

Medicare Rules

Module Two – Process Requirements

- I. What Medicare covers
- II. PPS
- III. Admission to Homecare
- IV. HHABNs
- V. Hospice

I. What Medicare Covers

A. Home Visits

Medicare pays for home visits by the following:

- ☐ Nurses
- ☐ Physical, Occupational, or Speech-Language Therapists
- ☐ Medical Social Workers
- ☐ Home Health Aides

Note that Medical Social Work and Home Health Aide services are *dependent services*. They cannot establish eligibility for Home Health services, but may be provided if a client meets skilled need criteria for a qualifying service.

Skilled Nursing and Physical, Occupational, and Speech-Language Pathology services were discussed in Module 1.

MSW services are services that are necessary to resolve the social or emotional problems that are or are expected to impede the effective treatment of the patient.

Home health Aides provide personal care. Personal care means bathing, dressing, grooming and other activities of daily living including feeding, assistance with ambulation and bed transfers.

B. Durable Medical Equipment

Medicare pays for the use of durable medical equipment, such as hospital beds, wheelchairs, oxygen and oxygen equipment, when the equipment is necessary and reasonable for the treatment of the patient's illness or injury or to improve the functioning of his or her malformed body member.

II. PPS (Prospective Payment System)

Home Health Agencies are paid under the Prospective Payment System (PPS). PPS pays Home Health agencies a flat rate for each 60-day period of care, referred to as 60-day episodes. The payment for each client is calculated on the basis of information contained in the Outcome and Assessment Information Set (OASIS).

III. Admission to Homecare

A. Initial Assessment

A Registered Nurse, Physical Therapist or Speech-Language Pathologist must conduct an initial assessment visit to determine the immediate care and support needs of the patient and, for Medicare patients, to determine eligibility for the Medicare home health benefit. If the physician has ordered any nursing services, a nurse must perform the initial assessment.

B. Comprehensive Assessment

A comprehensive assessment must be completed no later than 5 calendar days after the start of care. This assessment must be performed by an RN if any nursing services are ordered; otherwise, it may be completed by a PT, SLP, or OT. The assessment must include the Outcome and Assessment Information Set (OASIS), if applicable. OASIS is needed for all patients covered by Medicare or Medicaid, *except* those who are:

- ☐ Under age 18
- ☐ Receiving maternity services
- ☐ Receiving only personal care, homemaker, or chore services

C. Patient Rights

The Home Health Agency must provide patients with a written notice of the patient's rights in advance of furnishing care.

D. Plan of Care

The Plan of Care must indicate the type of services to be provided, both with respect to the type of professional who will provide them and the nature of the individual services, as well as the frequency of the services. The physician must sign the Plan of Care.

E. Recertification

Every 60 days the Nurse or Therapist must review and re-write the Plan of Care, and complete a Follow-Up OASIS. The review/OASIS visit must be made within the last 5 days of the 60-day episode. The new Plan of Care must be reviewed and signed by the ordering physician.

IV. Home Health Advance Beneficiary Notice (HHABN)

Home health agencies are required to provide a notice called an HHABN to Medicare beneficiaries under various circumstances involving the initiation, reduction or termination of services.

When do you issue an HHABN?

A. Initiation

If, at the initial visit, the admitting clinician determines that the client doesn't meet Medicare eligibility criteria, but still opts to admit the client, the clinician must issue an HHABN, offering the client the choice of either:

- a) declining the services;
- b) accepting the services but agreeing to pay for them if Medicare denies payment; or
- c) accepting the services but authorizing the Agency to bill another available insurance, such as Medicaid.

If the clinician isn't sure whether the client meets Medicare eligibility criteria, the clinician can issue an HHABN, offering the client the option of accepting the services, but authorizing the Agency to bill another available insurance, such as Medicaid, *if* Medicare denies payment.

B. Reduction of service (*not* a discharge)

In some cases, such as when a client improves more quickly than anticipated, the Physician may reduce the frequency of visits, or discontinue one service, (such as discontinuing Physical Therapy but continuing Nursing). If this happens, the clinician must issue an HHABN, to notify the client that the Agency is reducing services. A reduction occurs when the Agency will still be billing *some* services to Medicare.

This also applies when re-certifying a client for a subsequent episode, if services will be reduced in the new episode.

A different version of the HHABN, called "Option Box 3" is used for reductions.

C. Termination of service

Typically, when an Agency discharges a Medicare client, the clinician issues a standard discharge notice, the Notice of Medicare Provider Non-Coverage, also called an, "Expedited Determination" notice.

However, in some cases an agency may wish to continue certain services, but stop billing them to Medicare, as, for example, if the client no longer meets Medicare eligibility requirements. A termination occurs when the Agency will no longer be billing *any* services to Medicare.

In this case, the clinician must issue an HHABN, offering the client the choice of either:

- a) declining the services,
- b) accepting the services but agreeing to pay for them if Medicare denies payment, or
- c) accepting the services but authorizing the Agency to bill another available insurance, such as Medicaid.

If at any point during the episode the clinician becomes unsure whether the client meets Medicare eligibility criteria, the clinician can issue an HHABN, offering the client the option of accepting the services, but authorizing the Agency to bill another available insurance, such as Medicaid, *if* Medicare denies payment.

V. **Hospice**

Hospice care is a special type of care for people who are terminally ill. Medicare hospice is available if:

The patient is eligible for Medicare.

The patient's doctor and the Hospice Medical Director certify the patient has a life expectancy of six months or less.

No further aggressive or cure-oriented treatment is desired or recommended.

The patient and family understand hospice philosophy sign a statement choosing hospice care instead of standard Medicare or Medicaid benefits.

The Medicare hospice benefit pays for

Nursing visits



Medical Social Worker visits,

Physical, Occupational, and Speech Therapy visits

Home Health Aides

Homemakers

Hospice Volunteers

Hospice also pays for:

Medication necessary for pain control and symptom management
Durable Medical Equipment.

In certain circumstances Hospice will cover:

Short-term inpatient care of pain control and symptom management
In-patient Respite care for up to five days to give temporary relief.
24-hour-a-day nursing care during periods of crisis.

Quiz

1. Medicare pays for home visits by Nurses, Physical, Occupational, or Speech-Language Therapists, Medical Social Workers, and Home Health Aides.

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2. Medical Social Work and Home Health Aide services cannot establish eligibility for Home Health services.

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3. Home Health Agencies are required to complete an OASIS for all patients over the age of 18 covered by Medicare or Medicaid, except those receiving maternity services or only personal care, homemaker, or chore services.

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4. Only a Registered Nurse or a Physical or Speech therapist can conduct an initial assessment.

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5. The Plan of Care must indicate the type of professional providing services, the specific nature of the service, and the visit frequency.

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6. A new Plan of Care must be developed and signed by the physician every 60 days.

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7. If a client doesn't meet Medicare eligibility requirements, but wishes to be admitted to Home care, the admitting clinician must issue an HHABN.

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8. If at any point a clinician feels a client may not meet Medicare Eligibility requirements, the clinician must issue an HHABN.

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9. If a clinician makes an unanticipated reduction in his visit frequency, he must issue an HHABN.

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10. If an agency wishes to continue services to a client who no longer meets Medicare eligibility requirements, the clinician must issue an HHABN.

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11. In order for a client to be admitted to Hospice care, her physician must certify that she has less than six months to live.
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12. Hospice pays for curative medications and treatments.
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