

WHAT DOESN'T MEDICARE COVER?

Medicare does **not** pay for the following:

- 24-hour per day care at home,
- prescription drugs,
- meals delivered to your home,
- homemaker services such as shopping, cleaning and laundry,
- personal care given by home health aides, like bathing, using the toilet, or help in getting dressed *when this is the only care you need.*

HOME HEALTH CARE AND HMO COVERAGE

Medicare Advantage plans must cover all Medicare Part A and Part B services, including home health care. If you belong to a Medicare Advantage plan, you need to call your plan to determine how it covers home health care benefits.

If your Medicare Advantage plan thinks you no longer need home health services, it must give you written notice of termination, and you can appeal its decision.

NOTICES OF SERVICES ENDING

If you are not in a Medicare Advantage plan, the agency must give you a notice that explains why and when they think Medicare will stop paying for your home health care services. If you think you still need services at that time, you can request Medicare to continue services by asking the home health agency to send your claim to Medicare. You must keep using home health care during the request process.

Be sure to choose a home health agency that is Medicare approved or one that works with your managed care plan.

Learn more about Medicare by calling 1-800-MEDICARE or 1-800-633-4227. You can also look on the Internet at www.medicare.gov to get help with your Medicare questions.



Home Health Care Under Medicare

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Senior Citizens' Law Office is funded in part by the City of Albuquerque Area Agency on Aging, Bernalillo County, the Center for Civic Values (IOLTA Program), Sandia Foundation's Hugh and Helen Woodward Fund of the Albuquerque Community Foundation, the State Bar Pro Hac Vice Fund, McCune Charitable Foundation, and United Way of Central New Mexico.

AVAILABILITY OF HOME HEALTH CARE

All Medicare beneficiaries may be entitled to home health care benefits. If *medically necessary*, you can get the following services:

- **skilled nursing care** on a part-time or intermittent basis.
- **home health aide services** that include help with personal care, such as bathing, using the toilet or dressing, as part of the home care for your illness or injury.
- **therapies** such as physical, speech or occupational for regaining or strengthening skills.
- **medical social services** which might include counseling or help in finding resources in your community.
- **certain medical supplies**, like wound dressings, but not drugs or prescriptions.
- **medical equipment**, such as a wheelchair or walker, with prior approval.

AVAILABLE THERAPIES

- **physical therapy** includes exercise to regain movement and strength to a body area, and training on how to use special equipment or do daily activities, such as getting in and out of a wheelchair or bathtub.
- **speech language pathology services**, includes exercise to regain and strengthen speech and swallowing skills.
- **occupational therapy**, includes helping you become able to do usual daily activities by yourself. You might learn new ways to eat, dress, comb your hair, etc. **You may continue to receive occupational therapy even if you no longer need**

other skilled care services.

TO QUALIFY FOR MEDICARE HOME HEALTH CARE

1. Your doctor must decide that you need medical care in your home, and prescribe a plan of care at home; and
2. You must need part-time or intermittent skilled nursing care, or physical therapy or speech language pathology services; and
3. You must be homebound. This means that you are unable to leave home without great effort. You can leave home for many reasons, but such absences must be infrequent, for a short time, or to get medical care; and
4. You must use a Medicare approved home health agency.

Medicare defines part-time services as skilled nursing or home health aide services needed less than: 7 days a week, or 8 hours/day.

When more care is needed and can be planned ahead, hour and day limits can be increased.

PLAN OF CARE

The written plan of care developed by your doctor, usually in conjunction with home health care agency staff, must state:

- what kind of services you need,
- what type of health care professional should give these services, and
- how often you will need the services.

Your plan may also include your need for home medical equipment, special foods, and what outcome your doctor expects from your treatment.

The plan of care should be reviewed as needed, but at least once every 62 days.