


# Medicare Part A & Part B Therapy in the Home Setting: *Partners or Rivals?*

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*Value Beyond The Visit*

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## Session Objectives

- Examine the similarities and differences between home health and outpatient therapy
- Clarify “homebound status” in the context of the assisted living environment.
- Discuss challenges and opportunities present for home health in the assisted living environment.
- Create strategies to improve the ability for home health agencies to partner with Part B therapy providers.



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## Taking Your Questions



- Please use the chat box to type in any questions you have about today's topic



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## Similarities



- Skilled
- Reasonable
- Necessary
- Under the care of a physician
- Documentation Fundamentals
- Rehabilitative/Restorative
- Maintenance

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## Skilled

- “The services shall be of such a level of complexity and sophistication or the condition of the patient shall be such that the services required can be safely and effectively performed only by a therapist, or in the case of physical therapy and occupational therapy by or under the supervision of a therapist.”
  - **220.2 - Reasonable and Necessary Outpatient Rehabilitation Therapy Services**
- “The service of a physical therapist, speech-language pathologist, or occupational therapist is a skilled therapy service if the inherent complexity of the service is such that it can be performed safely and/or effectively only by or under the general supervision of a skilled therapist.”
  - **40.2.1 - General Principles Governing Reasonable and Necessary Physical Therapy, Speech-Language Pathology Services, and Occupational Therapy**

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## Role of Diagnosis

- “While a beneficiary’s particular medical condition is a valid factor in deciding if skilled therapy services are needed, a beneficiary’s diagnosis or prognosis cannot be the sole factor in deciding that a service is or is not skilled. The key issue is whether the skills of a therapist are needed to treat the illness or injury, or whether the services can be carried out by non-skilled personnel.”
  - **220.2 - Reasonable and Necessary Outpatient Rehabilitation Therapy Services**
- “While a patient’s particular medical condition is a valid factor in deciding if skilled therapy services are needed, a patient’s diagnosis or prognosis should never be the sole factor in deciding that a service is or is not skilled. The key issue is whether the skills of a therapist are needed to treat the illness or injury, or whether the services can be carried out by *unskilled* personnel.”
  - **40.2.1 - General Principles Governing Reasonable and Necessary Physical Therapy, Speech-Language Pathology Services, and Occupational Therapy**

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## Reasonable & Necessary

- “The amount, frequency, and duration of the services must be reasonable under accepted standards of practice. The contractor shall consult local professionals or the state or national therapy associations in the development of any utilization guidelines”.
- “Skilled therapy services may be necessary to improve a patient’s current condition, to maintain the patient’s current condition, or to prevent or slow further deterioration of the patient’s condition.”
  - **220.2 - Reasonable and Necessary Outpatient Rehabilitation Therapy Services**
- “To be considered reasonable and necessary for the treatment of the illness or injury:
  - ✓ The services must be consistent with the nature and severity of the illness or injury, the patient’s particular medical needs, including the requirement that the amount, frequency, and duration of the services must be reasonable; and
  - ✓ The services must be considered, under accepted standards of medical practice, to be specific, safe, and effective treatment for the patient’s condition, meeting the standards noted below. The home health record must specify the purpose of the skilled service provided.”
  - **40.2.1 - General Principles Governing Reasonable and Necessary Physical Therapy, Speech-Language Pathology Services, and Occupational Therapy**




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## Objective Measures / Evidence

- “Objective evidence consists of standardized patient assessment instruments, outcome measurements tools or measurable assessments of functional outcome. Use of objective measures at the beginning of treatment, during and/or after treatment is recommended to quantify progress and support justifications for continued treatment. Such tools are not required, but their use will enhance the justification for needed therapy.”
  - **220.3 - Documentation Requirements for Therapy Services**


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## Rehabilitative/Restorative

- “Rehabilitative therapy requires the skills of a therapist to safely and effectively furnish a recognized therapy service whose goal is improvement of an impairment or functional limitation.”
  - **220.2 - Reasonable and Necessary Outpatient Rehabilitation Therapy Service**
- “To meet this coverage condition, therapy services must be provided with the expectation, based on the assessment made by the physician of the patient’s restorative potential that the condition of the patient will improve materially in a reasonable and generally predictable period of time. Improvement is evidenced by objective successive measurements.”
  - **40.2.1 - General Principles Governing Reasonable and Necessary Physical Therapy, Speech-Language Pathology Services, and Occupational Therapy**




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## Maintenance



- "Coverage for skilled therapy services related to a reasonable and necessary maintenance program is available in the following circumstances:
  - ✓ **Establishment or design of maintenance programs.** If the specialized skill, knowledge and judgment of a qualified therapist are required to establish or design a maintenance program to maintain the patient's current condition or to prevent or slow further deterioration, the establishment or design of a maintenance program by a qualified therapist is covered.
  - ✓ **Delivery of maintenance programs.** Once a maintenance program is established, coverage of therapy services to carry out a maintenance program turns on the beneficiary's need for skilled care. However, skilled therapy services are covered when an individualized assessment of the patient's clinical condition demonstrates that the specialized judgment, knowledge, and skills of a qualified therapist are necessary for the performance of safe and effective services in a maintenance program. Unlike coverage for rehabilitation therapy, coverage of therapy services to carry out a maintenance program does not depend on the presence or absence of the patient's potential for improvement from the therapy."
- **220.2 - Reasonable and Necessary Outpatient Rehabilitation Therapy Services**




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## Maintenance



- "The patient's clinical condition requires the specialized skills, knowledge, and judgment of a qualified therapist to establish or design a maintenance program, related to the patient's illness or injury, in order to ensure the safety of the patient and the effectiveness of the program, to the extent provided by regulation,
- The skills of a qualified therapist (not an assistant) are needed to perform maintenance therapy:
  - ✓ Assuming all other eligibility and coverage requirements are met, skilled therapy services are covered when an individualized assessment of the patient's clinical condition demonstrates that the specialized judgment, knowledge, and skills of a qualified therapist ("skilled care") are necessary for the performance of a safe and effective maintenance program
  - ✓ Further, under the standard set forth in the previous paragraph, skilled care is necessary for the performance of a safe and effective maintenance program only when (a) the particular patient's special medical complications require the skills of a qualified therapist to perform a therapy service that would otherwise be considered non-skilled; or (b) the needed therapy procedures are of such complexity that the skills of a qualified therapist are required to perform the procedure."
- **40.2.1 - General Principles Governing Reasonable and Necessary Physical Therapy, Speech-Language Pathology Services, and Occupational Physical**




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## Differences



<ul style="list-style-type: none"> <li>• 60 days</li> <li>• OASIS</li> <li>• No co-pay</li> <li>• Visits</li> <li>• F2F</li> </ul>	<ul style="list-style-type: none"> <li>• 90 days</li> <li>• Functional Reporting</li> <li>• Co-pay / Therapy Cap</li> <li>• CPT Codes</li> <li>• Progress reports</li> </ul>
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### Part B Applicable Settings

- “Therapy services are payable under the Physician Fee Schedule when furnished by 1.) a provider to its outpatients in the patient’s home; 2.) a provider to patients who come to the facility’s outpatient department; 3.) a provider to inpatients of other institutions, or 4.) a supplier to patients in the office or in the patient’s home.
- Therapy services are payable when furnished in the home at the same physician fee schedule payment rates as in other outpatient settings. Additional expenses incurred by providers of outpatient therapy due to travel to the beneficiary are not covered.”
- **220.1.4 - Requirement That Services Be Furnished on an Outpatient Basis**




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### Home Health Qualifying Criteria

- “To qualify for the Medicare home health benefit, under §§1814(a)(2)(C) and 1835(a)(2)(A) of the Act, a Medicare beneficiary must meet the following requirements:
  - ✓ Be confined to the home;
  - ✓ Under the care of a physician;
  - ✓ Receiving services under a plan of care established and periodically reviewed by a physician;
  - ✓ Be 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.”
- **20.1.2 - Determination of Coverage / 30 - Conditions Patient Must Meet to Qualify for Coverage of Home Health Services**




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### Homebound Status

- For purposes of the statute, an individual shall be considered “confined to the home” (homebound) if the following **two criteria** are met:



**30.1.1 - Patient Confined to the Home**




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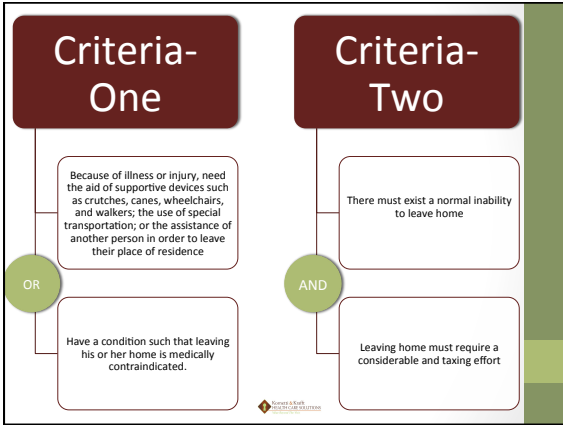
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### Absences from the Home

“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 care treatment include, but are not limited to:

- Attendance at adult day centers to receive medical care;
- Ongoing receipt of outpatient kidney dialysis; or
- The receipt of outpatient chemotherapy or radiation therapy.”

**30.1.1 - Patient Confined to the Home**

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### Other Absences from the Home

“Any other absence of an individual from the home shall not so disqualify an individual if the absence is of an infrequent or of relatively short duration. For purposes of the preceding sentence, any absence for the purpose of attending a religious service shall be deemed to be an absence of infrequent or short duration. It is expected that in most instances, absences from the home that occur will be for the purpose of receiving health care treatment.”

**30.1.1 - Patient Confined to the Home**

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## Absences from the Home

“However, occasional absences from the home for nonmedical 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 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.”



30.1.1 - Patient Confined to the Home

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## Can A Person Choose?

“The aged person who does not often travel from home because of feebleness and insecurity brought on by advanced age would not be considered confined to the home for purposes of receiving home health services unless they meet one of the above conditions.”



30.1.1 - Patient Confined to the Home

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## Outpatient Therapy?

“Although a patient must be confined to the home to be eligible for covered home health services, some services cannot be provided at the patient’s residence because equipment is required that cannot be made available there. If the services required by an individual involve the use of such equipment, the HHA may make arrangements with a hospital, skilled nursing facility (SNF), or a rehabilitation center to provide these services on an outpatient basis. (See §50.6.)”



30.1.1 - Patient Confined to the Home

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### Must Still be Homebound...

“However, even in these situations, for the services to be covered as home health services the patient must be considered as confined to home; and to receive such outpatient services a homebound patient will generally require the use of supportive devices, special transportation, or the assistance of another person to travel to the appropriate facility.”



30.1.1 - Patient Confined to the Home



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### Consolidated Billing

- “For individuals under a home health plan of care payment for all services and supplies, with the exception of the osteoporosis drugs and DME, is included in the PPS episodic rate. HHAs must provide the covered home health services (except DME) either directly or under arrangement, and must bill for such covered home health services.”
- Payment must be made to the HHA.
  - **10.11 - Consolidated Billing**



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### Place of Residence

- An individual may be "confined to the home" for purposes of Medicare coverage of home health services if he or she resides in an institution that is not primarily engaged in providing to inpatients:
  - Diagnostic and therapeutic services for medical diagnosis;
  - Treatment;
  - Care of *injured*, disabled or sick persons;
  - Rehabilitation services or *other skilled services needed to maintain a patient's current condition or to prevent or slow further deterioration*; or
  - Skilled nursing care or related services for patients who require medical or nursing care.
- **30.1.2 - Patient's Place of Residence**



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## Home Health in the ALF

- If it is determined that the assisted living facility (also called personal care homes, group homes, etc.) in which the individuals reside are not primarily engaged in providing the above services, then Medicare will cover reasonable and necessary home health care furnished to these individuals.
- If it is determined that the services furnished by the home health agency are duplicative of services furnished by an assisted living facility (also called personal care homes, group homes, etc.) when provision of such care is required of the facility under State licensure requirements, claims for such services should be denied under §1862(a)(1)(A) of the Act. Services to people who already have access to appropriate care from a willing caregiver would not be considered reasonable and necessary to the treatment of the individual's illness or injury.
  - **30.1.2 - Patient's Place of Residence / A. Assisted Living Facilities, Group Homes, and Personal Care Homes**




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## Home Health in the ALF

- Medicare coverage would not be an optional substitute for the services that a facility is required to provide by law to its patients or where the services are included in the base contract of the facility. An individual's choice to reside in such a facility is also a choice to accept the services it holds itself out as offering to its patients.
  - **30.1.2 - Patient's Place of Residence / A. Assisted Living Facilities, Group Homes, and Personal Care Homes**


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## Specific Part B Billing Issues

- "Under the Medicare law, there is no authority to require a provider to furnish a type of service. Therefore, a hospital or SNF may furnish therapy to its inpatients without having to set up facilities and procedures for furnishing those services to its outpatients.
- However, if the provider chooses to furnish a particular service, it may not charge any individual or other person for items or services for which the individual is entitled to have payment made under the program because it is bound by its agreement with Medicare.
- Thus, whenever a hospital or SNF furnishes outpatient therapy to a Medicare beneficiary (either directly or under arrangements with others) it must bill the program under Part B and may charge the patient only for the applicable deductible and coinsurance"
  - **220.1.4 - Requirement That Services Be Furnished on an Outpatient Basis**




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## Nursing and Aide Services

- If the ALF resident needs one or both of these services and qualifies for home health to provide them, they should be included in the plan of care.
- The ALF resident can choose to continue to pay for one or both of these services.
- Confirmation of offering the choice and the decision of the resident should be documented by the home health agency.




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## Who is the Decision Maker?



Is it an informed decision??




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## Ethical Implications

- If every reasonable effort has been made with no success:
  - Do you walk away from the referrals?
  - Do you consider reporting the facility?
  - What is your obligation?




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### Strategies for Successful Partnerships with Part B Therapy

- ✓ Focus on the skilled needs of the patient
- ✓ Know the rules for both parts of the Medicare benefit
- ✓ Consult with industry experts as indicated
- ✓ Utilize written references for the positions you take
- ✓ Keep the conversation focused on objective information
- ✓ Keep the boundaries clear
- ✓ Educate all parties involved
- ✓ Document your efforts clearly and consistently



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### Are you concerned about protecting the revenue you have earned from providing therapy services?

Kornetti & Krafft Health Care Solutions, physical therapists with over 70 years of clinical, management and ownership experience, is a consulting company with proven home health care solutions in interdisciplinary, patient-centered care management to fortify your agency's fiscal security.



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