

# Skilled Services Covered by Medicare in the Home

*A guide to assist physical therapists in determining the appropriate benefit:  
Medicare Part A or Part B*

Home Health

*a product of APTA Home Health, an Academy of the American Physical Therapy Association*

For services to be covered, all services must be medically necessary and certified by a physician before they can be billed to Medicare. Health care providers must perform due diligence to ensure compliance with federal law, federal regulations and state regulations (not described here).

This resource was created under the direction of the Practice Committee of APTA Home Health, an Academy of the American Physical Therapy Association (APTA)

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# Skilled Services Covered by Medicare in the Home

## Resource for determining the appropriate benefit: Part A vs. Part B

	Medicare A	Medicare B
<b>Payment Methodology</b>	<p>Prospective Payment System (PPS)</p> <ul style="list-style-type: none"><li>• Episodic payment currently based on a 60-day episode of care. Beneficiaries can be recertified for an unlimited number of HH episodes as long as the services are medically necessary.</li><li>• Medicare pays for 100% of charges.</li></ul>	<p>Fee for Service (FFS).</p> <ul style="list-style-type: none"><li>• Services are billed with CPT® codes.</li><li>• Charges are paid at 80% of the Medicare allowable per the Medicare Physician Fee Schedule.</li><li>• Beneficiary is responsible for the remaining 20%, although if the beneficiary has a supplemental insurance product, it generally covers this.</li><li>• The beneficiary is responsible for an annual Part B deductible. The deductible is updated annually.</li></ul>

# Skilled Services Covered by Medicare in the Home

## Resource for determining the appropriate benefit: Part A vs. Part B

	Medicare A	Medicare B
<p><b>Services Included in the Payment</b></p>	<p>All services provided are bundled together and paid for through the home health resource grouper (HHRG), including:</p> <ul style="list-style-type: none"> <li>• Skilled nursing services</li> <li>• Home health aide services</li> <li>• Skilled Physical therapy</li> <li>• Skilled Speech-language pathology services</li> <li>• Skilled Occupational therapy services</li> <li>• Medical social services</li> <li>• Some bundled medical supplies</li> </ul>	<p>Services, as described by the CPT® codes, are paid individually.</p> <ul style="list-style-type: none"> <li>• Skilled Physical therapy services</li> <li>• Skilled Speech-language pathology services</li> <li>• Skilled Occupational therapy services</li> <li>• Clinical social work (only when provided by a qualified social worker (MSW, DSW) for the treatment of mental, emotional and/or behavioral illness). Any other service provided by a CSW is non-covered under the Medicare Part B fee schedule.</li> </ul> <p>Outpatient PT, OT, ST services are impacted by the Multiple Procedure Payment Reduction (MPPR) policy: when more than one CPT® code is reported on a claim for PT services, only one code is paid at 100% of its value. The CPT® code with the highest practice value is paid at 100% of its value, while each additional code has its practice expense reduced by 50%. The net effect of the policy is dependent on the number of codes billed, and the value of the code(s) submitted together.</p>

	Medicare A	Medicare B
<p><b>Coverage Criteria</b> (for all coverage criteria, please reference the Medicare Regulations at <a href="http://www.cms.gov">www.cms.gov</a>)</p>	<p>In order for services to be covered under the Part A home health benefit; the following criteria must be met. The patient must be:</p> <ul style="list-style-type: none"> <li>• Confined to the home; (See Table 2 for definition of Homebound)</li> <li>• Under the care of a physician;</li> <li>• Receiving services under a plan of care established and periodically reviewed by a physician;</li> <li>• In need of skilled nursing care on an intermittent basis or physical therapy or speech-language pathology; or have a continuing need for occupational therapy</li> </ul>	<p>In order for services to be covered under the Part B outpatient therapy benefit, the following criteria must be met:</p> <ul style="list-style-type: none"> <li>• Services are required because the individual needs therapy services</li> <li>• A plan for furnishing such services is established by a physician/NPP or by the therapist providing such services and is periodically reviewed by a physician/NPP</li> <li>• Services are furnished while the individual is under the care of a physician</li> </ul> <p>For purposes of billing and medical review, two annual thresholds still exist: When a patient receives <math>\geq</math> \$1,980 PT and ST services in a calendar year, the provider must include a ‘KX’ modifier on every line item. The KX modifier indicates the therapist attests to the fact the therapy services are medically necessary, and the documentation is present to support that fact. When a patient receives <math>\geq</math> \$3,000 PT and ST services in a calendar year, the provider may be subject to the targeted medical review process. For explanation, visit: <a href="https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/TherapyCap.html">https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/TherapyCap.html</a></p> <p>Claims submitted for PT, OT, and SLP services must contain the required functional reporting. (See 42CFR410.59, 60, and 62), Pub. 100-04, Medicare Claims Processing Manual, chapter 5, section 10.6.)</p> <p>The patient’s functional limitations(s) reported on claims, as part of the functional reporting, must be consistent with the functional limitations identified as part of the therapy plan of care and expressed as part of the patient’s long-term goals* (see 42CFR410.61, 42CFR410.105, Pub. 100-04, Medicare Claims Processing Manual, chapter 5, section 10.6.).</p>

# Skilled Services Covered by Medicare in the Home

## Resource for determining the appropriate benefit: Part A vs. Part B

	Medicare A	Medicare B
<b>Nursing Visits</b>	Yes. Generally provided on an intermittent or part-time basis. (See Table 2 for definition of intermittent)	Skilled Nursing visits are not payable as an individual service under the Medicare Part B benefit.
<b>Home Health Aide Services</b>	Yes-on an intermittent basis or part-time basis as long as there is another qualifying discipline providing services concurrently. Home health aide services must be supervised on a regular basis.	Home Health Aide Services are not covered under the Medicare B benefit.
<b>Physical Therapy</b>	Yes	Yes
<b>Speech Therapy</b>	Yes	Yes
<b>Occupational Therapy</b>	Yes. Initially OT must have a qualifying discipline to start episode and qualify client for HH services. On a continuing basis, the HH episode is payable with OT as the sole skilled service	Yes
<b>Social Work Services</b>	Yes, as long as there is another qualifying discipline providing services concurrently.	Yes, if provided by a qualified social worker (MSW, DSW) for the treatment of mental, emotional and/or behavioral illness.
<b>Maintenance</b>	<b>YES</b>	<b>YES</b>

# Skilled Services Covered by Medicare in the Home

## Resource for determining the appropriate benefit: Part A vs. Part B

	Medicare A	Medicare B
<b>Maintenance Services</b>	<p>Lack of progress or rehab potential does not justify denying skilled services under a home health plan of care.</p> <p>Maintenance therapy is covered when a client is no longer progressing, BUT skilled care is required to <b>maintain</b> a clients' level of function. The skills of a professional are needed to maintain, prevent, or slow deterioration of a patient's functionality</p> <p>Skilled nursing is covered under a maintenance plan of care when the skilled care of a licensed nurse is needed due to the complexity of the client. The skilled intervention can only be effectively provided by a skilled nurse.</p> <p>Skilled therapy is covered under a maintenance plan of care, when skilled services are required to maintain current status or prevent further deterioration; for example, the skills of a therapist are required due to the complexity of the client's fluctuating status, and/or there is an ongoing need to utilize clinical decision-making skills during every treatment session.</p> <p>When a patient is under a maintenance plan of care, all the visits must be provided by a physical therapist, rather than a physical therapist assistant.</p> <p>The plan of care should be updated to reflect the decision to have the patient on a skilled plan of care, and goals formulated appropriately.</p> <p>If your therapy could be performed by an unskilled CG, therapy should be discontinued.</p>	<p>Lack of progress or rehab potential does not justify denying skilled services under a home health plan of care. Maintenance therapy is covered when a client is no longer progressing, BUT skilled care is required in order to <b>maintain</b> a clients' level of function. The skills of a professional are needed to maintain, prevent, or slow deterioration of a patient's functionality</p> <p>Skilled therapy is covered under a maintenance plan of care, when skilled services are required to maintain current status or prevent further deterioration; for example, the skills of a therapist are required due to the complexity of the client's fluctuating status, and/or there is an ongoing need to utilize clinical decision-making skills during every treatment session.</p> <p>When a patient is under a maintenance plan of care, all the visits must be provided by a physical therapist, rather than a physical therapist assistant.</p> <p>The plan of care should be updated to reflect the decision to have the patient on a skilled plan of care, and goals formulated appropriately.</p>

# Skilled Services Covered by Medicare in the Home

## Resource for determining the appropriate benefit: Part A vs. Part B

**TABLE 2. Centers for Medicare and Medicaid Services (CMS) Definitions**

Homebound Status defined by Medicare home health benefit must meet the following requirements:

“Confined to the home” (homebound) if the following TWO criteria are met:

1. Criteria-One:

The patient must be either:

- Because of illness or injury, need the aid of supportive devices such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the assistance of another person in order to leave their place of residence

OR

- Have a condition such that leaving his or her home is medically contraindicated.

If the patient meets one of the Criteria-One conditions, then the patient must ALSO meet two additional requirements defined in Criteria-Two below.

2. Criteria-Two

- There must exist a normal inability to leave home;

AND

- Leaving home must require a considerable and taxing effort.

If the patient does in fact leave the home, the patient may nevertheless be considered homebound if the absences from the home are infrequent or for periods of relatively short duration or are attributable to the need to receive health care treatment. Absences attributable to the need to receive health treatment include but are not limited to:

- Attendance at adult day centers (licensed by the state) to receive medical care;
- Ongoing receipt of outpatient kidney dialysis; or
- The receipt of outpatient Chemotherapy or Radiation therapy.

\*Occasional absences from the home for nonmedical purposes, e.g. and 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 if the absences are undertaken on an infrequent basis or are of relatively short duration and do not indicate that the patient has the capacity to obtain the health care provided outside rather than in the home. There is the need for these absences from the home to be infrequent OR of relatively short duration.

Medicare Benefit Policy Manual Chapter 7 Section 30.1.1

“‘Intermittent’ or ‘part time’ means skilled nursing and home health aide services that is either provided or needed on a fewer than 7 days each week or less than 8 hours of each day for periods of 21 days or less (with extensions in exceptional circumstances when the need for additional care is finite and predictable). ... Although most patients require services no more frequently than several times a week, Medicare will pay for part-time (as defined in §50.7) medically reasonable and necessary skilled nursing care 7 days a week for a short period of time (2 to 3 weeks). There may also be a few cases involving unusual circumstances where the patient's prognosis indicates the medical need for daily skilled services will extend beyond 3 weeks.”

Medicare Benefit Policy Manual Chapter 7; Sections 40.1.3, 50.7

# Skilled Services Covered by Medicare in the Home

## Resource for determining the appropriate benefit: Part A vs. Part B

A teamwork approach: Appropriate referrals among med A and med B is the key to providing clinically excellent care

1. A client has been participating in physical therapy under med part B; reasons for referring to med A include but are not limited to....
  - a. A therapist notices there is a stage 1 sacral ulcer when assisting the client with toileting
  - b. A client has pain that is unable to be managed by PT interventions
  - c. A clients BP fluctuates day to day and has variable responses to exercise; a thorough review of medications is needed and education on medication management is required
  - d. A client requires a comprehensive multi-disciplinary approach to ensure safety in the home including nursing care, social work, and home health aids
  - e. A client has a new diagnosis of Diabetes and demonstrates fluctuating BG levels requiring extensive training, education, and potential medication modifications. Client is found to be homebound and severely limited in mobility and unsafe. During assessment it was determined client can benefit from part A services initially prior to part B. This could even be a PT only case at times.
2. A client has been participating in physical therapy under med part A; reasons for referring to med B include but are not limited to:
  - a. Continued skilled therapy is needed and client would like therapy at a gym in her 55+ community that is outside her building
  - b. Client needing skilled therapy to instruct, educate, and determine safe ways for client to resume grocery shopping or other determined ADLs and therapist will be on site to do this at the location.
  - c. Client needs continued skilled therapy in the home but at this point is not homebound. This can include when a client in theory is home bound but the family or client choose to go to the local senior center for supervision or a non-state certified day care center.

MED A or B - Where do we go? – Samples

Scenario 1

Patient has undergone a total knee arthroplasty AND IS REFERRED FOR HOME HEALTH TO BEGIN ON POST OP DAY 3. PATIENT meets all the criteria to qualify for Medicare A in the home environment for the following:

\* Confined to the home; (See Table 2 for definition of Homebound)

\* Under the care of a physician

\* Receiving services under a plan of care established and periodically reviewed by a physician

\* In need of skilled nursing care on an intermittent basis or physical therapy or speech-language pathology; or have a continuing need for occupational therapy

FOLLOWING TWO WEEKS OF PHYSICAL THERAPY, THE PATIENT HAS PROGRESSED TO BE ABLE TO SAFELY EXIT THE HOME AND IS NO LONGER HOME BOUND BECAUSE HE IS ABLE TO LEAVE AT WILL WITHOUT TAXING EFFORT. PATIENT STILL HAS A MEDICAL NEED FOR PT SERVICE, BUT, IS NOT COVERED BY MEDICARE PART A. THERE ARE TWO OPTIONS FOR THE PATIENT TO CONTINUE TO RECEIVE PT IN THE HOME. OPTION 1. COMPLETE AN ADVANCED BENEFICIARY NOTICE (ABN) FINANCIAL NOTICE INFORMING THE PATIENT THAT ANY FURTHER VISITS WOULD NOT BE COVERED BY MEDICARE AND THAT THE PATIENT WAS FINANCIALLY RESPONSIBLE OPTION 2. CONTINUE PT UNDER PART B BILLING. Under the Medicare B criteria, the clinician may either go to their home or office. No Nursing or home health aide allowed for further services, only therapy to complete the POC as set by the team and supervising physician.



# Skilled Services Covered by Medicare in the Home

## Resource for determining the appropriate benefit: Part A vs. Part B

- \* Services are or were required because the individual needed therapy services
- \* A plan for furnishing such services has been established by a physician/NPP or by the therapist providing such services and is periodically reviewed by a physician/NPP
- \* Services are or were furnished while the individual is or was under the care of a physician

### Scenario 2

Patient admitted to home health with a multidisciplinary team for multiple chronic health issues, acute setbacks and multiple comorbidities the related to the chronic reported issues. Clinical team performs objective standardized tests demonstrating a need for POC to provide baselines and get outcomes. Patient shows improvement in three weeks and is retested and shows no change or improvement. Is there a Medical need? Nursing is completed and patient stable. THE PATIENTS CONDITION HAS STABILIZED AS NO FURTHER PROGRESS WAS MADE AND PATIENT'S FUNCTIONAL STATUS IS NOT EXPECTED TO IMPROVE ANY FURTHER AND PATIENT IS NOT AT RISK FOR DETERIORATION, THE PATIENT REMAINS HOME BOUND, BUT, NO LONGER HAS A MEDICAL NEED FOR SKILLED CARE. IS THIS PATIENT ELIGIBLE TO TRANSITION TO MEDICARE B BILLING? MEDICARE B WOULD BE REASONABLE IF THE PROVIDER IS PROVIDING DIFFERENT INTERVENTIONS THAN THOSE PROVIDED RECENTLY UNDER THE PART A EPISODE. IT WOULD NOT BE REASONABLE TO PROVIDE MORE OF THE SAME INTERVENTIONS JUST BY SWITCHING BILLING. MOST APPROPRIATELY MIGHT BE FOR THE PATIENT TO GO TO OUTPATIENT PT UNDER PART B TO UTILIZE MODALITIES NOT ROUTINELY AVAILABLE BY A MEDICARE B PROVIDER IN THE HOME. If the MEDICARE B PROVIDER CAN provide a new POC that ADDRESSES, THE CURRENT HEALTH issues then it will be appropriate to keep the patient in the home under Medicare B otherwise they need to address the transportation and move the patient on to outpatient services.

## References:

Center for Medicare and Medicaid Services. Medicare Benefit Policy Manual (100-2); Chapter 7 – Home Health Services. 2015. Available at: <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c07.pdf>. Accessed 11/25/2015.

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