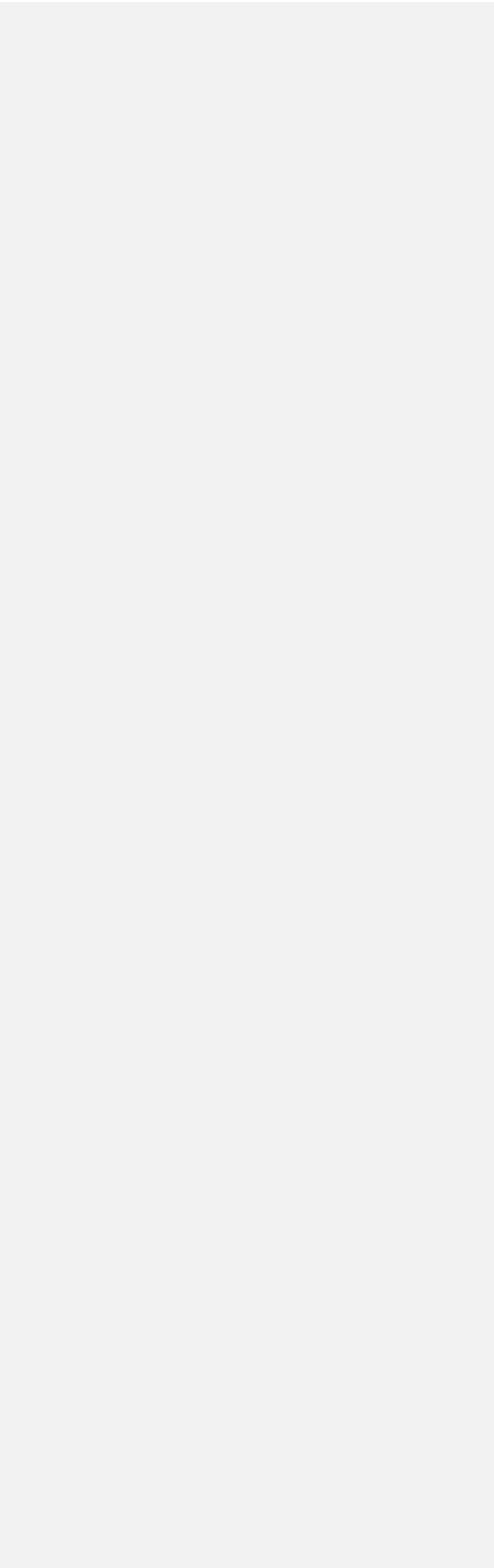
P.O. Box 23489

Washington, DC 20026

Please note that it's current Hotline policy not to respond directly to written communications.

- Call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

Important: If you're reporting a possible case of Medicare fraud, provide as much identifying information as possible. Include the person or company's name, address, and phone number. Details should include the basics of who, what, when, where, why, and how.



Definitions

Appeal—An appeal is the action you can take if you disagree with a coverage or payment decision made by Medicare, your Medicare health plan, or your Medicare Prescription Drug Plan. You can appeal if Medicare or your plan denies one of these:

- Your request for a health care service, supply, item, or prescription drug that you think you should be able to get
- Your request for payment for a health care service, supply, item, or prescription drug you already got
- Your request to change the amount you must pay for a health care service, supply, item or prescription drug

You can also appeal if Medicare or your plan stops providing or paying for all or part of a health care service, supply, item, or prescription drug you think you still need.

Durable Medical Equipment—Certain medical equipment, like a walker, wheelchair, or hospital bed, that's ordered by your doctor for use in the home.

Homebound—To be homebound means:

- You have trouble leaving your home without help (like using a cane, wheelchair, walker, or crutches; special transportation; or help from another person) because of an illness or injury, or
- Leaving your home isn't recommended because of your condition, and you're normally unable to leave your home because it's a major effort

You may leave home for medical treatment or short, infrequent absences for non-medical reasons, like 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, attending religious services. You can still get home health care if you attend adult day care or religious services.

Commented [MK12]: Medicare Benefit Policy Manual, Ch. 7, 30.1.1(2.)

Medicaid—A joint federal and state program that helps with medical costs for some people with limited income and resources. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid.

Medicare Advantage Plan (Part C)—A type of Medicare health plan offered by a private company that contracts with Medicare to provide you with all your Part A and Part B benefits. Medicare Advantage Plans include Health Maintenance Organizations, Preferred Provider Organizations, Private Fee-for-Service Plans, Special Needs Plans, and Medicare Medical Savings Account Plans. If you're enrolled in a Medicare Advantage Plan, most Medicare services are covered through the plan and aren't paid for under Original Medicare. Most Medicare Advantage Plans offer prescription drug coverage.

Medicare health plan—Generally, a plan offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the plan. Medicare health plans include all Medicare Advantage Plans, Medicare Cost Plans, and Demonstration/Pilot Programs. Programs of All-inclusive Care for the Elderly (PACE) organizations are special types of Medicare health plans that can be offered by public or private entities and provide Part D and other benefits in addition to Part A and Part B benefits.

Medigap Policy—Medicare Supplement Insurance sold by private insurance companies to fill “gaps” in Original Medicare coverage.

Original Medicare—Original Medicare is a fee-for-service health plan that has 2 parts: Part A (Hospital Insurance) and Part B (Medical Insurance). After you pay a deductible, Medicare pays its share of the Medicare-approved amount, and you pay your share (coinsurance and deductibles).

State Health Insurance Assistance Program (SHIP)—A state program that gets money from the federal government to give free local health insurance counseling to people with Medicare.

Notice of Availability of Auxiliary Aids & Services

We're committed to making our programs, benefits, services, facilities, information, and technology accessible in accordance with Sections 504 and 508 of the Rehabilitation Act of 1973. We've taken appropriate steps to make sure that people with disabilities, including people who are deaf, hard of hearing or blind, or who have low vision or other sensory limitations, have an equal opportunity to participate in our services, activities, programs, and other benefits. We provide various auxiliary aids and services to communicate with people with disabilities, including:

- **Relay service** — TTY users can call 1-877-486-2048.
- **Alternate formats** — This handbook is available in alternate formats, including large print, Braille, audio CD, or as an eBook. To request the handbook in an alternate format, visit [Medicare.gov/medicare-and-you](https://www.medicare.gov/medicare-and-you).

—To request other Medicare publications in alternate formats, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. —For all other CMS publications, you can do any of these:

1. Call 1-844-ALT-FORM (1-844-258-3676). TTY users should call 1-844-716-3676.
2. Send a fax to 1-844-530-3676.
3. Send an email to altformatrequest@cms.hhs.gov.

4. Send a letter to:

Centers for Medicare & Medicaid Services
Offices of Hearings and Inquiries (OHI)
7500 Security Boulevard, Room S1-13-25
Baltimore, MD 21244-1850
Attn: CMS Alternate Format Team

Note: Your request should include your name, phone number, mailing address where we should send the publication, and the title and product number, if available. If you don't know the title or product number, include a brief description of the publication. Also include the format you need, like Braille, large print, audio CD, or a qualified reader.

Nondiscrimination Notice

The Centers for Medicare & Medicaid Services (CMS) doesn't exclude, deny benefits to, or otherwise discriminate against any person on the basis of race, color, national origin, disability, sex, or age. If you think you've been discriminated against or treated unfairly for any of these reasons, you can file a complaint with the Department of Health and Human Services, Office for Civil Rights by:

- Calling 1-800-368-1019. TTY users can call 1-800-537-7697.
- Visiting [hhs.gov/ocr/civilrights/complaints](https://www.hhs.gov/ocr/civilrights/complaints).
- Writing: Office for Civil Rights U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

7500 Security Blvd. Baltimore, MD 21244-1850

Official Business Penalty for Private Use, \$300

CMS Product No. 10969 Revised March 2017

To get this publication in Spanish, visit Medicare.gov or call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

¿Necesita una copia en Español? Visite Medicare.gov en el sitio Web. Para saber si esta publicación esta impresa y disponible (en español), llame GRATIS al 1-800-MEDICARE (1-800-633-4227). Los usuarios de TTY deben llamar al 1-877-486-2048.