

Understanding Medicare Home Health Coverage

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Center for Medicare Advocacy

The Center for Medicare Advocacy, established in 1986, is a national nonprofit, nonpartisan law organization that provides education, advocacy, and assistance to help older people and people with disabilities obtain access to comprehensive Medicare coverage and quality health care. The Center is headquartered in Connecticut and Washington, DC with additional attorneys in California, Massachusetts, and New Jersey.

Key Lessons

1. Medicare covers home health services furnished by, or under arrangement with, a Medicare certified home health agency for beneficiaries who are under the care of a physician and have the following:
 - » A face-to-face (in-person) encounter with a physician or other qualified provider;
 - » A physician's order for home health care services and a Plan of Care;
 - » A normal inability to leave home (Homebound); and
 - » A need for Skilled Nursing and/or Therapy.¹
2. Six types of service are coverable in Medicare home health care—Skilled Nursing, Physical Therapy, Occupational Therapy, Speech Language Pathology, Home Health Aides, and Medical Social Services. Some supplies are also covered.²
3. When found to be Homebound and in need of Skilled Nursing or Therapy, a beneficiary can qualify for Home Health Aides who provide personal care services for less than 8 hours each day and less than 7 days each week (up to 28-35 hours combined with Skilled Nursing services), and/or Medical Social Services.³
4. Reasonable and necessary care can be covered so long as coverage criteria are met.⁴
5. Improvement is not required for coverage. Medicare-covered Skilled Nursing and Therapy include care to maintain an individual's condition or slow decline.⁵

All Medicare beneficiaries are entitled to the same home health coverage under Medicare Parts A and/or B, whether the beneficiary is enrolled in traditional (original) Medicare or a Medicare Advantage Plan.⁶

1 Medicare Home Health Care Statute, 42 U.S.C. § 1361(m).

2 Id.

3 Id.; Code of Federal Regulations 42 C.F.R. § 409.45; Medicare Benefit Policy Manual (MBPM) Chapter 7, § 50.2.

4 42 U.S.C. § 1861(m); 42 C.F.R. § 409.48(a) and (b); MBPM Chapter 7, § 70.1.

5 MBPM Chapter 7, §§ 20.1.2, 40.1, 40.1.1, 40.2 - 40.2.2; [cms.gov/Center/Special-Topic/Jimmo-Center](https://www.cms.gov/Center/Special-Topic/Jimmo-Center).

6 Code of Federal Regulations (C.F.R.), 42 C.F.R. Section 422.101.

Glossary

Beneficiary

People enrolled in Medicare are referred to as beneficiaries.

Beneficiary Payment

If a beneficiary meets the qualifications for Medicare home health care, services do not require a deductible or co-insurance in traditional Medicare. Medicare Advantage plans may impose cost-sharing (deductible, co-insurance, or co-payment) for home health services. A beneficiary should check with a Medicare Advantage plan to determine the plan's cost-sharing.

Caregivers in the Home

Ordinarily it can be presumed that there is no able or willing person in the home to provide services rendered by the home health agency unless the patient or family indicates otherwise.⁷

Face-to-Face Encounter

To certify the need for Medicare home health care, an in-person, “face-to-face” encounter is required by one of the following: the certifying physician, the physician who recently cared for the beneficiary in a facility, a nurse practitioner, a clinical nurse specialist, a certified nurse-midwife, or a physician assistant under physician supervision. The encounter must occur no more than 90 days prior to the home health start of care or within 30 days after the start of care.⁸

Home Health Aides

Home Health Aides are individuals who provide personal hands-on care for the beneficiary, including services needed to maintain the beneficiary's health or to facilitate treatment of the beneficiary's illness or injury. Personal care services include: bathing, dressing, grooming, caring for hair, nail and oral hygiene, changing the bed linens, shaving, deodorant application, skin care, foot care, ear care, feeding, assistance with elimination, assistance with ambulation and transfers, changing positions in bed, assistance with medications and simple dressing changes, and assistance with activities that are directly supportive of skilled therapy services but do not require skills of a therapist to be safe and effective.⁹

Homebound

Beneficiaries must be “homebound” to qualify for Medicare home health coverage. A beneficiary is considered homebound when they have trouble leaving home without help (like using a cane, wheelchair, walker, crutches, special transportation, or help from another person) because of an illness or injury, OR leaving home is not medically recommended because of their condition. In addition, to be considered homebound, a beneficiary must be normally unable to leave home; if they do leave, it requires a major effort.¹⁰

Medical Social Services

Services must be performed by a qualified social worker (or qualified social worker assistant under supervision of a qualified social worker) and must be necessary to resolve the social or emotional problems that are expected to be an impediment to the effective treatment of the beneficiary's condition or to their rate of recovery. Services may also be furnished to a beneficiary's family or caregiver.¹¹

7 Medicare Benefit Policy Manual (MBPM), Chapter 7, Section 20.2, Impact of Other Available Caregivers.

8 MBPM, Chapter 7, Section 30.5.1.1 Face-to-Face Encounter.

9 42 C.F.R. Section 409.45 (b).

10 MBPM, Chapter 7, Section 30.1 Confined to Home.

11 42 C.F.R. Section 409.45 (c); MBPM, Chapter 7, Section 50.3.

Medical Supplies

Medical Supplies are covered as a home health benefit when needed to treat the beneficiary's illness or injury that requires home health care. Supplies may include: catheters, catheter supplies, ostomy bags and supplies relating to ostomy care but excluding drugs and biologicals.¹² Note: Durable medical equipment (DME) is usually covered separately, under Medicare Part B with 20% coinsurance.¹³

Part-Time or Intermittent Services

Skilled nursing and home health aide services that are provided any number of days per week and, combined, less than 8 hours each day and 28 or fewer hours each week (or, subject to review on a case-by-case basis, 35 or fewer hours per week).¹⁴

Physician Order and Plan of Care

A prerequisite for Medicare coverage (a physician's Order or an individualized Plan of Care) must specify the services necessary to meet the patient-specific needs identified in the assessment performed by the home health agency. The Plan of Care must identify the types of services, goals, and the frequency and duration of all visits. Only a physician can certify the Order.¹⁵

Reasonable and Necessary Skilled Care

Services for specific, safe, and effective treatment of the beneficiary's condition that are of such a level of complexity (or the condition of the beneficiary requires such a level of skill), that the services required can safely and effectively be performed only by a qualified skilled nurse or therapist, or qualified assistants.¹⁶

Skilled Nursing

Services that require the skills of a registered nurse, or a licensed practical (vocational) nurse under the supervision of a registered nurse and are reasonable and necessary for the treatment of illness or injury, and services must be intermittent. Coverage of skilled nursing does not turn on the presence or absence of a patient's potential for improvement from nursing, but rather on the need for skilled care.¹⁷

Skilled Therapy

Services that require the skills of a qualified therapist, or qualified therapist assistant, and are reasonable and necessary for the treatment of the patient's illness or injury. Coverage does not turn on the presence or absence of an individual's potential for improvement, but rather on the beneficiary's need for skilled care.¹⁸ While physical therapy or speech-language pathology qualify as skilled services to start care, occupational therapy only qualifies as a skilled service to continue care.¹⁹

12 Code of Federal Regulations (C.F.R.), 42 C.F.R. Section 409.45 (f); MBPM, Chapter 7, Section 50.4.

13 Medicare Benefit Policy Manual (MBPM), Chapter 7, Section 50.4.2

14 Medicare Home Health Statute, 42 United States Code (U.S.C.) Section 1361(m).

15 42 C.F.R. Section 424.22, 484.60; MBPM, Chapter 7, Section 30.2.2.

16 42 C.F.R. Section 409.44 (b) and (c), MBPM, Chapter 7 Section 20.1 and 20.1.2.

17 42 C.F.R. Section 409.44 (b); MBPM, Chapter 7, Sections 40.1 – 40.1.3.

18 42 C.F.R. Section 409.44(c); MBPM, Chapter 7, Sections 40.2 – 40.2.4.3.

19 42 C.F.R. Section 409.44(c).

Home Health Case Examples from the Medicare Benefit Policy Manual

CASE EXAMPLE #1

A patient was discharged from the hospital with an open draining wound that requires irrigation, packing, and dressing twice each day. The home health agency (HHA) has taught the family to perform the dressing changes. The HHA continues to see the patient for the wound care that is needed during the time that the family is not available and willing to provide the dressing changes. The wound care continues to be skilled nursing care, notwithstanding that the family provides it part of the time, and may be covered as long as the patient requires it.²⁰

CASE EXAMPLE #2

A Parkinson's patient may require the services of a physical therapist to determine what type of exercises are required to maintain the patient's present level of function or to prevent or slow further deterioration. Covered skilled therapy would consist of the initial evaluation of the patient's needs; the designing of a maintenance program appropriate to the patient's capacity and tolerance to the treatment objectives of the physician; the instruction of the patient, family, or caregivers to carry out the program safely and effectively (unless the condition of the patient is such that a skilled therapist is needed to ensure the care is delivered safely and effectively); and such reevaluations as may be required by the patient's condition. Each component of this process must be documented in the health record.²¹

CASE EXAMPLE #3

A physician has ordered home health aide visits to assist the patient in personal care because the patient is recovering from a stroke and continues to have significant right side weakness that causes the patient to be unable to bathe, dress, or perform hair and oral care. The plan of care established by the patient's HHA nurse sets forth the specific tasks with which the patient needs assistance. Home health aide visits at an appropriate frequency would be reasonable and necessary to assist in these tasks.²²

Beneficiary Practice Tips

Getting Medicare—Covered Home Health Care Started

A beneficiary should discuss the need for home health care with his/her treating provider. A Physician Order, a Plan of Care, and a Face-to-Face Encounter are required, as described above. Be certain orders and goals for services clearly indicate the intended functional outcome—improvement or maintenance.

Finding a Home Health Agency

A treating provider may recommend a Medicare-certified home health agency. If a beneficiary is in traditional Medicare, additional information about agencies that serve their zip code can be found at Home Health Compare²³ or by calling 1-800-MEDICARE (1-800-633-4227). If a beneficiary is in a Medicare Advantage Plan, information about agencies that are in that Plan's approved network can be found by calling the MA Plan directly. Contact multiple agencies to inquire about services, including agencies that do not have five star quality ratings (quality ratings are highly weighted toward measuring functional improvement).

20 Medicare Benefit Policy Manual (MBPM), Chapter 7, Section 40.1.1, Example 5 (page 42).

21 Medicare Benefit Policy Manual (MBPM), Chapter 7, Section 40.2.2, Example 5 (page 69).

22 MBPM, Chapter 7, Section 50.2, Example 1 (page 76).

23 [medicare.gov/homehealthcompare/search.html](https://www.medicare.gov/homehealthcompare/search.html).

Keeping Benefits in Place

Documentation should explain why continued skilled care is needed and that it was provided. Vague phrases such as “patient tolerated treatment well” or “continue with plan of care” or “patient remains stable” do not provide enough specificity to support coverage. Confirm there is clear, supportive documentation in the medical record, and that requirements are met and services are provided. As a practical matter, a beneficiary may have to accept less services than are optimum and less than is authorized under the law if a home health agency is unable or unwilling to meet all ordered services.

Note: If improvement is initially expected and that goal is reached or changed, get a new order with new goals, if the goal is now to maintain, deter, or slow decline of a condition.

Immediate Appeal to Keep Benefits in Place

When an agency plans to end all home health services, the beneficiary has a right to an expedited (fast) appeal if they think services are ending too soon. The agency must give the beneficiary a written notice called a Notice of Medicare Non-Coverage (NOMNC) at least 2 days before all covered services end. The beneficiary should request an immediate appeal as soon as possible, but no later than noon of the day before the effective date on the NOMNC. The NOMNC contains important information, including a right to get a detailed notice about why services are ending and how to ask for an appeal. In an appeal, the beneficiary should show why care should continue. Get support from the attending physician(s) and other providers, if at all possible. The beneficiary has appeal rights when all covered services are to end, but no appeal rights when home health services are reduced or terminated but other types of services continue.²⁴

Standard Appeal

For those enrolled in traditional Medicare, a home health agency must give a beneficiary an Advanced Beneficiary Notice (ABN) if the agency does not think services will be covered by Medicare. The agency must also give the beneficiary an ABN or Home Health Change of Care Notice (HHCCN) if the agency reduces or stops providing home health services or supplies. The ABN or HHCCN will explain what services or supplies are going to be reduced or stopped and includes instructions about what to do to keep getting those services or supplies. Again, get support from the attending physician(s) and other providers if at all possible.

Note: Review the Medicare Home Health Conditions of Participation that require home health agencies to provide certain beneficiary protections, including a Patient Bill of Rights and a requirement that the patient’s physician agrees if an agency proposes to discharge the patient.²⁵

Resources

- [Center for Medicare Advocacy Medicare Home Health Related Resources](#) (including tool kits, brochures, fact sheets, self-help packets, and other helpful and materials articles)
- [Medicare’s Website Information](#)
- [The Centers for Medicare & Medicaid Services \(CMS\) Official Government Handbook on Medicare Home Health Care](#)
- [Medicare Home Health Compare](#) (to search for Medicare-certified home health agencies by beneficiary zip code)

²⁴ For Original Medicare: 42 C.F.R. Sections 405.1200-1204, Medicare Claims Processing Manual (MCPM) Chapter 30; for Medicare Advantage Plans: 42 C.F.R. 422.624-626; Medicare Managed Care Manual (MMCM) Chapter 13.

²⁵ 42 C.F.R. Section 484.2 through 484.110.

- [Medicare Benefit Policy Manual, Chapter 7 Home Health Services](#)
- [Medicare Claims Processing Manual, Chapter 10 Home Health Agency Billing](#)

Case consultation assistance is available for attorneys and professionals seeking more information to help older adults. Contact NCLER at ConsultNCLER@acl.hhs.gov.

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