

Understanding How Medicare Determines Payment for Your Therapy Services in Nursing Homes or Home Health Care

A Resource for Patients

If you or your loved one is receiving physical therapy, occupational therapy, and/or speech-language pathology services in a **nursing home** or if you are receiving **care at home** by a home health agency, Medicare implemented major payment changes for those services that you should be aware of.

Therapy Services in Nursing Homes: On October 1, 2019, Medicare shifted to a new payment system called the Patient-Driven Payment Model (PDPM) for all skilled nursing facilities or SNFs.

Therapy Services at Home: On January 1, 2020, Medicare applied a similar payment change called the Patient-Driven Groupings Model (PDGM) for therapy services managed by home health agencies (often called HHAs) provided in your home.

Patient-Driven Care: Medicare implemented the payment changes to support and promote patient-focused care as the most appropriate way to pay for services by basing care on the unique characteristics, needs, and goals of each patient. These models for patient-focused care were supported as the most appropriate way to pay for services by the three national associations representing physical therapists, physical therapist assistants, and physical therapy students (American Physical Therapy Association), occupational therapists, occupational therapy assistants, and occupational therapy students, (American Occupational Therapy Association), and speech-language pathologists (American Speech-Language-Hearing Association).

Unfortunately, some SNFs and HHAs are using this payment model transition to stint on care, which may put patients' health at risk. Medicare requires that SNFs and HHAs provide medically necessary physical therapy, occupational therapy, and speech-language pathology services, regardless of the diagnosis.

To protect your rights and ensure that you are receiving necessary therapy you should be aware of the following:

Common statements shared with patients receiving therapy that are not true.

- **Statement from provider:** Medicare limits the amount of therapy Medicare beneficiaries can receive.

FACT: Medicare does *not* limit the amount of therapy you can receive in a SNF or from an HHA and the clinical judgment of your therapist should be a key factor in determining the amount of therapy you receive. However, many SNFs and HHAs use computer programs that “predict” the amount of therapy a patient needs in order to dictate visits, without accounting for the clinical judgment of your treating therapist. This may force therapists to restrict the amount of therapy provided. For example, you may be told that Medicare restricts therapy minutes or visits provided but—in fact—Medicare **does not restrict therapy to 15-minute sessions or three home health visits**. Care decisions should be made by the interdisciplinary care team in consultation with patients, not computer algorithms.

- **Statement from provider:** Medicare dictates what forms of therapy a therapist can deliver. For example, you may be told that Medicare states that only occupational therapists or speech-language pathologists can deliver cognitive treatment.

FACT: Medicare defers to state law and the scope of practice of the treating clinician. For example, an occupational therapist and a speech-language pathologist could both address distinct traits of cognitive deficits within their respective scopes of practice as functionally necessary for the patient.

- **Statement from provider:** A portion of SNF therapy treatment *must* be provided in a group.

FACT: Medicare does *not* require patients to receive group therapy in a SNF setting. Group therapy may be clinically indicated for a patient and Medicare allows up to 25% of the patient's treatment to be provided either in a group (2-6 individuals) and/or as concurrent (two individuals) during the length of stay in the SNF. Medicare expects that the needs of the patient and the clinical judgment of the clinicians for the most effective therapeutic intervention will drive the decision whether to use individual, concurrent, and/or group treatment. The clinician or SNF cannot and should not use group therapy to manage schedules or for the convenience of the clinician or SNF.

- **Statement from provider:** Medicare will only pay for therapy services designed to improve a patient's condition.

FACT: Medicare will pay for services designed to improve **or maintain function** for the patient. Improvement or progress is *not* required. Medicare *must* cover maintenance therapy, when medically appropriate, under a legal settlement called *Jimmo v. Sebelius*.

- **Statement from provider:** Medicare does not pay for therapy for certain diagnoses.

FACT: Certain diagnoses or clinical conditions trigger additional payment for therapy, but Medicare requires SNFs and HHAs to provide all medically necessary services, including therapy services, to patients regardless of their diagnoses. CMS has stated:

“While these clinical groups represent the primary reason for home health services during a 30-day period of care, this does not mean that they represent the only reason for home health services. While there are clinical groups where the primary reason for home health services is for therapy (for example, Musculoskeletal Rehabilitation) and other clinical groups where the primary reason for home health services is for nursing (for example, Complex Nursing Interventions), home health remains a multidisciplinary benefit and payment is bundled to cover all necessary home health services identified on the individualized home health plan of care.”

- **Statement from provider:** Medicare does not cover home health services unless the patient is discharged from the hospital or institutional setting.

FACT: Under PDGM, a payment differential exists based on the source of admission (whether you came from the community or an institution like a hospital), but patients remain eligible for home health regardless of the source of admission or where they reside prior to starting an episode of care.

- **Statement from provider:** Medicare won't reimburse for any home health care services that exceed a total of 30 days of service.

FACT: While the unit of payment has changed to a 30-day period of care instead of the previous 60-day episode of care effective January 1, 2020, lengths of care that exceed 30 days of service may be medically necessary and are covered by Medicare. For example, a patient may require a total of 60 days of home health care or more. Medicare makes payments on a 30-day cycle, with a lower payment made for the second 30-day payment cycle. Some HHAs may inappropriately discharge patients within the first 30 days to avoid the lower reimbursement of the second 30-day billing cycle.

If you think that your SNF or HHA has inappropriately restricted access to therapy services, you have options to get help.

- Contact your physician and ask them to help get the care that they ordered, you need, and that you are entitled to receive.
- Register a complaint with the SNF or HHA compliance officer/staff or a manager. In most states, patients can file SNF complaints with state ombudsman offices and HHA complaints with state survey and certification agencies.
- Contact Medicare at 1-800-Medicare (1-800-633-4227).
- Reach out to a consumer advocacy group to share your story and get help with accessing your medically necessary care:
 - **Center for Medicare Advocacy** (<https://www.medicareadvocacy.org/about/contact-us-2/>): provides education, advocacy and legal assistance to help older people and people with disabilities obtain access to Medicare and quality health care.
 - **Medicare Rights Center** (<https://www.medicarerights.org>): helps people with Medicare understand their rights and benefits, navigate the Medicare system, and secure the quality health care they deserve.
 - **Senior Medicare Patrol** (<https://www.smpresource.org/>): empowers and assists Medicare beneficiaries, their families, and caregivers to prevent, detect, and report health care fraud, errors, and abuse through outreach, counseling, and education.
 - **Local Area on Aging** (https://eldercare.acl.gov/Public/About/Aging_Network/AAA.aspx): linking those who need assistance with state and local agencies on aging, as well as community-based organizations that serve older adults and their caregivers.
- If you receive an advanced beneficiary notice (ABN) from the HHA or SNF indicating a denial or stop of service, the Centers for Medicare & Medicaid Services has information about your rights to appeal. <https://www.medicare.gov/Pubs/pdf/11525-Medicare-Appeals.pdf>
- Consider getting services from a different SNF or HHA, if possible.



ASHA is the national professional, scientific, and credentialing association for 211,000 members and affiliates who are audiologists, speech-language pathologists (SLPs), speech, language, and hearing scientists, audiology and speech-language pathology support personnel, and students.

For questions related to speech-language pathology services, contact Sarah Warren, MA, ASHA's director of health care policy for Medicare, at swarren@asha.org or 301-296-5696.



APTA is an individual membership professional organization representing more than 100,000 member physical therapists (PTs), physical therapist assistants (PTAs), and students of physical therapy. APTA seeks to improve the health and quality of life of individuals in society by advancing physical therapist practice, education, and research, and by increasing the awareness and understanding of physical therapy's role in the nation's health care system.

For questions related to physical therapy, contact Kara Gainer, APTA's director of regulatory affairs, at karagainer@apta.org or 703-706-8547.



AOTA is the national professional association representing more than 60,000 occupational therapy practitioners and students of occupational therapy. The science-driven, evidence-based practice of occupational therapy enables people of all ages to live life to its fullest by promoting participation in daily occupations or activities.

For questions related to occupational therapy, contact Jennifer Bogenrief, AOTA's assistant director of regulatory affairs, at jbogenrief@aota.org or 240-482-4150.