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## Reimbursement in the Alternate Care Setting

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Reimbursement issues in alternate sites are complex, constantly changing, and impact patient/resident care.

The different payer sources in alternate care are: Medicare A, Medicare B, Medicare D, Medicare C, Medicaid, Managed care, and Private Pay.

### Glossary:

**Managed Care:** All-inclusive health care which is provided to participating members of an organized health care organization through the use of a network of health care providers and facilities. Example would be an HMO (Health Maintenance Organization)

**Medicare A:** The part of Medicare for those over the age of 65 that covers hospice care, home health care, skilled nursing facilities, and inpatient hospital stays.

**Medicare B:** The part of Medicare for those over the age of 65 that covers doctors' services, outpatient hospital care, and other medical services that Part A doesn't cover such as physical and occupational therapy. Other examples include X-rays, medical equipment or limited ambulance service.

**Medicare D:** A federal program to subsidize the costs of prescription drugs for Medicare beneficiaries in the United States.

**Medicaid:** Health program for eligible individuals and families with low incomes and resources. It is jointly funded by the states and federal government, and is managed by the states.

**Medicare Advantage (C):** Health plan options that are part of the Medicare program. Replaces traditional Medicare. Similar to HMOs (Health Maintenance Organization) which is group insurance that entitles members to services of participating hospitals and clinics and physicians. May cover nursing home and home health costs. Can also include prescription drug coverage.

**Medigap:** Private health insurance designed to supplement the coverage provided under Medicare.

**Per Diem:** Health provider is paid an agreed upon rate that is all inclusive.

**Fee for Service:** Health provider is paid a fee for each service or supply provided.

The following chart shows the different payer sources for home infusion therapy. Keep in mind that although Medicaid is a federal program, it is state run service, so reimbursement varies from state to state. Medicare is federally run, therefore reimbursement will be the same in every state.

## Reimbursement in Home Care

	Part A Home Health	Part B DME(Durable Medical Equipment) Benefit	Part C Medicare Advantage	Part D Prescription Drug Plan	State Medicaid Program	Other Payer Coverage
Requirement	Homebound and in need of part-time or intermittent skilled nursing or therapy services, if such services are reasonable and necessary to the treatment of the illness or injury.	If medically necessary for the drug to be administered through an infusion pump.	Coverage of at least Part A/B services. Coordinated care plans may include additional coverage and mechanisms to control utilization.	Drugs that are not currently covered under Parts A and B of Medicare, or otherwise excluded under Part D.	Provided that coverage is not available through Parts A, B, C, or D of Medicare, Medicaid home health benefit may cover services, equipment and supplies necessary to administer home infusion drugs.	Varies, but generally like Part C.
Professional Fees	Yes	No	Yes	No	Yes – May be billed separately or as part of bundled rate.	Varies, but generally like Part C.
Equipment and Supplies	Sometimes - Home Health Therapy responsible for providing hydration fluid and IV supplies if infusion is provided via gravity feed method.	Yes – Supplies are billed separately by a DME vendor to appropriate DME Regional Carrier.	Yes – Included in per diem payment (generally bundled).	No – Cost of supplies, equipment, and professional fees must be covered via Medicare Parts A or B, Medicare Advantage Plan, Medicaid, other insurance, or out-of-pocket.	Yes – May be billed separately or as part of bundled rate.	Varies, but generally like Part C.
Drug Ingredient and Dispensing Fee	No – Drugs and biologicals are specifically excluded from the Part A home health benefit.	Part B pays the drug costs as a part of the DME benefit but there is no separate dispensing fee paid.	If covered under Part B, yes. If not covered under Part B, must be covered under Part D.	Yes	No – Unless drugs are included in bundled rate.	Varies

## Reimbursement in Long Term Care/Skilled Facilities

Medicare A will pay a per diem (total amount allowed for a particular resident's care) for up to 100 days for infusion in a skilled nursing facility. Medicare pays 100% of the first 20 days of a covered stay. A copayment of \$133.50 per day (in 2009) is required for days 21-100. This per diem includes supplies.

- The resident must enter a Medicare-approved "skilled nursing facility" or nursing home within 30 days of a hospital stay that lasted at least three days.
- The care in the nursing home must be for the same condition as the hospital stay. In addition, the resident must need "skilled care." (infusions; physical therapy; speech therapy; wound care, etc.) Otherwise, reimbursement depends on the resident's insurance.
- Medicare does not pay for long term "custodial care" in a nursing home.

Medicaid will pay a per diem based on state coverage policies for eligible residents.

The bottom line is, for both Nursing Homes and Home Care, when we talk about the additional incurred costs of occlusions and CR-BSIs, it depends on the patient/resident insurance coverage as to who incurs these costs.

- If a Medicaid resident, the skilled facility would probably incur the additional expense, but it would depend on the individual state Medicaid reimbursement policy.
- If a Medicare A resident, the resident would incur the additional expense for anything over the allowed per diem.
- If a private pay resident, the resident is responsible for all expenses.

## Reimbursement in Out Patient Infusion Suites

- Medicare B will pay 80% for patients over the age of 65. The patient is responsible for remaining 20%
- Private insurance pays for those patients without Medicare. The patient usually pays a co-pay.
- Patients with no insurance are responsible for the total amount.
- Medicaid reimbursement will vary based on state policies.

In summary, unlike in hospitals, reimbursement for infusion therapy in the alternate care setting is not a clear cut issue. Medicare and insurance issues can be complicated. There are many variables, including type of therapy and patient/resident insurance coverage. Sorting out all the issues and understanding reimbursement in the alternate care setting is an important part of assuring that patients receive quality care and positive outcomes.



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