



CENTERS FOR MEDICARE & MEDICAID SERVICES



Medicare and Home Health Care

This is the official government booklet about Medicare home health care benefits for people in the Original Medicare Plan. This booklet has important information about the following:

- ★ Who is eligible
- ★ What services are covered
- ★ How to find and compare home health agencies
- ★ Your Medicare rights
- ★ Where to get more information



Many health care treatments that used to be done only in a hospital can now be done in your home. Health care given in the home is usually less expensive, more convenient, and just as effective as care you get in a hospital or skilled nursing facility. If you are eligible, Medicare pays for you to get certain health care services in your home. This is known as the Medicare home health benefit.

This book explains the Medicare home health benefit including the following:

- The conditions you must meet to be eligible
- What home health services are covered by the **Original Medicare Plan**
- Information on comparing and choosing home health agencies
- Where to go for more information, including extra help paying your Medicare costs if you have limited income and resources

If you get your Medicare benefits through a **Medicare Health Plan**, other than the Original Medicare Plan, check your plan's membership materials and call the plan for details about how the plan provides your Medicare-covered home health benefits.

The information, telephone numbers, and web addresses in this booklet were correct at the time of printing. Changes may occur after printing. To get the most up-to-date information and Medicare telephone numbers, visit www.medicare.gov on the web. Or, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

“Medicare and Home Health Care” isn't a legal document. Official Medicare Program legal guidance is contained in the relevant statutes, regulations, and rulings.

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Introduction

Home health care and Medicare

In general, the goal of home health care is to provide treatment for an illness or injury. It helps you get better, regain your independence, and become as self-sufficient as possible. If you have long-term health problems, the goal of home health care is to maintain your highest level of ability or health, and help you learn to live with your illness or disability.

Home health care includes part-time or intermittent skilled nursing care, as well as other skilled care services like physical and occupational therapy, and speech-language pathology (therapy) services. Services may also include medical social services, and assistance from a home health aide (when needed, if you are also getting skilled care). In order for Medicare to pay for these services, you must meet certain eligibility criteria, and the services must be reasonable and necessary for the treatment of your illness or injury. Usually, a specific home health care agency coordinates the services your doctor orders for you.

Health care professionals from a Medicare-certified home health agency work with you and your doctor to evaluate your health care needs and write your plan of care (see page 15). The plan of care tells you what home care services you need. Your home health agency must provide you with all the home care listed in your plan of care, including services and medical supplies. The agency may do this through its own staff, through an arrangement with another agency, or by hiring nurses, therapists, home health aides, and medical social service counselors to meet your needs.

The home health agency staff will teach you (and your family or friends who are helping you) to continue any care you may need, including wound care, therapy, and disease management. You should learn to recognize problems like infection or shortness of breath, and what to do or who to contact if they happen.

Section 1 Medicare Coverage of Home Health Care

Who is eligible to get Medicare-covered home health care?

If you have Medicare, you can use your home health benefits if you meet all the following conditions:

1. Your doctor must decide that you need medical care at home, and make a plan for this care.
2. You must need one or more of the following:
 - Intermittent skilled nursing care
 - Physical therapy
 - Speech-language pathology services
 - Continued occupational therapy
3. The home health agency caring for you must be approved by the Medicare Program (Medicare-certified).
4. You must be homebound or normally unable to leave home unassisted. To be homebound means that leaving home takes considerable and taxing effort. A person may leave home for medical treatment or short, infrequent absences for non-medical reasons, such as a trip to attend religious services. You can still get home health care if you attend adult day care.

Eligibility is also based on the amount of services you need

If you meet the conditions above, Medicare pays for your covered home health services for as long as you are eligible and your doctor says you need them. However, the skilled nursing care and home health aide services are only covered on a part-time or “intermittent” basis. This means there are limits on the number of hours per day or days per week that you can get skilled nursing or home health aide services.

Section 1 Medicare Coverage of Home Health Care

Eligibility is also based on the amount of services you need (continued)

To decide whether or not you are eligible for home health care, Medicare defines part time or “intermittent” as skilled nursing care that is needed or given on fewer than 7 days each week or less than 8 hours each day over a period of 21 days (or less) with some exceptions in special circumstances. See the examples below.

Example #1: Jane’s doctor says that she needs a nurse to visit her every day for 15 days to care for a wound. The skilled wound care that is ordered by the doctor is medically reasonable and necessary for the treatment of Jane’s wound. The total time that the nurse will be at Jane’s house will be about an hour each day. Jane only needs the nurse to come for 15 days. Jane’s need for home health care meets the Medicare definition of “intermittent.”

Hour and day limits may be extended in exceptional circumstances when your doctor can predict when your need for care will end.

Once you are getting home health care, Medicare defines part-time or intermittent as skilled nursing or home health aide services combined to total less than 8 hours per day and 28 or fewer hours each week. Based on your need for care, on a case-by-case basis, the weekly total may be increased to up to 35 hours. This definition helps Medicare make decisions about your coverage.

Example #2: Jane’s doctor now says that he also wants Jane to start physical therapy and get home health aide services, in addition to getting wound care. The nurse will be at Jane’s house about an hour each day for wound care, the physical therapist will visit 1 hour 3 times a week for 4 weeks, and the home health aide will visit 4 times a week for 2 hours. Jane’s weekly total for skilled nursing and home health aide services is still less than 8 hours per day and 28 or fewer hours each week. Jane’s home health care needs still meet the Medicare definition of “intermittent.”

Section 1 Medicare Coverage of Home Health Care

How the Original Medicare Plan pays for home health care

In the **Original Medicare Plan**, Medicare pays your Medicare-certified home health agency a set amount of money for each 60 days that you need care. This 60-day period is called an “episode of care.” The payment is based on what kind of health care an average person in your situation would need.

Getting treatment from a home health agency that is Medicare-certified can reduce your out-of-pocket costs. A Medicare-certified home health agency agrees to the following conditions:

- To be paid by Medicare
- To accept only the amount Medicare approves for their services
- To only charge you, or other insurance you may have, 20% coinsurance for any **durable medical equipment** the agency provides, like a wheelchair or walker

Words in **red** are defined on pages 26–27.

The Original Medicare Plan’s home health benefit only pays for services provided by the home health agency. Other medical services, like visits to your doctor, are still covered by your other Medicare benefits. Look in your copy of the “Medicare and You” handbook, mailed to each Medicare household every fall, for information on how these services are covered under the Original Medicare Plan. To view or download this booklet, visit www.medicare.gov on the web. Under “Search Tools,” select “Find a Medicare Publication.” Or, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Section 1 Medicare Coverage of Home Health Care

What the Original Medicare Plan covers

If you are eligible for home health care, the **Original Medicare Plan** will cover the following:

- Skilled nursing care on a part-time or intermittent basis. Skilled nursing care includes services and care that can only be done safely and correctly by a licensed nurse (either a registered nurse or a licensed practical nurse). The services must be reasonable and necessary for the treatment of your illness or injury.
- Home health aide services on a part-time or intermittent basis. A home health aide doesn't have a nursing license. The aide provides support services for skilled nursing care. These services include help with personal care such as bathing, using the toilet, or dressing. Medicare doesn't cover home health aide services unless you are also getting skilled care such as nursing care or other therapy from the home health agency. The home health aide services must be part of the care for your illness or injury.
- Certain types of therapy for as long as your doctor says you need it. Medicare covers the following:
 - Physical therapy, which includes exercise to regain movement and strength to a body area, and training on how to use special equipment or perform daily activities, like how to get in and out of a wheelchair or bathtub.
 - Speech-language pathology services, which includes therapy to regain and strengthen speaking and swallowing skills, as well as listening, reading, and memory skills.
 - Occupational therapy, which helps you learn to do usual daily activities by yourself. You might learn new ways to eat, put on clothes, comb your hair, and perform other usual daily activities. You may continue to get occupational therapy even if you no longer need other skilled care.
- Medical social services under the direction of a doctor to help you with social and emotional concerns related to your illness. This might include counseling or help in finding resources in your community.
- Certain medical supplies, like wound dressings, that are ordered as part of your care.
- **Durable medical equipment**, when ordered, is covered separately by Medicare. This equipment must meet criteria for coverage. Medicare usually pays 80% of the Medicare-approved amount for certain pieces of medical equipment, such as a wheelchair or walker. If the home health agency doesn't supply durable medical equipment directly, the home health agency staff will usually arrange for a home equipment supplier to bring the items you need to your home.

Words in **red** are defined on pages 26–27.

Section 1 Medicare Coverage of Home Health Care

What the Original Medicare Plan covers (continued)

Note: Before your care begins, the home health agency should tell you how much of your bill Medicare will pay. The agency should also tell you if any items or services they give you aren't covered by Medicare, and how much you will have to pay for them. This should be explained both by talking with you and in writing.

What isn't covered by the Original Medicare Plan

Medicare doesn't pay for the following:

- 24-hour-a-day care at home
- Meals delivered to your home
- Homemaker services like shopping, cleaning, and laundry when this is the only care you need, and when these services aren't related to your plan of care (see page 15)
- Personal care given by home health aides like bathing, dressing, and using the bathroom when this is the only care you need

Note: If you have a **Medigap** (Medicare Supplement Insurance) **policy** or other health insurance coverage, be sure to tell your doctor or other health care provider so your bills can be paid correctly.

What you have to pay

You may be billed for

- medical services and supplies that Medicare doesn't pay for (in certain cases the home health agency will give you a notice called the Home Health Advance Beneficiary Notice (HHABN). See page 8.
- 20% of the Medicare-approved amount for Medicare-covered medical equipment such as wheelchairs, walkers, and oxygen equipment.

Section 1 Medicare Coverage of Home Health Care

Home Health Advance Beneficiary Notice

If a home health agency cuts back or stops your services, in most cases, the agency should give you a written notice called a Home Health Advance Beneficiary Notice (HHABN). The HHABN should both describe the items and/or services the agency believes Medicare won't pay for and explain why they believe Medicare won't pay.

If a home health agency cuts back or stops your services, you may have an option to keep getting the services, even though Medicare isn't expected to pay for them. The HHABN gives clear directions for getting an official decision from Medicare about payment for home health services and for filing an **appeal** if Medicare says it won't pay.

In general, to get an official decision on payment, you should

- Keep getting the home health services if you think you need them. The home health agency should tell you how much they will cost. Talk to your doctor and family about this decision.
- Understand you may have to pay the home health agency for these services.
- Ask the home health agency to send your claim to Medicare so that Medicare will decide if it will pay. You have the right to have the agency bill Medicare for your care.

Words in **red** are defined on pages 26–27.

If the **Original Medicare Plan** decides to pay for your care, you will get back all of your payments, except for any coinsurance payments you made for **durable medical equipment**.

Section 1 Medicare Coverage of Home Health Care

Your right to a fast appeal when covered home health services are ending

If you are getting Medicare-covered services from a home health agency, you may have the right to a fast **appeal** if you think these services are ending too soon. During a fast appeal, an independent reviewer called a Quality Improvement Organization (QIO) looks at your case and decides if you need to keep getting home health services. The QIO is a group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients.

Your provider will give you a written notice called the Notice of Medicare Provider Non-Coverage at least 2 days before covered services end. If you don't get this notice, ask for it. Read the notice carefully. It contains the following information:

- The date your covered services will end
- How much you will have to pay if you keep getting services
- How to ask for a fast appeal
- Your right to get a detailed notice about why your services are ending

If you ask for a fast appeal, the QIO will ask for your opinion about why you believe coverage for the services should continue. The QIO will also look at your medical information and talk to your doctor. The QIO will notify you of its decision as soon as possible, generally no later than 2 days after the effective date of the Notice of Medicare Provider Non-Coverage.

If the QIO decides your home health services should continue, Medicare will continue to cover your home health care services for as long as medically necessary (except for any applicable coinsurance or deductibles).

If the QIO decides that your coverage should end, you will have to pay for any services you received after the date on the Notice of Medicare Provider Non-Coverage that says your covered services should end. You won't be responsible for paying for any covered services provided before that date.

You may stop getting services on or before the date given on the Notice of Medicare Provider Non-Coverage and avoid any possible financial liability.

Section 1 Medicare Coverage of Home Health Care

General Medicare appeal rights

After Medicare makes a decision on a claim, you have the right to a fair, efficient, and timely process for appealing health care payment decisions or initial determinations on items or services you received.

You may **appeal** if

- a service or item you received isn't covered, and you think it should be; or
- a service or item is denied, and you think it should be paid.

The Medicare Summary Notice is mailed to you by the company that handles claims for Medicare. This notice tells you if your claim is approved or denied. If the claim is denied, the reason for the denial will be included on the notice. The notice will also include information about how to file an appeal. You can file an appeal if you disagree with Medicare's decision on payment or coverage for the items or services you received. If you appeal, ask your doctor, health care provider, or supplier for any information that might help your case. You should keep a copy of everything you send to Medicare as part of your appeal.

For more information on your right to a fast appeal and other Medicare appeal rights, look at your "Medicare & You" handbook or "Your Medicare Rights and Protections" booklet. To view or download these booklets, visit www.medicare.gov on the web. Under "Search Tools," select "Find a Medicare Publication." Or, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Words in **red** are defined on pages 26–27.

Section 2 Choosing a Home Health Agency

Finding a Medicare-certified home health agency

If your doctor decides you need home health care, you may choose an agency from the participating Medicare-certified home health agencies that serve your area. Home health agencies are certified to make sure they meet certain Federal health and safety requirements. Your choice should be honored by your doctor, hospital discharge planner, or other referring agency. Although you have a say in which agency you use, your choices may be limited by agency availability, or by your insurance coverage. ([Medicare Advantage Plans](#) or other [Medicare Health Plans](#) may require that you get home health services from agencies they contract with.)

Comparing home health agencies

You can use Medicare’s “Home Health Compare” tool on the web to compare home health agencies in your area. Visit www.medicare.gov on the web. Under “Search Tools,” select “Compare Home Health Agencies in Your Area.” You can compare home health agencies by the types of services they offer and the quality of care they provide. Home Health Compare provides the following information:

- Name, address, and telephone number of the agency
- Services offered by the agency (such as nursing care, physical therapy, occupational therapy, speech-language pathology services, medical/social services, and home health aide services)
- Initial date of the agency’s Medicare certification
- Type of ownership (For Profit, Government, Non-Profit)
- Information about the quality of care provided by the agency (quality measures)

Comparing quality

In general, quality care means the right care, at the right time, in the right way, for the right person, and having the best possible results. The quality measures on Home Health Compare give you information about how well home health agencies provide care for their patients. The quality measures provide information about patients’ physical and mental health, and whether their ability to perform basic daily activities is maintained or improved.

Section 2 Choosing a Home Health Agency

Home Health Agency Checklist

Use this checklist when choosing a home health agency.

Name of the Home Health Agency _____

The Home Health Agency	Yes	No	Comments
1. is Medicare-certified.			
2. is Medicaid-certified (if you have both Medicare and Medicaid).			
3. offers the specific health care services I need (like nursing or physical therapy).			
4. meets my special needs (like language or cultural preference).			
5. offers the personal care services I need (like help bathing, dressing, and using the bathroom).			
6. offers the support services I need, or can help me arrange for additional services, such as Meals on Wheels, that I may need.			
7. has staff available to provide the type and hours of care my doctor ordered, and can start when I need them.			
8. is recommended by my hospital discharge planner, doctor, or social worker.			
9. has staff available at night and on weekends for emergencies.			
10. explained what my insurance will cover, and what I must pay out-of-pocket.			
11. does background checks on all staff.			
12. has letters from satisfied patients, family members, and doctors that testify to the home health agency staff providing good care.			

Section 2 **Choosing a Home Health Agency**

Special rules

In general, most Medicare-certified home health agencies will accept all Medicare patients. An agency isn't required to accept a patient if it can't meet the patient's medical needs. An agency shouldn't refuse to take a specific Medicare patient because of the patient's condition, unless the agency also refuses to take other people with the same condition.

Medicare will only pay for you to get care from one home health agency at a time. You may decide to end your relationship with one agency and choose another at any time. Contact your doctor to get a referral to a new agency. You should tell both the agency you are leaving and the new agency you choose that you are changing home health agencies.

Find out more about home health agencies

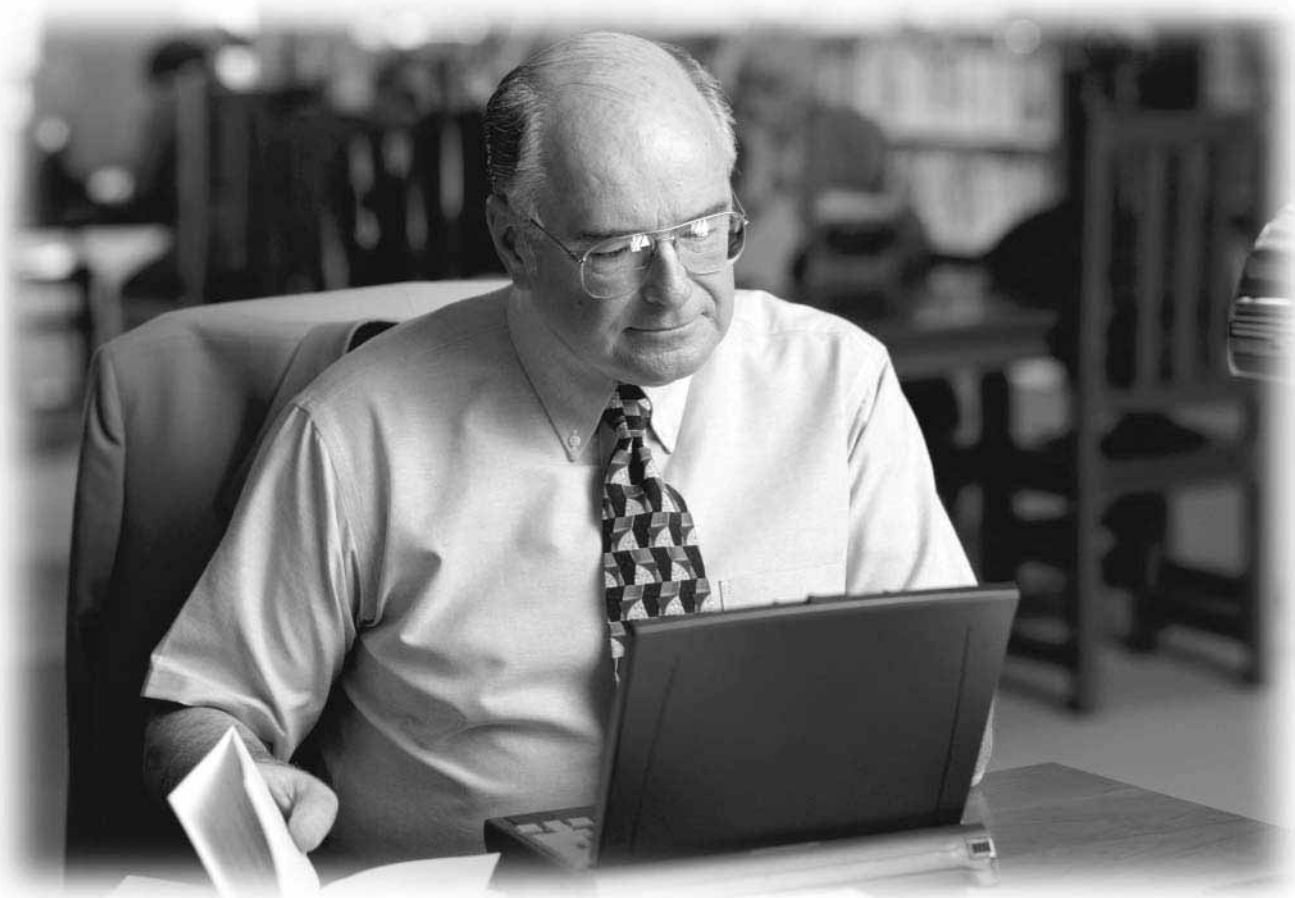
Your State Survey Agency, the agency that inspects and certifies home health agencies for Medicare, also has information about home health agencies. Ask them for the state survey report on the home health agency of interest to you. Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. Or, visit www.medicare.gov on the web to get their telephone number.

In some cases, your local long-term care ombudsman may have information on the home health agencies in your area. You can find a local long-term care ombudsman by visiting www.ltcombudsman.org on the web. Or, you can call the Eldercare Locator at 1-800-677-1116 or visit www.eldercare.gov on the web.

To find out more about home health agencies, you can do any of the following:

- Ask your doctor, hospital discharge planner, or social worker. Or, ask friends or family about their home health care experiences.
- Use a senior community referral service, or other community agencies that help you with your health care.
- Look in your telephone directory in the Yellow Pages under "home care" or "home health care."

Visit “Home Health Compare” at www.medicare.gov on the web for information about home health agencies in your area.



Section 3 **Getting Home Health Care**

Getting started

Usually, once your doctor refers you for home health services, staff from the home health agency will come to your home to talk to you about your needs and ask you some questions about your health. The home health agency will also talk to your doctor about your care and keep your doctor updated about your progress. Doctor's orders are needed to start care.

Your plan of care

Your home health agency will work with you and your doctor to develop your plan of care. A plan of care lists what kind of services and care you should get for your health problem. You have the right to be involved in any decisions about your plan of care and your treatment. Your plan of care includes the following:

- What services you need
- What health care professionals should give these services
- How often you will need the services
- The medical equipment you need
- What results your doctor expects from your treatment

Your doctor and home health agency staff review your plan of care as often as necessary, but at least once every 60 days. If your health problems change, the home health staff should tell your doctor right away. Your plan of care will be reviewed and may change. Your home health agency should only change your plan of care with your doctor's approval. Your home health agency should also tell you about any changes in your plan of care.

If you have a question about your care, or if you feel your needs aren't being met, talk to both your doctor and the home health agency.

Section 3 Getting Home Health Care

Your rights as a person with Medicare

In general, as a person with Medicare getting home health care from a Medicare-certified home health agency, you are guaranteed certain rights, including the following:

- To get a written notice of your rights before your care is started
- To have your home and property treated with respect
- To be told, in advance,
 - what care you will be getting
 - when your plan of care is going to change
- To participate in your care planning and treatment
- To get written information about your privacy rights and your **appeal** rights
- To have your personal information kept private
- To get written and verbal information about how much Medicare is expected to pay and how much you will have to pay for any services that you will be getting
- To make complaints about your care and have the home health agency follow up on them
- To know the phone number of the home-health hotline in your state where you can call with complaints or questions about your care

Words in **red** are defined on pages 26–27.

Section 3 Getting Home Health Care

Home Health Care Checklist

This checklist can help you (and your family or friends who are helping you) monitor your home health care. Use this checklist to help ensure that you are getting good quality home health care.

When I get my home health care	Yes	No	Comments
1. the staff is polite and treats me and my family members with respect.			
2. the staff explains my plan of care to me and my family, lets us participate in creating the plan of care, and lets us know ahead of time of any changes.			
3. the staff is properly trained and licensed to perform the type of health care I need.			
4. the agency explains what to do if I have a problem with the staff or the care I am getting.			
5. the agency responds quickly to my requests.			
6. the staff checks my physical and emotional status at each visit.			
7. the staff responds quickly to changes in my health or behavior.			
8. the staff checks my home and suggests changes to meet my special needs and to ensure my safety.			
9. the staff has told me what to do if I have an emergency.			
10. the agency and its staff protect my privacy.			

Your plan of care includes the kind of services you need, and what type of health care professionals should give these services.



Section 4 Medicare Prescription Drug Coverage (Medicare Part D)

Medicare offers prescription drug coverage

Medicare's home health benefit doesn't cover prescription drugs that you usually give yourself. However, Medicare offers prescription drug coverage for everyone with Medicare. This coverage is called "Part D." Medicare prescription drug coverage can protect against future drug costs and give you access to drugs that you can use to stay physically and mentally healthy. To get Medicare prescription drug coverage, you must join a Medicare drug plan. Medicare drug plans are run by insurance companies and other private companies approved by Medicare. Each plan can vary in cost and drugs covered.

Find out more about Medicare prescription drug coverage

There is more information about Medicare prescription drug coverage in your "Medicare & You" handbook. You can also learn more about Medicare prescription drug coverage and get personalized help comparing Medicare drug plans.

- Visit www.medicare.gov on the web. Under "Search Tools," select "Compare Medicare Prescription Drug Plans."
- Look at the booklet called "Your Guide to Medicare Prescription Drug Coverage." Visit www.medicare.gov on the web. Under "Search Tools," select "Find a Medicare Publication."
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
- Call your **State Health Insurance Assistance Program (SHIP)**. Visit www.medicare.gov on the web, or call 1-800-MEDICARE (1-800-633-4227) to get the telephone number of your SHIP. TTY users should call 1-877-486-2048.

Words in red are defined on pages 26–27.

Have your Medicare card, a list of your drugs and their dosages, and the name of the pharmacy you use available.



**Home health services
are given by a variety
of skilled health care
professionals at home.**

Section 5 Getting the Help You Need

Medicare is here to help you get the information you need.

This section includes information about the following:

- Help for people with limited income and resources
- Where to get more information
- Words to know

Help for people with limited income and resources

Extra Help Paying for Medicare Prescription Drug Coverage

You may qualify for “extra help” (low-income subsidy) from Medicare to help pay prescription drug costs if you have a yearly income (in 2007) below \$15,315 (\$20,535 for a married person living with a spouse and no other dependents) and resources (in 2007) less than \$11,710 (\$23,410 for a married person living with a spouse and no other dependents). For more information, look at your “Medicare & You” handbook or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

State Pharmacy Assistance Programs

Several states have **State Pharmacy Assistance Programs (SPAPs)** that help certain people pay for prescription drugs. In general, each SPAP makes its own rules about how to provide drug coverage to its members. Depending on your state, the SPAP will have different ways of helping you pay your prescription drug costs. To find out about the SPAPs in your state, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Words in **red** are defined on pages 26–27.

Section 5 **Getting the Help You Need**

Help for people with limited income and resources (continued)

Medicaid

Medicaid is a joint Federal and state program that helps pay medical costs for some people with limited income and resources. Some people qualify for both Medicare and Medicaid. In general, most of your health care costs are covered if you have Medicare and Medicaid.

Medicaid programs vary from state to state. They may also be called by different names, like “Medical Assistance” or “Medi-Cal.” People with Medicaid may get coverage for services that aren’t fully covered by Medicare, such as nursing home and home health care. The income limits for Medicaid vary from state to state.

Call your State Medical Assistance (Medicaid) office to see if you qualify or to get more information about Medicaid. To get the telephone number for your State Medical Assistance office, visit www.medicare.gov on the web. Under “Search Tools,” select “Find Helpful Phone Numbers and Websites.” Or, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Section 5 Getting the Help You Need

Help for people with limited income and resources (continued)

Medicare Savings Programs (Help from **Medicaid** to pay Medicare premiums)

States have programs for people with limited income and resources that pay Medicare premiums and, in some cases, may also pay **Medicare Part A** and **Medicare Part B** deductibles and coinsurance. These programs help millions of people with Medicare save money each year.

To qualify for a **Medicare Savings Program**, you must

- have Medicare Part A.
- be an individual with resources of \$4,000 or less, or a married couple with resources of \$6,000 or less. Resources include money in a checking or savings account, stocks, and bonds. Resources don't include your home, car, burial plot, up to \$1,500 for burial expenses, furniture, or other household items.
- be an individual with a monthly income of less than \$1,169, or a married couple with a monthly income of less than \$1,561.

Note: These amounts are for 2007. Individual states may have higher income and/or resource limits, or they may have no resource limits. Income limits will increase slightly in 2008 or if you have other dependents in your household.

To find out more, call your State Medical Assistance (**Medicaid**) office. Since the names of these programs may vary by state, ask for information on Medicare Savings Programs. It's very important to call if you think you qualify for any of these programs, even if you aren't sure. To get the telephone number for your state, visit www.medicare.gov on the web. Under "Search Tools," select "Find Helpful Phone Numbers and Websites." Or, call 1-800-MEDICARE (1-800-633-4227) to get the telephone number for your state. TTY users should call 1-877-486-2048.

Words in **red** are defined on pages 26–27.

Section 5 Getting the Help You Need

Help with questions about home health coverage

If you have questions about your Medicare home health care benefits or coverage and you are in the **Original Medicare Plan**, call your Regional Home Health Intermediary (RHHI). The RHHI is an organization that handles home health care bills for Medicare. To get the telephone number for the RHHI in your area, visit www.medicare.gov on the web. Under “Search Tools,” select “Find Helpful Phone Numbers and Websites.” Or, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Words in **red** are defined on pages 26–27.

You may also call the **State Health Insurance Assistance Program** (SHIP). Every State and territory, plus Puerto Rico, the Virgin Islands, and the District of Columbia has a SHIP with counselors who can give you free health insurance information and help. The SHIP counselors answer questions about Medicare’s home health benefits and what Medicare, **Medicaid**, and other types of insurance pay for. In addition, these counselors help with Medicare payment questions; questions on buying a **Medigap** (Medicare Supplement Insurance) **policy**, or long-term care insurance; concerns about payment denials and **appeals**; Medicare rights and protections; complaints about your care or treatment; or choosing a **Medicare Health Plan**. To get the telephone number for your SHIP, visit www.medicare.gov on the web, or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Where to file a complaint about the quality of your home health care

If you have a complaint about the quality of care you are getting from a home health agency, you should call either of the following organizations:

- Your state home health hotline. Your home health agency should give you this number when you start getting home health services.
- The Quality Improvement Organization (QIO) in your state. The QIO is a group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients. To get the telephone number for your QIO, visit www.medicare.gov on the web. Under “Search Tools,” select “Find Helpful Phone Numbers and Websites.” Or, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Section 5 Getting the Help You Need

How to report fraud

In general, most home health agencies are honest and use correct billing information. Unfortunately, fraud sometimes occurs. Fraud wastes Medicare dollars and takes money that could be used to pay claims. You are important in the fight to prevent fraud, waste, and abuse in the Medicare Program. To report Medicare fraud, call 1-800-447-TIPS (1-800-447-8477). You should look for the following:

- Home health visits that your doctor orders that you didn't get
- Visits by home health staff that aren't needed
- Bills for services and equipment you never got
- Fake signatures (yours or your doctor's)
- Pressure to accept items and services that you don't need or that Medicare doesn't cover
- Items listed on your Medicare Summary Notice that you don't think you got
- Home health services your doctor didn't order. The doctor who approves home health services for you should know you, and should be involved in your care. If your plan of care changes, make sure that your doctor was involved in making those changes.
- A home health agency that offers you free goods or services in exchange for your Medicare number. Treat your Medicare card like a credit card or cash. Never give your Medicare or **Medicaid** number to people who tell you a service is free, and they need your number for their records.

The best way to protect your home health benefit is to know what Medicare covers and to know what your doctor has planned for you. If you don't understand something in your plan of care, ask questions.

To report any suspected home health care fraud, call the Regional Home Health Intermediary for your state. To get their telephone number, visit www.medicare.gov on the web, or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You can also call 1-800-447-TIPS (1-800-447-8477).

Section 5 Getting the Help You Need

Words to know

Appeal—A special kind of complaint you make if you disagree with a coverage or payment decision made by Medicare, your Medicare Health Plan, or your Medicare Prescription Drug Plan. You can appeal if you request a health care service, supply, or prescription that you think you should be able to get, or if you request payment for health care you already got, and Medicare or your plan denies the request. You can also appeal if you are already getting coverage and Medicare or the plan stops paying.

Durable Medical Equipment (DME)—Medical equipment that is ordered by a doctor for use in the home. Examples are walkers, wheelchairs or hospital beds. DME is paid for under both Medicare Part A or Part B for home health services.

Medicaid—A joint Federal and state program that helps with medical costs for some people with limited income and resources. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid.

Medicare Advantage Plan (Part C)—A type of Medicare health plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. Also called “Part C,” Medicare Advantage Plans include Health Maintenance Organizations, Preferred Provider Organizations, Private Fee-for-Service Plans, Special Needs Plans, and Medicare Medical Savings Account Plans. If you are enrolled in a Medicare Advantage Plan, Medicare services are covered through the plan, and aren’t paid for under the Original Medicare Plan. Most Medicare Advantage Plans offer prescription drug coverage.

Medicare Health Plan—A Medicare Advantage Plan (such as an HMO, PPO, or Private Fee-for-Service Plan) or other plan such as a Medicare Cost Plan. Everyone who has Medicare Part A and Part B is eligible for a plan in their area, except those who have End-Stage Renal Disease (unless certain exceptions apply).

Section 5 Getting the Help You Need

Medicare Savings Program—A Medicaid program that helps people with limited income and resources pay some or all of their Medicare premiums and deductibles.

Medigap Policy—Medicare Supplement Insurance sold by private insurance companies to fill “gaps” in Original Medicare Plan coverage.

Original Medicare Plan—The Original Medicare Plan has 2 parts: Part A (Hospital Insurance) and Part B (Medical Insurance). It is a fee-for-service health plan. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share (coinsurance and deductibles).

State Health Insurance Assistance Program (SHIP)—A state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

State Pharmacy Assistance Program (SPAP)—A state program that provides help paying for drug coverage based on financial need, age, or medical condition.



Home health aide services are covered if you are also getting Medicare-covered skilled care.

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My Medicare.

To get this publication in Spanish, visit www.medicare.gov on the web, or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

¿Necesita una copia en español? Visite www.medicare.gov en el sitio Web. Para saber si esta publicación esta impresa y disponible (en español), llame GRATIS al 1-800-MEDICARE (1-800-633-4227). Los usuarios de TTY deben llamar al 1-877-486-2048.