PART A HOME HEALTH THERAPY VS OUTPATIENT IN THE HOME PART B THERAPY

	PART A HOME HEALTH	PART B OUTPATIENT BENEFIT
Location of Services	**Only in home**	Home or clinic
Patient Financial Responsibility	Non-advantage plans are $0 co pay so long as criteria met	Non-advantage plans are 20% co-pay so long as criteria met, 20% will be covered by secondary or supplemental insurance, at 1st of year, there may be a deductible, and some advantage plans require pre-authorization or co-pays that are higher
Homebound Criteria	**Yes, MUST be homebound**	**No**
PT, OT, and ST	Yes, all are available	Yes, all are available
Typical amount of visits	4-10 total visits over a 30-60 day period	Up to 24 visits of each PT/OT/ST over 8 weeks At times even 5X a week for a new total knee for example
Purpose	Bridge between new onset of physical or medical issues and becoming safe enough to be at home and get out and or notify someone in case of emergency, get to point where able to get out to get to clinic or doctor's office for intermittent treatment	Rehab to get as high level of independence in Activities of Daily Living (personal care, mobility, etc) as reasonably possible and necessary
Criteria for Restorative Therapy Plan to be Covered by Medicare	**1.** Reasonable- e**xpectation that there is potential to show material functional progress in a 20-30 day period** **2.** Necessary- **related to PRIMARY condition home care episode has been certified by referring physician. Will be needed to allow patient to be safe in their home environment.** 3. Skilled- cannot be easily replicated by someone other than a licensed therapist even if there is no one else available or willing **4. Homebound** 5. Face to Face visit by physician to certify need for the 60 day episode 6. Physician certified Plan of Care every 60 days 7. Therapy must be intermittent and on a regular basis	1. Reasonable- expectation that there is potential to show material functional progress in a 60-90 day period 2. Necessary- related to functional deficits causing issues with ADL or IADL activities 3. Skilled- cannot be easily replicated by someone other than a licensed therapist even if there is no one else available or willing 4. Physician certifies plan of care at least every 90 days 5. Therapy must be intermittent and on a regular basis (at least two times per week)
Includes access to intermittent skilled nursing	Yes, until someone can be safely taught to take over any nursing care	No
Includes access to aide to assist in bathing	Only during bridge period if deemed necessary for short term, cannot be custodial (meaning will be needed for long term or ongoing basis)	No
Cost to Medicare (With attention to a directive of transitioning to Value Based Care, Medicare systems and providers are paying attention to cost of services.)	A typical 60-day episode of Home Care costs Medicare about $4,000	About $1800 over a 60-day period
How many therapy visits per year?	Unlimited so long as criteria is met, though it is a bridge, so typically about 6-10 sessions of therapy for a THERAPY focused case	Criteria must be met, then about 30 visits before there is a medical review which would need to show extenuating circumstances as to why therapy visits have gone past this threshold
Other notes	**Cannot do part A home health (nurse or therapy) and outpatient therapy at same time**	

What is the true definition of being homebound?

It needs to be difficult and taxing, and unreasonable for the patient to leave the home. Plenty of people go to outpatient centers for wound care, IV antibiotics, and more. Being blind, having an arm in a sling, not being able to drive, not having a ride, nor even being in a wheel chair **doesn't make someone homebound**. Leaving home must be at least one of the following examples-

- Completely unsafe, where leaving home can cause a medical emergency
- Inability to be out of home unattended due to cognitive reasons, and no one available to assist out of home
- Leaving home causes such pain that the patient would be incapacitated if it were for anything other than emergencies
- Leaving home causes such shortness of breath, that it is unreasonable to have to be out except for emergency and infrequent situation
- Leaving home requires something like a walker and someone to hold onto the patient and is generally unsafe and difficult and would happen infrequently
- Medical conditions like a compromised immune system makes leaving home unsafe
- Patient is bedbound and taking a stretcher transport is very difficult

The following examples **don't on their own** qualify for meeting homebound status for part A services-

- Being in a wheelchair (plenty of people can wheel themselves or be pushed out of the home, and not having someone to push does not negate the fact that this is a true statement)
- Using a walker or cane
- Being blind (plenty of blind people live alone and navigate city streets every day
- Having a wound tended to by a nurse (plenty of patients get this done a wound care center or doctor's office, home care services should not be used as a convenience measure)

How does Part B billing work?

On average, most therapy sessions are billed out at about $95 to Medicare. This equates to about a $20 patient co-insurance responsibility per visit. Most of the time, supplemental/gap or secondary insurances cover this 20% so there is no out of pocket expense except at the beginning of the first enrollment into Medicare and beginning January 1st every year where often there is a small yearly deductible. Some plans cover this deductible, others do not. If it has not been covered and not met, it will be the patient's responsibility to pay to whichever provider submits a claim first. Most of the time, if you are seen at a clinic, these co-insurance costs and deductibles are collected at the time of service. For home based visits, these charges are collected often times via statements weeks after the treatment.

If therapy is deemed not necessary by Medicare, is the patient then responsible for the full charges?

So long as you do not sign an ABN (advanced beneficiary notice) explaining that therapy will NOT be covered, there is no liability for the patient should the therapy visits be deemed unnecessary by Medicare. If you change your insurance plan at any point after beginning therapy to one that may not have coverage for outpatient therapy services, have an open liability claim (car accident type claim) that you did not disclose, are in an open home health part A episode, do not have insurance coverage for part B, and some other rare instances, then you would have financial liability even if you do not sign an ABN.

If I have used a lot of my therapy benefits this year, can I be refused service?

Technically, you cannot be refused service just because you have utilized a lot of therapy. However, if the treating provider feels that you do not meet the criteria to continue therapy, then they can continue to see you with a signed ABN that explains that you understand you will be responsible for the cost of care. You can always see if another provider feels differently and will see you under your benefits.