Health care providers often need to assist patients with exploring ways they can access and afford health care. This is true for accessing and affording the recommended rehabilitation therapy patients may need after a stroke. This document contains information for you to help your patient understand their benefits for therapy if they are:

- Uninsured, Underinsured or Self-insured
- Insured with Private Health Insurance
- Insured with Medicare
- Insured with Medicaid

Topics covered include:

- Accessing Home Health Therapy
- Accessing Outpatient Therapy
- Coverage for Durable Medical Equipment

Consider visiting the COMPASS Website for additional handouts to give to your patients. There are also other helpful resources for you and your patients: [www.nccompass-study.org](http://www.nccompass-study.org)

### Considerations for the Uninsured or Underinsured

- The patient may qualify for Medicaid, see [https://medicaid.ncdhhs.gov/medicaid/get-started/eligibility-medicaid-or-health-choice](https://medicaid.ncdhhs.gov/medicaid/get-started/eligibility-medicaid-or-health-choice)
- The patient can enroll for health insurance on the Healthcare Marketplace, see [https://www.healthcare.gov/](https://www.healthcare.gov/)
- Consider community-based exercise programs.
- Community health centers and senior centers may offer therapy services.
- Some private therapy clinics may offer charity care.
- Therapy education programs in the area may offer free clinics.
- Community services, churches, and other support programs may have equipment (e.g., walkers, canes, etc.) for free or at a reduced cost.
Coverage will vary based on the insurance company and the specific plan.

**Home health therapy** is for patients who are home bound (defined as unable to leave the home without considerable and taxing effort) and in need of the skilled care of a therapist (physical, occupational, and/or speech) on a part-time or intermittent basis. They may also need and qualify for other services, e.g., skilled nursing.

**Home Health Coverage Policy**
- The patient should contact his/her insurance provider to find out about their benefits.
- The patient will likely have to cover some of the costs through deductible, copays and/or cost-sharing.
- The patient will likely have a limit on the number of therapy visits/year.

**Outpatient therapy** is care provided by physical, occupational, and/or speech therapists (PT, OT, and/or SLP) in an office-based practice, an outpatient hospital department, or a comprehensive outpatient rehabilitation facility.

**Outpatient Therapy Coverage Policy**
- The patient should contact his/her provider to find out about their benefits.
- The patient will likely have to cover some of the costs through deductible, copays and/or cost-sharing.
- The patient will likely have a limit on the number of therapy visits/year.
- Many private insurers in the state of NC allow direct access to physical therapy services.

**Other Considerations**
- Copays may range from $20-$70 per visit and may be financially challenging for some.
- The patient’s plan may cover health/wellness programs.
- The patient’s plan may cover equipment.
**Coverage Policy**

- Medicare Part A covers all of the costs of home health therapy for qualified beneficiaries. There are no copayments or cost-sharing by the beneficiary.
- To qualify for Medicare Part A home health therapy services, a physician must identify a need for therapy services and certify the patient as homebound.
- Payment for home health therapy is based on 60-day episodes of care and the number of therapy visits in the 60 days.
- Beneficiaries can receive an unlimited number of 60-day episodes of care if coverage criteria are met (i.e., the patient is still homebound, still in need of skilled therapy services, and continues to make progress with therapy).
- The home health agency providing the services must be Medicare-certified.
- Patients in Medicare Advantage plans are entitled to all services covered under original Medicare.

**Therapist Requirements**

- Physician referral is needed and the therapist must establish a plan of care that is reviewed by the referring physician.
- Reassessment of the plan of care is required at least once every 30 calendar days by each therapy discipline (PT, OT and SLP) treating the patient. The therapist (PT, OT, SLP) must perform the necessary treatment during the visit and assess the patient, measure progress and document objectives and goals of treatment consistent with the plan of care.

**Other Considerations**

- Once a patient is discharged from a home health plan of care and no longer eligible for Medicare Part A services, a therapist may provide in-home services under Medicare Part B.
- Payment policies for Medicare Part B therapy provided in the home are subject to the same policies as other outpatient therapy.
- Medicare Part A does not cover durable medical equipment (DME) the patient may need in their home.
- This is covered under Medicare Part B.
- Patients in Medicare Advantage plans may have extra coverage for health and wellness programs. The therapist/patient should check about this option.
Coverage Policy

- Outpatient therapy is covered by Medicare Part B and is subject to a yearly limit or cap.
- The Medicare deductible for Part B is $185 for 2019.
- After the deductible is reached, Medicare pays 80% and the patient pays 20% until combined costs reach the therapy cap.
- Outpatient therapy caps for 2019:
  - $2,040 for PT and speech-language pathology (SLP) services combined
  - $2,040 for occupational therapy services
  - Exceptions process allows costs above caps if medically necessary and reasonable.

□ Medicare Advantage (MA) plans (e.g., HMO, PPO provided by a private insurer) are not mandated by caps. Patients in MA plans may receive extra coverage for therapy services.

Therapist Requirements

□ Physician referral is required.
□ Written plan of care must be forwarded to the physician as soon as it is established and signed by the physician within 30 days of the initial therapy treatment session.
□ Plan of care needs to be recertified by physician every 90 days.
□ For office-based settings, PTs must directly supervise PTAs (i.e., in office suite).
□ For hospital outpatient settings, supervision of PTAs is dictated by state law.
□ Therapists practicing in all outpatient settings must complete claims-based functional reporting (a quality improvement initiative by CMS) for Medicare patients.

Other Considerations

□ When deciding on an outpatient setting, consider patient convenience (distance from home, parking/walk to the practice).
□ Covering 20% of costs may be financially difficult for some beneficiaries. **While some may have supplemental insurance to help cover these costs, they may still have copays.**
□ Patients in **Medicare Advantage** plans may have extra coverage for health and wellness programs. The therapist/patient should check about this option.
Durable medical equipment (DME) is long-lasting equipment used in the home for medical reasons.

Coverage Policy for Durable Medical Equipment (DME)

- Covered by Medicare Part B.
- Must be prescribed by a physician enrolled in Medicare.
- DME supplier must also be enrolled in Medicare.
- Patient responsible for 20% of the Medicare-approved amount for the DME if the supplier is enrolled and participating in Medicare.
- If supplier is enrolled in Medicare, but not participating, there is no limit on the amount charged for the DME.
- The Part B deductible ($185 for 2019) applies.

Durable Medical Equipment Covered by Medicare Includes (but is not limited to):

- Canes, walkers, crutches
- Manual wheelchairs and power mobility devices
- Oxygen equipment and accessories
- Patient lifts
- Commode chairs
- Hospital beds

Other Considerations

- Shower seats are not covered by Medicare.
- Community service organizations and/or churches may have DME that the patient can get for free or at a reduced cost.
- Patients can rent or buy the equipment, depending on their needs.
Coverage Policy

- Covers medically necessary home health therapy services.
- Must include documentation supporting one or more of the following reasons that services must be provided in the patient’s home:
  - Beneficiary requires assistance in leaving the primary private residence, such as with opening doors and other routine activities, due to a physical impairment or a medical condition.
  - Beneficiary is non-ambulatory or wheelchair bound with a medical condition that precludes leaving primary private residence on a regular basis.
  - Beneficiary would require ambulance transportation.
  - Beneficiary is medically fragile or unstable.
  - Leaving the primary private residence would interfere with the effectiveness of the services.
  - Beneficiary requires in-home training for the use of assistive devices specifically customized for his or her primary private residence environment (such as bath chairs and shower grab bars).
- Must be ordered by a physician and rendered according to an authorized plan of care.
- May have up to three therapy evaluations and a total of 24 therapy treatment visits when the beneficiary is within six calendar months of discharge from inpatient services for a cerebrovascular accident (CVA).
- A documented occurrence of a new CVA with a corresponding inpatient stay allows for a new episode of up to three therapy evaluations and a total of 24 therapy treatment visits. (Evaluations and visits are the combined sum of PT, OT, and ST).

Therapist Requirements

- Prior approval for all specialized therapy treatment visits prior to the start of treatment services.
- All services must be provided according to a written plan.
  - Written plan must include defined goals (specific and measurable and must have reasonable expectation to be achieved within a six month plan period) for each therapeutic discipline.
  - Each plan must include skilled interventions, frequency of services, duration of the therapy plan, and length of each treatment visit for each therapeutic discipline.
  - Service providers shall review and renew or revise plans and goals no less often than every six calendar months, to include obtaining another dated physician signature for the renewed or revised orders.

Other Considerations

- Patient may qualify for PACE (Program of All-inclusive Care for the Elderly). See https://www.medicaid.gov/medicaid/ltss/pace/index.html
- Patient may qualify for NC Community Alternatives Program for Disabled Adults (CAP/DA). See https://medicaid.ncdhhs.gov/medicaid/get-started/find-programs-and-services/community-alternatives-program-for-disabled-adults
- Patient may qualify for Special Assistance In-Home Program for Adults. See https://www.payingforseniorcare.com/home-care/nc-saih-program.html
**Coverage Policy**

- A beneficiary 21 years of age and older may have up to three therapy evaluations, and a total of 24 therapy treatment visits when the beneficiary is within six calendar months of discharge from inpatient services for a cerebrovascular accident (CVA).
- A documented occurrence of a new CVA with a corresponding inpatient stay allows for a new episode of up to three therapy evaluations and a total of 24 therapy treatment visits. Therapy evaluations and visits are the combined sum of PT, OT, and ST.
- The combined sum of visits is for home health and outpatient therapy.
- Medicaid covers medically necessary outpatient specialized therapies for beneficiaries over 21 only when provided in the home or by hospital outpatient departments and physician offices. (Does not include private practice therapists).

**Therapist Requirements**

- Medicaid requires prior approval for all outpatient specialized therapy treatment visits.
- Prior approval is required prior to the start of treatment services.
- All services must be provided according to a written plan:
  - The written plan for services must include defined goals (specific and measurable and must have reasonable expectation to be achieved within a six-month plan period) for each therapeutic discipline.
  - Each plan must include skilled interventions, frequency of services, duration of the therapy plan, and length of each treatment visit for each therapeutic discipline.
  - Service providers shall review and renew or revise plans and goals no less often than every six calendar months, to include obtaining another dated physician signature for the renewed or revised orders.
  - Orders are valid for no more than six months from the date of the physician’s documented verbal order or written order signature.

**Other Considerations**

- Access to therapy services is more limited due to coverage policy excluding care provided in private practices.
- Some private outpatient therapy practices may provide charity care for Medicaid patients.
**MEDICAID COVERAGE**
**FOR DURABLE MEDICAL EQUIPMENT**

**Coverage Policy for Durable Medical Equipment (DME)**
- Medical necessity for DME must be documented by the physician.
- Prior approval is required before obtaining DME.
- Medicaid will also pay for the service or repair of patient-owned DME.

**Durable Medical Equipment Covered by Medicaid Includes (but is not limited to):**
- Canes, walkers, crutches
- Manual wheelchairs and power mobility devices
- Oxygen equipment and accessories
- Commode chairs
- Hospital beds
  - See [https://medicaid.ncdhhs.gov/providers/fee-schedule/durable-medical-equipment-dme-fee-schedule](https://medicaid.ncdhhs.gov/providers/fee-schedule/durable-medical-equipment-dme-fee-schedule) for NC Medicaid Fee Schedule for DME

**Durable Medical Equipment Not Covered by Medicaid**
- Lift chairs
- 3-wheeled scooters