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Medicare Benefit Policy Manual
Chapter 7 - Home Health Services

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(Rev. 179, 01-14-14)

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10 - Home Health Prospective Payment System (PPS)
(Rev. 1, 10-01-03)
HH-201

The unit of payment under home health PPS is a national 60-day episode rate with applicable adjustments. The episodes, rate, and adjustments to the rates are detailed in the following sections.

10.1 - National 60-Day Episode Rate
(Rev. 1, 10-01-03)
HH-201.1

A. Services Included

The law requires the 60-day episode to include all covered home health services, including medical supplies, paid on a reasonable cost basis. That means the 60-day episode rate includes costs for the six home health disciplines and the costs for routine and nonroutine medical supplies. The six home health disciplines included in the 60-day episode rate are:

1. Skilled nursing services
2. Home health aide services;
3. Physical therapy;
4. Speech-language pathology services;
5. Occupational therapy services; and
6. Medical social services.

The 60-day episode rate also includes amounts for:

1. Nonroutine medical supplies and therapies that could have been unbundled to part B prior to PPS. See §10.12.C for those services;
2. Ongoing reporting costs associated with the outcome and assessment information set (OASIS); and
3. A one time first year of PPS cost adjustment reflecting implementation costs associated with the revised OASIS assessment schedules needed to classify patients into appropriate case-mix categories.

B. Excluded Services

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The law specifically excludes durable medical equipment from the 60-day episode rate and consolidated billing requirements. DME continues to be paid on the fee schedule outside of the PPS rate.

The osteoporosis drug (injectable calcitonin), which is covered where a woman is postmenopausal and has a bone fracture. This drug is also excluded from the 60-day episode rate but must be billed by the home health agency (HHA) while a patient is under a home health plan of care since the law requires consolidated billing of osteoporosis drugs. The osteoporosis drug continues to be paid on a reasonable cost basis.

10.2 - Adjustments to the 60-Day Episode Rates

(Rev. 1, 10-01-03)
HH-201.2

A. Case-Mix Adjustment

A case-mix methodology adjusts payment rates based on characteristics of the patient and his/her corresponding resource needs (e.g., diagnosis, clinical factors, functional factors, service needs). The 60-day episode rates are adjusted by case-mix methodology based on data elements from the OASIS. The data elements of the case-mix adjustment methodology are organized into three dimensions to capture clinical severity factors, functional severity factors, and service utilization factors influencing case mix. In the clinical, functional, and service utilization dimensions, each data element is assigned a score value. The scores are summed to determine the patient's case-mix group.

B. Labor Adjustments

The labor portion of the 60-day episode rates is adjusted to reflect the wage index based on the site of service of the beneficiary. The beneficiary's location is the determining factor for the labor adjustment. The home health PPS rates are adjusted by the pre-floor and pre-reclassified hospital wage index. The hospital wage index is adjusted to account for the geographic reclassification of hospitals in accordance with §§1886(d)(8)(B) and 1886(d)(10) of the Social Security Act (the Act.) According to the law, geographic reclassification only applies to hospitals. Additionally, the hospital wage index has specific floors that are required by law. Because these reclassifications and floors do not apply to HHAs, the home health rates are adjusted by the pre-floor and pre-reclassified hospital wage index.

NOTE: The pre-floor and pre-reclassified hospital wage index varies slightly from the numbers published in the Medicare inpatient hospital PPS regulation that reflects the floor and reclassification adjustments. The wage indices published in the home health final rule and subsequent annual updates reflect the most recent available pre-floor and pre-reclassified hospital wage index available at the time of publication.

10.3 - Continuous 60-Day Episode Recertification

(Rev. 1, 10-01-03)

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HH-201.3

Home health PPS permits continuous episode recertifications for patients who continue to be eligible for the home health benefit. Medicare does not limit the number of continuous episode recertifications for beneficiaries who continue to be eligible for the home health benefit.

10.4 - Counting 60-Day Episodes

(Rev. 1, 10-01-03)
HH-201.4

A. Initial Episodes

The "From" date for the initial certification must match the start of care (SOC) date, which is the first billable visit date for the 60-day episode. The "To" date is up to and including the last day of the episode which is not the first day of the subsequent episode. The "To" date can be up to, but never exceed a total of 60 days that includes the SOC date plus 59 days.

B. Subsequent Episodes

If a patient continues to be eligible for the home health benefit, the home health PPS permits continuous episode recertifications. At the end of the 60-day episode, a decision must be made whether or not to recertify the patient for a subsequent 60-day episode. An eligible beneficiary who qualifies for a subsequent 60-day episode would start the subsequent 60-day episode on day 61. The "From" date for the first subsequent episode is day 61 up to including day 120. The "To" date for the subsequent episode in this example can be up to, but never exceed a total of 60 days that includes day 61 plus 59 days.

Note that the certification or recertification visit can be done during a prior episode.

10.5 - Split Percentage Payment Approach to the 60-Day Episode

(Rev. 1, 10-01-03)
HH-201.5

In order to ensure adequate cash flow to HHAs, the home health PPS has set forth a split percentage payment approach to the 60-day episode. The split percentage occurs through the request for anticipated payment (RAP) at the start of the episode and the final claim at the end of the episode. For initial episodes, there will be a 60/40 split percentage payment. An initial percentage payment of 60 percent of the episode will be paid at the beginning of the episode and a final percentage payment of 40 percent will be paid at the end of the episode, unless there is an applicable adjustment. For all subsequent episodes for beneficiaries who receive continuous home health care, the episodes will be paid at a 50/50-percentage payment split.

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10.6 - Physician Signature Requirements for the Split Percentage Payments

(Rev. 1, 10-01-03)
HH-201.6
A. Initial Percentage Payment

If a physician-signed plan of care is not available at the beginning of the episode, the HHA may submit a RAP for the initial percentage payment based on physician verbal orders OR a referral prescribing detailed orders for the services to be rendered that is signed and dated by the physician. If the RAP submission is based on a physician's verbal orders, the verbal order must be recorded in the plan of care, include a description of the patient's condition and the services to be provided by the home health agency, and include an attestation (relating to the physician's orders and the date received per Code of Federal Regulation (CFR) 42 CFR 409.43). The plan of care is copied and immediately submitted to the physician. A billable visit must be rendered prior to the submission of a RAP.

The CMS has the authority to reduce or disapprove requests for anticipated payments in situations when protecting Medicare program integrity warrants this action. Since the request for anticipated payment is based on verbal orders and is not a Medicare claim for purposes of the Act (although it is a claim for purposes of Federal, civil, criminal, and administrative law enforcement authorities, including but not limited to the Civil Monetary Penalties Law, Civil False Claims Act, and the Criminal False Claims Act), the request for anticipated payment will be canceled and recovered unless the claim is submitted within the greater of 60 days from the end of the episode or 60 days from the issuance of the request for anticipated payment.

B. Final Percentage Payment

The plan of care must be signed and dated by a physician who meets the certification and recertification requirements of 42 CFR 424.22 before the claim for each episode for services is submitted for the final percentage payment. Any changes in the plan of care must be signed and dated by a physician.

10.7 - Low Utilization Payment Adjustment (LUPA)

(Rev. 139, Issued: 02-16-11, Effective: 01-01-11, Implementation: 03-10-11)

An episode with four or fewer visits is paid the national per visit amount by discipline adjusted by the appropriate wage index based on the site of service of the beneficiary. Such episodes of four or fewer visits are paid the wage-adjusted per visit amount for each of the visits rendered instead of the full episode amount. The national per visit amounts by discipline (skilled nursing, home health aide, physical therapy, speech-language pathology, occupational therapy, and medical social services) are updated and published annually by the applicable market basket for each visit type.

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Beginning in CY 2008, to offset the full cost of longer, initial visits in some LUPA episodes, CMS has modified the LUPA by increasing the payment by an add-on amount for LUPAs that occur as the only episode or the initial episode during a sequence of adjacent episodes. The initial LUPA add-on amount was $92.63 for CY 2008, and is updated annually by the home health market basket update percentage, plus or minus any percentage mandated by Congress.

10.8 - Partial Episode Payment (PEP) Adjustment

(Rev. 139, Issued: 02-16-11, Effective: 01-01-11, Implementation: 03-10-11)

A. PEP Adjustment Criteria

The PEP adjustment accounts for key intervening events in a patient's care defined as:

- A beneficiary elected transfer; or
- A discharge resulting from the beneficiary reaching the treatment goals in the original plan of care and returning to the same HHA during the 60-day episode.

The intervening event defined as the beneficiary elected transfer or discharge and return to the same HHA during the 60-day episode warrants a new 60-day episode for purposes of payment. A start of care OASIS assessment and physician certification of the new plan of care are required. When a new 60-day episode begins due to the intervening event of the beneficiary elected transfer or discharge and return to the same HHA during the 60-day episode, the original 60-day episode is proportionally adjusted to reflect the length of time the beneficiary remained under the agency's care prior to the intervening event.

Home health agencies have the option to discharge the patient within the scope of their own operating policies. However, an HHA discharging a patient as a result of hospital (SNF or rehab facility) admission with the patient returning to home health services at the same HHA during the 60-day episode will not be recognized by Medicare as a discharge for billing and payment purposes, and thus a Partial Episode Payment (PEP) adjustment would not apply. An intervening hospital (SNF or rehab facility) stay will result in a full 60-day episode spanning the start of care date prior to the hospital (SNF or rehab facility) admission, through and including the days of the hospital admission, and ending 59 days after the original start of care date.

B. Methodology Used to Calculate PEP Adjustment

The PEP adjustment for the original 60-day episode is calculated to reflect the length of time the beneficiary remained under the care of the original HHA based on the first billable visit date through and including the last billable visit date. The PEP adjustment is calculated by determining the actual days served by the original HHA (first billable visit date through and including last billable visit date as a proportion of 60 multiplied by the original 60-day episode payment).

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C. Application of Therapy Threshold to PEP Adjusted Episode

The therapy threshold item included in the case-mix methodology used in home health PPS is not combined or prorated across episodes. Each episode whether full or proportionately adjusted is subject to the therapy threshold for purposes of case-mix adjusting the payment for that individual patient's resource needs.

D. Common Ownership Exception to PEP Adjustment

If an HHA has a significant ownership as defined in 42 CFR 424.22, then the PEP adjustment would not apply in those situations of beneficiary elected transfer. Those situations would be considered services provided under arrangement on behalf of the originating HHA by the receiving HHA with the ownership interest until the end of the episode. The common ownership exception to the transfer PEP adjustment does not apply if the beneficiary moved out of their MSA or non-MSA during the 60-day episode before the transfer to the receiving HHA.

E. Beneficiary Elected Transfer Verification

In order for a receiving HHA to accept a beneficiary elected transfer, the receiving HHA must document that the beneficiary has been informed that the initial HHA will no longer receive Medicare payment on behalf of the patient and will no longer provide Medicare covered services to the patient after the date of the patient's elected transfer in accordance with current patient rights requirements at 42 CFR 484.10(e). The receiving HHA must also document in the record that it accessed the regional home health intermediaries (RHHI) inquiry system to determine whether or not the patient was under an established home health plan of care and it must contact the initial HHA on the effective date of transfer. In the rare circumstance of a dispute between HHAs, the RHHI is responsible for working with both HHAs to resolve the dispute. If the receiving HHA can provide documentation of its notice of patient rights on Medicare payment liability provided to the patient upon transfer and its contact of the initial HHA of the transfer date, then the initial HHA will be ineligible for payment for the period of overlap in addition to the appropriate PEP adjustment. If the receiving HHA cannot provide the appropriate documentation, the receiving HHA's RAP and/or final claim will be cancelled, and full episode payment will be provided to the initial HHA. For the receiving HHA to properly document that it contacted the initial HHA on the effective date of transfer it must maintain similar information as the initial HHA, including the same basic beneficiary information, personnel contacted, dates and times. The initial HHA must also properly document that it was contacted and it accepted the transfer. Where it disputes a transfer, the initial HHA must call its RHHI to resolve the dispute. The RHHI is responsible for working with both HHAs to resolve the dispute.

10.9 - Outlier Payments

(Rev. 139, Issued: 02-16-11, Effective: 01-01-11, Implementation: 03-10-11)

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When cases experience an unusually high level of services in a 60-day period, Medicare systems will provide additional or "outlier" payments to the case-mix and wage-adjusted episode payment. Outlier payments can result from medically necessary high utilization in any or all-home health service disciplines. CMS makes outlier payments when the cost of care exceeds a threshold dollar amount. The outlier threshold for each case-mix group is the episode payment amount for that group or the PEP adjustment amount for the episode, plus a fixed dollar loss amount, which is the same for all case-mix groups. The outlier payment is a proportion of the amount of imputed costs beyond the threshold. CMS calculates the imputed cost for each episode by multiplying the national per visit amount of each discipline by the number of visits in the discipline and computing the total imputed cost for all disciplines. If the imputed cost for the episode is greater than the sum of the case-mix and wage-adjusted episode payment plus the fixed dollar loss amount (the outlier threshold), a set percentage (the loss sharing ratio) of the difference between the imputed amount and outlier threshold will be paid to the HHA as a wage-adjusted outlier payment in addition to the episode payment. The amount of the outlier payment is determined as follows:

1. Calculate the case-mix and wage-adjusted episode payment (including non-routine supplies (NRS));

2. Add the wage-adjusted fixed dollar loss amount. The sum of steps 1 and 2 is the outlier threshold for the episode;

3. Calculate the wage-adjusted imputed cost of the episode by first multiplying the total number of visits for each home health discipline by the national per visit amounts, and wage-adjusting those amounts. Sum the per discipline wage-adjusted imputed amounts to yield the total wage-adjusted imputed cost for the episode;

4. Subtract the total imputed cost for the episode (total from Step 3) from the sum of the case-mix and wage-adjusted episode payment and the wage-adjusted fixed dollar loss amount (sum of Steps 1 and 2 - outlier threshold);

5. Multiply the difference by the loss sharing ratio; and

6. That total amount is the outlier payment for the episode.

Effective January 1, 2010, an outlier cap precludes any HHA from receiving more than 10 percent of their total home health payment in outliers.

10.10 - Discharge Issues

(Rev. 139, Issued: 02-16-11, Effective: 01-01-11, Implementation: 03-10-11)

A. Hospice Election Mid-Episode

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If a patient elects hospice before the end of the episode and there was no PEP or LUPA adjustment, the HHA will receive a full episode payment. Home health PPS does not change the current rules that permit a hospice patient to receive home health services for a condition unrelated to his/her reason for hospice election. Consistent with all episodes in which a patient receives four or fewer visits, the episode with four or fewer visits in which a patient elects hospice would be paid at the low utilization payment adjusted amount.

B. Patient's Death

The documented event of a patient's death would result in a full episode payment, unless the death occurred in a low utilization payment adjusted episode. Consistent with all episodes in which a patient receives four or fewer visits, if the patient's death occurred during an episode with four or fewer visits, the episode would be paid at the low utilization payment adjusted amount. In the event of a patient's death during an adjusted episode, the total adjusted episode would constitute the full episode payment. However, the HHA is not constrained to bill for a higher case-mix group if the net effect is a lower payment for the episode than if the adjustment had not occurred.

C. Patient is No Longer Eligible for Home Health (e.g., no longer homebound, no skilled need).

If the patient is discharged because he or she is no longer eligible for the Medicare home health benefit and has received more than four visits, then the HHA would receive full episode payment. However, if the patient becomes subsequently eligible for the Medicare home health benefit during the same 60-day episode and later transferred to another HHA or returned to the same HHA, then the latter situation would result in a PEP adjustment.

D. Discharge Due to Patient Refusal of Services or is a Documented Safety Threat, Abuse Threat or is Noncompliant.

If the patient is discharged because he or she refuses services or becomes a documented safety, abuse, or noncompliance discharge and has received more than four visits, then the HHA would receive full episode payment unless the patient becomes subsequently eligible for the Medicare home health benefit during the same 60-day episode and later transferred to another HHA or returned to the same HHA, then the latter situation would result in a PEP adjustment.

E. Patient Becomes Managed Care Eligible Mid-Episode

If a patient's enrollment in a Medicare Advantage (MA) plan becomes effective mid episode, the 60-day episode payment will be made proportionally adjusted with a PEP adjustment since the patient is receiving coverage under MA. Beginning with the effective date of enrollment, the MA plan will receive a capitation payment for covered services.

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F. Submission of Final Claims Prior to the End of the 60-day Episode

The claim may be submitted upon discharge before the end of the 60-day episode. However, subsequent adjustments to any payments based on the claim may be made due to an intervening event resulting in a PEP adjustment or other adjustment.

G. Patient Discharge and Financial Responsibility for Part B Bundled Medical Supplies and Services

As discussed in detail under §10.11, below, the law governing the Medicare home health PPS requires the HHA to provide all bundled home health services (except DME) either directly or under arrangement while a patient is under a home health plan of care during an open episode. The HHA is responsible for providing all covered home health services (except DME) either directly or under arrangement while a patient is under a home health plan of care during an open episode. Once the patient is discharged, the HHA is no longer responsible for providing home health services including the bundled Part B medical supplies and therapy services.

H. Discharge Issues Associated With Inpatient Admission Overlapping Into Subsequent Episodes

1. If a patient is admitted to an inpatient facility and the inpatient stay overlaps into what would have been the subsequent episode and there is no reassessment or recertification of the patient, then the certification begins with the new start of care date after inpatient discharge.

10.11 - Consolidated Billing

(Rev. 139, Issued: 02-16-11, Effective: 01-01-11, Implementation: 03-10-11)

For individuals under a home health plan of care payment for all services and supplies, with the exception of the osteoporosis drugs and DME, is included in the PPS episodic rate. HHAs must provide the covered home health services (except DME) either directly or under arrangement, and must bill for such covered home health services.

Payment must be made to the HHA.

A. Home Health Services Subject to Consolidated Billing Requirements

The home health services included in the consolidated billing governing home health PPS are:

- Part-time or intermittent skilled nursing services;
- Part-time or intermittent home health aide services;

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- Physical therapy;
- Speech-language pathology services;
- Occupational therapy;
- Medical social services;
- Routine and nonroutine medical supplies;
- Covered osteoporosis drug as defined in §1861(kk) of the Act, but excluding other drugs and biologicals;
- Medical services provided by an intern or resident-in-training of the program of the hospital in the case of an HHA that is affiliated or under common control with a hospital with an approved teaching program; and
- Home health services defined in §1861(m) provided under arrangement at hospitals, SNFs, or rehabilitation centers when they involve equipment too cumbersome to bring to the home or are furnished while the patient is at the facility to receive such services.

B. Medical Supplies

The law requires all medical supplies (routine and nonroutine) bundled to the agency while the patient is under a home health plan of care. The agency that establishes the episode is the only entity that can bill and receive payment for medical supplies during an episode for a patient under a home health plan of care. Both routine and nonroutine medical supplies are included in the base rates for every Medicare home health patient regardless of whether or not the patient requires medical supplies during the episode.

Due to the consolidated billing requirements, CMS provided additional amounts in the base rates for those nonroutine medical supplies that have a duplicate Part B code that could have been unbundled to Part B prior to PPS. See §§50.4 for detailed discussion of medical supplies.

Medical supplies used by the patient, provider, or other practitioners under arrangement on behalf of the agency (other than physicians) are subject to consolidated billing and bundled to the HHA episodic payment rate. Once a patient is discharged from home health and not under a home health plan of care, the HHA is not responsible for medical supplies.

The DME, including supplies covered as DME, are paid separately from the PPS rates and are excluded from the consolidated billing requirements governing PPS. The determining factor is the medical classification of the supply, not the diagnosis of the patient. For example, infusion therapy will continue to be covered under the DME

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benefit separately paid from the PPS rate and excluded from the consolidated billing requirements governing PPS. The DME supplies that are currently covered and paid in accordance with the DME fee schedule as category SU are billed under the DME benefit and not included in the bundled HHA episodic payment rate. The HHAs are not required to do consolidated billing of SU supplies.

Osteoporosis drugs are included in consolidated billing under the home health benefit. However, payment is not bundled into the episodic payment rate. The HHAs must bill for osteoporosis drugs in accordance with billing instructions. Payment is in addition to the episodic payment rate.

C. Relationship Between Consolidated Billing Requirements and Part B Supplies and Part B Therapies Included in the Baseline Rates That Could Have Been Unbundled Prior to PPS That No Longer Can Be Unbundled.

The HHA is responsible for the services provided under arrangement on their behalf by other entities. Covered home health services at §1861(m) of the Act (except DME) are included in the baseline PPS rates and subject to the consolidated billing requirements while the patient is under a plan of care of the HHA. The time the services are bundled is while the patient is under a home health plan of care.

Physician services or nurse practitioner services that are bundled into the physician fee schedule payments are not recognized as a home health service included in the PPS rate. Supplies incident to a physician service or related to a physician service billed to the carrier are not subject to the consolidated billing requirements. The physician would not be acting as a supplier billing the DMERC in this situation.

Therapies (physical therapy, occupational therapy, and speech-language pathology services) are covered home health services that are included in the baseline rates and subject to the consolidated billing requirements. In addition to therapies that had been paid on a cost basis under home health, CMS has included in the rates additional amounts for Part B therapies that could have been unbundled prior to PPS. These therapies are subject to the consolidated billing requirements. There are revenue center codes that reflect the ranges of outpatient physical therapy, occupational therapy, and speech-language pathology services and HCPCS codes that reflect physician supplier codes that are physical therapy, occupational therapy, and speech-language pathology services by code definition and are subject to the consolidated billing requirements. Therefore, the above-mentioned therapies must be provided directly or under arrangement on behalf of the HHA while a patient is under a home health plan of care cannot be separately billed to Part B during an open 60-day episode.

D. Freedom of Choice Issues

A beneficiary exercises his or her freedom of choice for the services under the home health benefit listed in §1861(m) of the Act, including medical supplies, but excluding DME covered as a home health service by choosing the HHA. Once a home health

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patient chooses a particular HHA, he or she has clearly exercised freedom of choice with respect to all items and services included within the scope of the Medicare home health benefit (except DME). The HHA's consolidated billing role supersedes all other billing situations the beneficiary may wish to establish for home health services covered under the scope of the Medicare home health benefit during the certified episode.

E. Knowledge of Services Arranged for on Behalf of the HHA

The consolidated billing requirements governing home health PPS requires that the HHA provide all covered home health services (except DME) either directly or under arrangement while a patient is under a home health plan of care. Providing services either directly or under arrangement requires knowledge of the services provided during the episode. In addition, in accordance with current Medicare conditions of participation and Medicare coverage guidelines governing home health, the patient's plan of care must reflect the physician ordered services that the HHA provides either directly or under arrangement. An HHA would not be responsible for payment in the situation in which they have no prior knowledge (unaware of physicians orders) of the services provided by an entity during an episode to a patient who is under their home health plan of care. An HHA is responsible for payment in the situation in which services are provided to a patient by another entity, under arrangement with the HHA, during an episode in which the patient is under the HHA's home health plan of care. However, it is in the best interest of future business relationships to discuss the situation with any entity that seeks payment from the HHA during an episode in an effort to resolve any misunderstanding and avoid such situations in the future.

10.12 - Change of Ownership Relationship to Episodes Under PPS

(Rev. 139, Issued: 02-16-11, Effective: 01-01-11, Implementation: 03-10-11)

A. Change of Ownership With Assignment

When there is a change of ownership and the new owner accepts assignment of the existing provider agreement, the new owner is subject to all the terms and conditions under which the existing agreement was issued. The provider number remains the same if the new HHA owner accepts assignment of the existing provider agreement. As long as the new owner complies with the regulations governing home health PPS, billing, and payment for episodes with applicable adjustments for existing patients under an established plan of care will continue on schedule through the change in ownership with assignment. The episode would be uninterrupted spanning the date of sale. The former owner is required to file a terminating cost report. Instructions regarding when a cost report is filed are in the Provider Reimbursement Manual, Part 1, §1500.

B. Change of Ownership Without Assignment

When there is a change of ownership, and the new owner does not take the assignment of the existing provider agreement, the provider agreement and provider number of the former owner is terminated. The former owner will receive partial episode payment

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adjusted payments in accordance with the methodology set forth in the Medicare Claims Processing Manual, Chapter 10, "Home Health Agency Billing," §40.2, and 42 CFR 484.235, based on the last billable visit date for existing patients under a home health plan of care ending on or before the date of sale. The former owner is required to file a terminating cost report. The new owner cannot bill Medicare for payment until the effective date of the Medicare approval. The new HHA will not be able to participate in the Medicare program without going through the same process as any new provider, which includes an initial survey. Once the new owner is Medicare-approved, the HHA may start a new episode for purposes of payment, OASIS assessment, and certification of the home health plan of care for all new patients in accordance with the regulations governing home health PPS, effective with the date of the new provider certification.

C. Change of Ownership - Mergers

The merger of a provider corporation into another corporation constitutes a change of ownership. For information on specific procedures, refer to Pub. 100-07, State Operations Manual, chapter 2, section 2202.17.

20 - Conditions To Be Met for Coverage of Home Health Services

(Rev. 1, 10-01-03)
A3-3116, HHA-203

Medicare covers HHA services when the following criteria are met:

1. The person to whom the services are provided is an eligible Medicare beneficiary;

2. The HHA that is providing the services to the beneficiary has in effect a valid agreement to participate in the Medicare program;

3. The beneficiary qualifies for coverage of home health services as described in §30;

4. The services for which payment is claimed are covered as described in §§40 and 50;

5. Medicare is the appropriate payer; and

6. The services for which payment is claimed are not otherwise excluded from payment.

20.1 - Reasonable and Necessary Services

(Rev. 1, 10-01-03)
A3-3116.1. HHA-203.1

20.1.1 - Background

(Rev. 1, 10-01-03)

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A3-3116.1A, HHA-203.1A

In enacting the Medicare program, Congress recognized that the physician would play an important role in determining utilization of services. The law requires that payment can be made only if a physician certifies the need for services and establishes a plan of care. The Secretary is responsible for ensuring that Medicare covers the claimed services, including determining whether they are "reasonable and necessary."

20.1.2 - Determination of Coverage

(Rev. 179, Issued: 01-14-14, Effective: 01-07-14, Implementation: 01-07-14)
A3-3113.1.B, HHA-203.1.B

The intermediary's decision on whether care is reasonable and necessary is based on information reflected in the home health plan of care, the OASIS as required by 42 CFR 484.55 or a medical record of the individual patient. Medicare does not deny coverage solely on the basis of the reviewer's general inferences about patients with similar diagnoses or on data related to utilization generally, but bases it upon objective clinical evidence regarding the patient's individual need for care. *Coverage of skilled nursing care or therapy to perform a maintenance program does not turn on the presence or absence of a patient's potential for improvement from the nursing care or therapy, but rather on the patient's need for skilled care. Skilled care may be necessary to improve a patient's current condition, to maintain the patient's current condition, to prevent or slow further deterioration of the patient's condition.*

20.2 - Impact of Other Available Caregivers and Other Available Coverage on Medicare Coverage of Home Health Services

(Rev. 1, 10-01-03)
A3-3116.2, HHA-203.2

Where the Medicare criteria for coverage of home health services are met, patients are entitled by law to coverage of reasonable and necessary home health services. Therefore, a patient is entitled to have the costs of reasonable and necessary services reimbursed by Medicare without regard to whether there is someone available to furnish the services. However, where a family member or other person is or will be providing services that adequately meet the patient's needs, it would not be reasonable and necessary for HHA personnel to furnish such services. Ordinarily it can be presumed that there is no able and willing person in the home to provide the services being rendered by the HHA unless the patient or family indicates otherwise and objects to the provision of the services by the HHA, or unless the HHA has first hand knowledge to the contrary.

EXAMPLE 1:

A patient who lives with an adult daughter and otherwise qualifies for Medicare coverage of home health services, requires the assistance of a home health aide for bathing and assistance with an exercise program to improve endurance. The daughter is unwilling to

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bathe her elderly father and assist him with the exercise program. Home health aide services would be reasonable and necessary.

Similarly, a patient is entitled to have the costs of reasonable and necessary home health services reimbursed by Medicare even if the patient would qualify for institutional care (e.g., hospital care or skilled nursing facility care).

EXAMPLE 2:

A patient who is being discharged from a hospital with a diagnosis of osteomyelitis and requires continuation of the I.V. antibiotic therapy that was begun in the hospital was found to meet the criteria for Medicare coverage of skilled nursing facility services. If the patient also meets the qualifying criteria for coverage of home health services, payment may be made for the reasonable and necessary home health services the patient needs, notwithstanding the availability of coverage in a skilled nursing facility.

Medicare payment should be made for reasonable and necessary home health services where the patient is also receiving supplemental services that do not meet Medicare's definition of skilled nursing care or home health aide services.

EXAMPLE 3:

A patient who needs skilled nursing care on an intermittent basis also hires a licensed practical (vocational) nurse to provide nighttime assistance while family members sleep. The care provided by the nurse, as respite to the family members, does not require the skills of a licensed nurse (as defined in §40.1) and therefore has no impact on the beneficiary's eligibility for Medicare payment of home health services even though another third party insurer may pay for that nursing care.

20.3 - Use of Utilization Screens and "Rules of Thumb"

(Rev. 1, 10-01-03)
A3-3116.3, HHA-203.3

Medicare recognizes that determinations of whether home health services are reasonable and necessary must be based on an assessment of each beneficiary's individual care needs. Therefore, denial of services based on numerical utilization screens, diagnostic screens, diagnosis or specific treatment norms is not appropriate.

30 - Conditions Patient Must Meet to Qualify for Coverage of Home Health Services

(Rev. 1, 10-01-03)
A3-3117, HHA-204, A-98-49

To qualify for the Medicare home health benefit, under §§1814(a)(2)(C) and 1835(a)(2)(A) of the Act, a Medicare beneficiary must meet the following requirements:

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- Be confined to the home;
- Under the care of a physician;
- Receiving services under a plan of care established and periodically reviewed by a physician;
- Be in need of skilled nursing care on an intermittent basis or physical therapy or speech-language pathology; or
- Have a continuing need for occupational therapy.

For purposes of benefit eligibility, under §§1814(a)(2)(C) and 1835(a)(2)(A) of the Act, "intermittent" means skilled nursing care that is either provided or needed on fewer than 7 days each week or less than 8 hours of each day for periods of 21 days or less (with extensions in exceptional circumstances when the need for additional care is finite and predictable).

A patient must meet each of the criteria specified in this section. Patients who meet each of these criteria are eligible to have payment made on their behalf for services discussed in §§40 and 50.

30.1 - Confined to the Home

(Rev. 1, 10-01-03)
A3-3117.1, HHA-204.1

30.1.1 - Patient Confined to the Home

(Rev. 172, Issued: 10-18-13, Effective: 11-19-13, Implementation: 11- 19 -13)

For a patient to be eligible to receive covered home health services under both Part A and Part B, the law requires that a physician certify in all cases that the patient is confined to his/her home. For purposes of the statute, an individual shall be considered “confined to the home” (homebound) if the following two criteria are met:

1. Criteria-One:

The patient must either:

- Because of illness or injury, need the aid of supportive devices such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the assistance of another person in order to leave their place of residence

OR

- Have a condition such that leaving his or her home is medically contraindicated.

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If the patient meets one of the Criteria-One conditions, then the patient must ALSO meet two additional requirements defined in Criteria-Two below.

2. Criteria-Two:

    - There must exist a normal inability to leave home;

    AND

    - Leaving home must require a considerable and taxing effort.

If the patient does in fact leave the home, the patient may nevertheless be considered homebound if the absences from the home are infrequent or for periods of relatively short duration, or are attributable to the need to receive health care treatment. Absences attributable to the need to receive health care treatment include, but are not limited to:

- Attendance at adult day centers to receive medical care;
- Ongoing receipt of outpatient kidney dialysis; or
- The receipt of outpatient chemotherapy or radiation therapy.

Any absence of an individual from the home attributable to the need to receive health care treatment, including regular absences for the purpose of participating in therapeutic, psychosocial, or medical treatment in an adult day-care program that is licensed or certified by a State, or accredited to furnish adult day-care services in a State, shall not disqualify an individual from being considered to be confined to his home. Any other absence of an individual from the home shall not so disqualify an individual if the absence is of an infrequent or of relatively short duration. For purposes of the preceding sentence, any absence for the purpose of attending a religious service shall be deemed to be an absence of infrequent or short duration. It is expected that in most instances, absences from the home that occur will be for the purpose of receiving health care treatment. However, occasional absences from the home for nonmedical purposes, e.g., an occasional trip to the barber, a walk around the block or a drive, attendance at a family reunion, funeral, graduation, or other infrequent or unique event would not necessitate a finding that the patient is not homebound if the absences are undertaken on an infrequent basis or are of relatively short duration and do not indicate that the patient has the capacity to obtain the health care provided outside rather than in the home.

Some examples of homebound patients that illustrate the factors used to determine whether a homebound condition exists would be:

- A patient paralyzed from a stroke who is confined to a wheelchair or requires the aid of crutches in order to walk;

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- A patient who is blind or senile and requires the assistance of another person in leaving their place of residence;

- A patient who has lost the use of their upper extremities and, therefore, is unable to open doors, use handrails on stairways, etc., and requires the assistance of another individual to leave their place of residence;

- A patient in the late stages of ALS or neurodegenerative disabilities. In determining whether the patient has the general inability to leave the home and leaves the home only infrequently or for periods of short duration, it is necessary (as is the case in determining whether skilled nursing services are intermittent) to look at the patient's condition over a period of time rather than for short periods within the home health stay. For example, a patient may leave the home (under the conditions described above, e.g., with severe and taxing effort, with the assistance of others) more frequently during a short period when, for example, the presence of visiting relatives provides a unique opportunity for such absences, than is normally the case. So long as the patient's overall condition and experience is such that he or she meets these qualifications, he or she should be considered confined to the home.

- A patient who has just returned from a hospital stay involving surgery who may be suffering from resultant weakness and pain and, therefore, their actions may be restricted by their physician to certain specified and limited activities such as getting out of bed only for a specified period of time, walking stairs only once a day, etc.;

- A patient with arteriosclerotic heart disease of such severity that they must avoid all stress and physical activity; and

- A patient with a psychiatric illness that is manifested in part by a refusal to leave home or is of such a nature that it would not be considered safe for the patient to leave home unattended, even if they have no physical limitations.

The aged person who does not often travel from home because of feebleness and insecurity brought on by advanced age would not be considered confined to the home for purposes of receiving home health services unless they meet one of the above conditions.

Although a patient must be confined to the home to be eligible for covered home health services, some services cannot be provided at the patient's residence because equipment is required that cannot be made available there. If the services required by an individual involve the use of such equipment, the HHA may make arrangements with a hospital, skilled nursing facility (SNF), or a rehabilitation center to provide these services on an outpatient basis. (See §50.6.) However, even in these situations, for the services to be covered as home health services the patient must be considered as confined to home; and to receive such outpatient services a homebound patient will generally require the use of

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supportive devices, special transportation, or the assistance of another person to travel to the appropriate facility.

If a question is raised as to whether a patient is confined to the home, the HHA will be requested to furnish the intermediary with the information necessary to establish that the patient is homebound as defined above.

30.1.2 - Patient's Place of Residence

(Rev. 179, Issued: 01-14-14, Effective: 01-07-14, Implementation: 01-07-14)

A3-3117.1.B, HHA-204.1.B

A patient's residence is wherever he or she makes his or her home. This may be his or her own dwelling, an apartment, a relative's home, a home for the aged, or some other type of institution. However, an institution may not be considered a patient's residence if the institution meets the requirements of §§1861(e)(1) or 1819(a)(1) of the Act. Included in this group are hospitals and skilled nursing facilities, as well as most nursing facilities under Medicaid. (See the Medicare State Operations Manual, §2166.)

Thus, if a patient is in an institution or distinct part of an institution identified above, the patient is not entitled to have payment made for home health services under either Part A or Part B since such an institution may not be considered their residence. When a patient remains in a participating SNF following their discharge from active care, the facility may not be considered their residence for purposes of home health coverage.

A patient may have more than one home and the Medicare rules do not prohibit a patient from having one or more places of residence. A patient, under a Medicare home health plan of care, who resides in more than one place of residence during an episode of Medicare covered home health services will not disqualify the patient's homebound status for purposes of eligibility. For example, a person may reside in a principal home and also a second vacation home, mobile home, or the home of a caretaker relative. The fact that the patient resides in more than one home and, as a result, must transit from one to the other, is not in itself, an indication that the patient is not homebound. The requirements of homebound must be met at each location (e.g., considerable taxing effort etc.).

A. Assisted Living Facilities, Group Homes, and Personal Care Homes

An individual may be "confined to the home" for purposes of Medicare coverage of home health services if he or she resides in an institution that is not primarily engaged in providing to inpatients:

- Diagnostic and therapeutic services for medical diagnosis;
- Treatment;
- Care of *injured,* disabled or sick persons;

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- Rehabilitation services or *other skilled services needed to maintain a patient's current condition or to prevent or slow further deterioration; or*

- Skilled nursing care or related services for patients who require medical or nursing care.

If it is determined that the assisted living facility (also called personal care homes, group homes, etc.) in which the individuals reside are not primarily engaged in providing the above services, then Medicare will cover reasonable and necessary home health care furnished to these individuals.

If it is determined that the services furnished by the home health agency are duplicative of services furnished by an assisted living facility (also called personal care homes, group homes, etc.) when provision of such care is required of the facility under State licensure requirements, claims for such services should be denied under §1862(a)(1)(A) of the Act. Section 1862(a)(1)(A) excludes services that are not necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member from Medicare coverage. Services to people who already have access to appropriate care from a willing caregiver would not be considered reasonable and necessary to the treatment of the individual's illness or injury.

Medicare coverage would not be an optional substitute for the services that a facility is required to provide by law to its patients or where the services are included in the base contract of the facility. An individual's choice to reside in such a facility is also a choice to accept the services it holds itself out as offering to its patients.

B. Day Care Centers and Patient's Place of Residence

The current statutory definition of homebound or confined does not imply that Medicare coverage has been expanded to include adult day care services.

The law does not permit an HHA to furnish a Medicare covered billable visit to a patient under a home health plan of care outside his or her home, except in those limited circumstances where the patient needs to use medical equipment that is too cumbersome to bring to the home. Section 1861(m) of the Act stipulates that home health services provided to a patient be provided to the patient on a visiting basis in a place of residence used as the individual's home. A licensed/certified day care center does not meet the definition of a place of residence.

C. State Licensure/Certification of Day Care Facilities

Section 1861(m) of the Act, an adult day care center must be either licensed or certified by the State or accredited by a private accrediting body. State licensure or certification as an adult day care facility must be based on State interpretations of its process. For example, several States do not license adult day care facilities as a whole, but do certify

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some entities as Medicaid certified centers for purposes of providing adult day care under the Medicaid home and community based waiver program. It is the responsibility of the State to determine the necessary criteria for "State certification" in such a situation. A State could determine that Medicaid certification is an acceptable standard and consider its Medicaid certified adult day care facilities to be "State certified." On the other hand, a State could determine Medicaid certification to be insufficient and require other conditions to be met before the adult day care facility is considered "State certified".

D. Determination of the Therapeutic, Medical or Psychosocial Treatment of the Patient at the Day Care Facility

It is not the obligation of the HHA to determine whether the adult day care facility is providing psychosocial treatment, but only to assure that the adult day care center is licensed/certified by the State or accrediting body. The intent of the law, in extending the homebound exception status to attendance at such adult day care facilities, recognizes that they ordinarily furnish psychosocial services.

30.2 - Services Are Provided Under a Plan of Care Established and Approved by a Physician

(Rev. 1, 10-01-03)
A3-3117.2, HHA-204.2

30.2.1 - Content of the Plan of Care

(Rev. 139, Issued: 02-16-11, Effective: 01-01-11, Implementation: 03-10-11)

The HHA must be acting upon a physician plan of care that meets the requirements of this section for HHA services to be covered.

The plan of care must contain all pertinent diagnoses, including:

- The patient's mental status;
- The types of services, supplies, and equipment required;
- The frequency of the visits to be made;
- Prognosis;
- Rehabilitation potential;
- Functional limitations;
- Activities permitted;
- Nutritional requirements;

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- All medications and treatments;
- Safety measures to protect against injury;
- Instructions for timely discharge or referral; and
- Any additional items the HHA or physician choose to include.

If the plan of care includes a course of treatment for therapy services:

- The course of therapy treatment must be established by the physician after any needed consultation with the qualified therapist;
- The plan must include measurable therapy treatment goals which pertain directly to the patient's illness or injury, and the patient's resultant impairments;
- The plan must include the expected duration of therapy services; and
- The plan must describe a course of treatment which is consistent with the qualified therapist's assessment of the patient's function.

30.2.2 - Specificity of Orders

(Rev. 1, 10-01-03)
A3-3117.2.B, HHA-204.2.B

The orders on the plan of care must indicate the type of services to be provided to the patient, both with respect to the professional who will provide them and the nature of the individual services, as well as the frequency of the services.

EXAMPLE 1:

SN x 7/wk x 1 wk; 3/wk x 4 wk; 2/wk x 3 wk, (skilled nursing visits 7 times per week for 1 week; 3 times per week for 4 weeks; and 2 times per week for 3 weeks) for skilled observation and evaluation of the surgical site, for teaching sterile dressing changes and to perform sterile dressing changes. The sterile change consists of (detail of procedure).

Orders for care may indicate a specific range in the frequency of visits to ensure that the most appropriate level of services is provided during the 60-day episode to home health patients. When a range of visits is ordered, the upper limit of the range is considered the specific frequency.

EXAMPLE 2:

SN x 2-4/wk x 4 wk; 1-2/wk x 4 wk for skilled observation and evaluation of the surgical site.

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Orders for services to be furnished "as needed" or "PRN" must be accompanied by a description of the patient's medical signs and symptoms that would occasion a visit and a specific limit on the number of those visits to be made under the order before an additional physician order would have to be obtained.

30.2.3 - Who Signs the Plan of Care

(Rev. 1, 10-01-03)
A3-3117.2.C, HHA-204-2.C

The physician who signs the plan of care must be qualified to sign the physician certification as described in 42 CFR 424.22.

30.2.4 - Timeliness of Signature

(Rev. 1, 10-01-03)
A3-3117.2.D, HHA-204-2.D

A. Initial Percentage Payment

If a physician signed plan of care is not available at the beginning of the episode, the HHA may submit a RAP for the initial percentage payment based on physician verbal orders OR a referral prescribing detailed orders for the services to be rendered that is signed and dated by the physician. If the RAP submission is based on physician verbal orders, the verbal order must be recorded in the plan of care, include a description of the patient's condition and the services to be provided by the home health agency, include an attestation (relating to the physician's orders and the date received per 42 CFR 409.43), and the plan of care is copied and immediately submitted to the physician. A billable visit must be rendered prior to the submission of a RAP.

B. Final Percentage Payment

The plan of care must be signed and dated by a physician as described who meets the certification and recertification requirements of 42 CFR 424.22 and before the claim for each episode for services is submitted for the final percentage payment. Any changes in the plan of care must be signed and dated by a physician.

30.2.5 - Use of Oral (Verbal) Orders

(Rev. 1, 10-01-03)
A3-3117.2.E, HHA-204-2.E

When services are furnished based on a physician's oral order, the orders may be accepted and put in writing by personnel authorized to do so by applicable State and Federal laws and regulations as well as by the HHA's internal policies. The orders must be signed and dated with the date of receipt by the registered nurse or qualified therapist (i.e., physical therapist, speech-language pathologist, occupational therapist, or medical social worker) responsible for furnishing or supervising the ordered services. The orders

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may be signed by the supervising registered nurse or qualified therapist after the services have been rendered, as long as HHA personnel who receive the oral orders notify that nurse or therapist before the service is rendered. Thus, the rendering of a service that is based on an oral order would not be delayed pending signature of the supervising nurse or therapist. Oral orders must be countersigned and dated by the physician before the HHA bills for the care in the same way as the plan of care.

Services which are provided from the beginning of the 60-day episode certification period based on a request for anticipated payment and before the physician signs the plan of care are considered to be provided under a plan of care established and approved by the physician where there is an oral order for the care prior to rendering the services which is documented in the medical record and where the services are included in a signed plan of care.

EXAMPLE 1:

The HHA acquires an oral order for I.V. medication administration for a patient to be performed on August 1. The HHA provides the I.V. medication administration August 1 and evaluates the patient's need for continued care. The physician signs the plan of care for the I.V. medication administration on August 15. The visit is covered since it is considered provided under a plan of care established and approved by the physician, and the HHA had acquired an oral order prior to the delivery of services.

Services that are provided in the subsequent 60-day episode certification period are considered provided under the plan of care of the subsequent 60-day episode where there is an oral order before the services provided in the subsequent period are furnished and the order is reflected in the medical record. However, services that are provided after the expiration of a plan of care, but before the acquisition of an oral order or a signed plan of care are not considered provided under a plan of care.

EXAMPLE 2:

The patient is under a plan of care in which the physician orders I.V. medication administration every two weeks. The last day covered by the initial plan of care is July 31. The patient's next I.V. medication administration is scheduled for August 5 and the physician signs the plan of care for the new period on August 1. The I.V. medication administration on August 5 was provided under a plan of care established and approved by the physician. The episode begins on the 61 day regardless of the date of the first covered visit.

EXAMPLE 3:

The patient is under a plan of care in which the physician orders I.V. medication administration every two weeks. The last day covered by the plan of care is July 31. The patient's next I.V. medication administration is scheduled for August 5 and the physician does not sign the plan of care until August 6. The HHA acquires an oral order for the

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I.V. medication administration before the August 5 visit, and therefore the visit is considered to be provided under a plan of care established and approved by the physician. The episode begins on the 61 day regardless of the date of the first covered visit.

Any increase in the frequency of services or addition of new services during a certification period must be authorized by a physician by way of a written or oral order prior to the provision of the increased or additional services.

30.2.6 - Frequency of Review of the Plan of Care

(Rev. 1, 10-01-03)
A3-3117.2.F, HHA-204.2.F

The plan of care must be reviewed and signed by the physician who established the plan of care, in consultation with HHA professional personnel, at least every 60 days. Each review of a patient's plan of care must contain the signature of the physician and the date of review.

30.2.7 - Facsimile Signatures

(Rev. 1, 10-01-03)
A3-3117.2.G, HHA-204.2.G

The plan of care or oral order may be transmitted by facsimile machine. The HHA is not required to have the original signature on file. However, the HHA is responsible for obtaining original signatures if an issue surfaces that would require verification of an original signature.

30.2.8 - Alternative Signatures

(Rev. 1, 10-01-03)
A3-3117.2.H, HHA-204.2.H

HHAs that maintain patient records by computer rather than hard copy may use electronic signatures. However, all such entries must be appropriately authenticated and dated. Authentication must include signatures, written initials, or computer secure entry by a unique identifier of a primary author who has reviewed and approved the entry. The HHA must have safeguards to prevent unauthorized access to the records and a process for reconstruction of the records in the event of a system breakdown.

30.2.9 - Termination of the Plan of Care - Qualifying Services

(Rev. 1, 10-01-03)
A3-3117.2.I, HHA-204.2.I

The plan of care is considered to be terminated if the patient does not receive at least one covered skilled nursing, physical therapy, speech-language pathology service, or occupational therapy visit in a 60-day period since these are qualifying services for the home health benefit. An exception is if the physician documents that the interval without such care is appropriate to the treatment of the patient's illness or injury.

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30.2.10 - Sequence of Qualifying Services and Other Medicare Covered Home Health Services

(Rev. 1, 10-01-03)
A3-3117.2.J, HHA-204.2.J

Once patient eligibility has been confirmed and the plan of care contains physician orders for the qualifying service as well as other Medicare covered home health services, the qualifying service does not have to be rendered prior to the other Medicare covered home health services ordered in the plan of care. The sequence of visits performed by the disciplines must be dictated by the individual patient's plan of care. For example, for an eligible patient in an initial 60-day episode that has both physical therapy and occupational therapy orders in the plan of care, the sequence of the delivery of the type of therapy is irrelevant as long as the need for the qualifying service is established prior to the delivery of other Medicare covered services and the qualifying discipline provides a billable visit prior to transfer or discharge in accordance with 42 CFR 409.43(f).

NOTE: Dependent services provided after the final qualifying skilled service are not covered under the home health benefit, except when the dependent service was followed by a qualifying skilled service as a result of the unexpected inpatient admission or death of the patient or due to some other unanticipated event.

30.3 - Under the Care of a Physician

(Rev. 1, 10-01-03)
A3-3117.3, HHA-204.3

The patient must be under the care of a physician who is qualified to sign the physician certification and plan of care in accordance with 42 CFR 424.22.

A patient is expected to be under the care of the physician who signs the plan of care and the physician certification. It is expected, but not required for coverage, that the physician who signs the plan of care will see the patient, but there is no specified interval of time within which the patient must be seen.

30.4 - Needs Skilled Nursing Care on an Intermittent Basis (Other than Solely Venipuncture for the Purposes of Obtaining a Blood Sample), Physical Therapy, Speech-Language Pathology Services, or Has Continued Need for Occupational Therapy

(Rev. 1, 10-01-03)
A3-3117.4, HHA-204.4

The patient must need one of the following types of services:

1. Skilled nursing care that is

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- Reasonable and necessary as defined in §40.1;
- Needed on an "intermittent" based as defined in §40.1; and
- Not solely needed for venipuncture for the purposes of obtaining blood sample as defined in §40.1.2.13;or

2. Physical therapy as defined in §40.2.2; or
3. Speech-language pathology services as defined in §40.2.3; or
4. Have a continuing need for occupational therapy as defined in §§40.2.4.

The patient has a continued need for occupational therapy when:

1. The services which the patient requires meet the definition of "occupational therapy" services of §40.2, and
2. The patient's eligibility for home health services has been established by virtue of a prior need for skilled nursing care (other than solely venipuncture for the purposes of obtaining a blood sample), speech-language pathology services, or physical therapy in the current or prior certification period.

EXAMPLE: A patient who is recovering from a cerebrovascular accident (CVA) has an initial plan of care that called for physical therapy, speech-language pathology services, and home health aide services. In the next certification period, the physician orders only occupational therapy and home health aide services because the patient no longer needs the skills of a physical therapist or a speech-language pathologist, but needs the services provided by the occupational therapist. The patient's need for occupational therapy qualifies him for home health services, including home health aide services (presuming that all other qualifying criteria are met).

30.5 - Physician Certification

(Rev. 139, Issued: 02-16-11, Effective: 01-01-11, Implementation: 03-10-11)

The HHA must be acting upon a plan of care as described in §30.2, and a physician certification which meets the requirement of this section for HHA services to be covered.

30.5.1 - Content of the Physician Certification

(Rev. 139, Issued: 02-16-11, Effective: 01-01-11, Implementation: 03-10-11)

The physician must certify that:

1. The home health services are or were needed because the patient is or was confined to the home as defined in §20.1;

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2. The patient needs or needed skilled nursing services on an intermittent basis (other than solely venipuncture for the purposes of obtaining a blood sample), or physical therapy, or speech-language pathology services; or continues to need occupational therapy after the need for skilled nursing care, physical therapy, or speech-language pathology services ceased. Where a patient's sole skilled service need is for skilled oversight of unskilled services (management and evaluation of the care plan as defined in §40.1.2.2), the physician must include a brief narrative describing the clinical justification of this need as part of the certification and recertification, or as a signed addendum to the certification and recertification;

3. A plan of care has been established and is periodically reviewed by a physician;

4. The services are or were furnished while the patient is or was under the care of a physician;

5. For episodes with starts of care beginning January 1, 2011 and later, prior to initially certifying the home health patient's eligibility, the certifying physician must document that he or she, or an allowed non-physician practitioner (NPP) had a face-to-face encounter with the patient as described in §30.5.1.1. The encounter and documentation are a condition of payment. The initial certification is incomplete without them.

30.5.1.1 – Face-to-Face Encounter

(Rev. 139, Issued: 02-16-11, Effective: 01-01-11, Implementation: 03-10-11)

1. The certifying physician must document that he or she or an allowed non-physician practitioner (NPP) had a face-to-face encounter with the patient.

Certain NPPs may perform the face-to-face encounter and inform the certifying physician regarding the clinical findings exhibited by the patient during the encounter. However, the certifying physician must document the encounter and sign the certification. NPPs who are allowed to perform the encounter are:

- A nurse practitioner or clinical nurse specialist working in collaboration with the certifying physician in accordance with State law;
- A certified nurse-midwife as authorized by State law;
- A physician assistant under the supervision of the certifying physician

NPPs performing the encounter are subject to the same financial restrictions with the HHA as the certifying physician, as described in 42CFR 424.22(d).

2. Encounter Documentation Requirements:

- The documentation must include the date when the physician or allowed NPP saw the patient, and a brief narrative composed by the certifying physician who

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describes how the patient's clinical condition as seen during that encounter supports the patient's homebound status and need for skilled services.

- The certifying physician must document the encounter either on the certification, which the physician signs and dates, or a signed addendum to the certification. It may be written or typed.

- It is acceptable for the certifying physician to dictate the documentation content to one of the physician's support personnel to type. It is also acceptable for the documentation to be generated from a physician's electronic health record.

- It is unacceptable for the physician to verbally communicate the encounter to the HHA, where the HHA would then document the encounter as part of the certification for the physician to sign.

3. Timeframe Requirements:

- The encounter must occur no more than 90 days prior to the home health start of care date or within 30 days after the start of care.

- In situations when a physician orders home health care for the patient based on a new condition that was not evident during a visit within the 90 days prior to start of care, the certifying physician or an allowed NPP must see the patient again within 30 days after admission. Specifically, if a patient saw the certifying physician or NPP within the 90 days prior to start of care, another encounter would be needed if the patient's condition had changed to the extent that standards of practice would indicate that the physician or a non-physician practitioner should examine the patient in order to establish an effective treatment plan.

4. Exceptional Circumstances:

When a home health patient dies shortly after admission, before the face-to-face encounter occurs, if the contractor determines a good faith effort existed on the part of the HHA to facilitate/coordinate the encounter and if all other certification requirements are met, the certification is deemed to be complete.

5. If the below conditions are met, an encounter between the home health patient and the attending physician who cared for the patient during an acute/post acute stay can satisfy the face-to-face encounter requirement.

- A physician who attended to the patient in an acute or post-acute setting, but does not follow the patient in the community (such as a hospitalist) may certify the need for home health care based on his/her contact with the patient, and establish and sign the plan of care. The acute/post-acute physician would then

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transfer/hand off the patient's care to a designated community-based physician who assumes care for the patient.

Or,

- A physician who attended to the patient in an acute or post-acute setting may certify the need for home health care based on his/her contact with the patient, initiate the orders for home health services, and transfer the patient to a designated community-based physician to review and sign off on the plan of care.

6. Telehealth

The face-to-face encounter can be performed via a telehealth service, in an approved originating site. An originating site is considered to be the location of an eligible Medicare beneficiary at the time the service being furnished via a telecommunications system occurs. Medicare beneficiaries are eligible for telehealth services only if they are presented from an originating site located in a rural health professional shortage area or in a county outside of a Metropolitan Statistical Area.

Entities that participate in a Federal telemedicine demonstration project approved by (or receiving funding from) the Secretary of the Department of Health and Human Services as of December 31, 2000, qualify as originating sites regardless of geographic location.

The originating sites authorized by law are:

- The office of a physician or practitioner;
- Hospitals;
- Critical Access Hospitals (CAH);
- Rural Health Clinics (RHC);
- Federally Qualified Health Centers (FQHC);
- Hospital-based or CAH-based Renal Dialysis Centers (including satellites);
- Skilled Nursing Facilities (SNF); and
- Community Mental Health Centers (CMHC).

30.5.2 - Periodic Recertification

(Rev. 139, Issued: 02-16-11, Effective: 01-01-11, Implementation: 03-10-11)

At the end of the 60-day episode, a decision must be made whether or not to recertify the patient for a subsequent 60-day episode. An eligible beneficiary who qualifies for a subsequent 60-day episode would start the subsequent 60-day episode on day 61. Under HH PPS, the plan of care must be reviewed and signed by the physician every 60 days unless one of the following occurs:

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- A beneficiary transfers to another HHA;
- A discharge and return to the same HHA during the 60-day episode.

Medicare does not limit the number of continuous episode recertifications for beneficiaries who continue to be eligible for the home health benefit. The physician certification may cover a period less than but not greater than 60 days.

See §10.4 for counting initial and subsequent 60-day episodes and recertifications. See §10.5 for recertifications for split percentage payments.

30.5.3 - Who May Sign the Certification
(Rev. 1, 10-01-03)
A3-3117.5.C, HHA-204.5.C

The physician who signs the certification must be permitted to do so by 42 CFR 424.22.

40 - Covered Services Under a Qualifying Home Health Plan of Care
(Rev. 1, 10-01-03)
A3-3118, HHA-205

Section 1861(m)of the Act governs the Medicare home health services that may be provided to eligible beneficiaries by or under arrangements made by a participating home health agency (HHA). Section 1861(m) describes home health services as

- Part-time or intermittent skilled nursing care (other than solely venipuncture for the purposes of obtaining a blood sample);
- Part-time or intermittent home health aide services;
- Physical therapy;
- Speech-language pathology;
- Occupational therapy;
- Medical social services;
- Medical supplies (including catheters, catheter supplies, ostomy bags, supplies related to ostomy care, and a covered osteoporosis drug (as defined in §1861(kk) of the Act), but excluding other drugs and biologicals);
- Durable medical equipment while under the plan of care established by physician;

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- Medical services provided by an intern or resident-in-training under an approved teaching program of the hospital in the case of an HHA which is affiliated or under common control with a hospital; and

- Services at hospitals, skilled nursing facilities, or rehabilitation centers when they involve equipment too cumbersome to bring to the home.

The term "part-time or intermittent" for purposes of coverage under §1861(m) of the Act means skilled nursing and home health aide services furnished any number of days per week as long as they are furnished (combined) less than 8 hours each day and 28 or fewer hours each week (or, subject to review on a case-by-case basis as to the need for care, less than 8 hours each day and 35 or fewer hours per week). See §50.7.

For any home health services to be covered by Medicare, the patient must meet the qualifying criteria as specified in §30, including having a need for skilled nursing care on an intermittent basis, physical therapy, speech-language pathology services, or a continuing need for occupational therapy as defined in this section.

40.1 - Skilled Nursing Care

(Rev. 179, Issued: 01-14-14, Effective: 01-07-14, Implementation: 01-07-14)
A3-3118.1, HHA-205.1

To be covered as skilled nursing services, the services must require the skills of a registered nurse, or a licensed practical (vocational) nurse under the supervision of a registered nurse, must be reasonable and necessary to the treatment of the patient's illness or injury as discussed in §40.1.1, below, and must be intermittent as discussed in §40.1.3. *Coverage of skilled nursing care does not turn on the presence or absence of a patient's potential for improvement from the nursing care, but rather on the patient's need for skilled care.*

40.1.1 - General Principles Governing Reasonable and Necessary Skilled Nursing Care

(Rev. 179, Issued: 01-14-14, Effective: 01-07-14, Implementation: 01-07-14)
A3-3118.1, HHA-205.1

If all other eligibility and coverage requirements under the home health benefit are met, skilled nursing services are covered when an individualized assessment of the patient's clinical condition demonstrates that the specialized judgment, knowledge, and skills of a registered nurse or, when provided by regulation, a licensed practical (vocational) nurse ("skilled care") are necessary. Skilled nursing services are covered where such skilled nursing services are necessary to maintain the patient's current condition or prevent or slow further deterioration so long as the beneficiary requires skilled care for the services to be safely and effectively provided. When, however, the individualized assessment does not demonstrate such a necessity for skilled care, including when the services needed do not require skilled nursing care because they could safely and effectively be performed by

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the patient or unskilled caregivers, such services will not be covered under the home health benefit.

Skilled nursing care is necessary only when (a) the particular patient's special medical complications require the skills of a registered nurse or, when provided by regulation, a licensed practical nurse to perform a type of service that would otherwise be considered non-skilled; or (b) the needed services are of such complexity that the skills of a registered nurse or, when provided by regulation, a licensed practical nurse are required to furnish the services. To be considered a skilled service, the service must be so inherently complex that it can be safely and effectively performed only by, or under the supervision of, professional or technical personnel as provided by regulation, including 42 C.F.R. 409.32.

Some services may be classified as a skilled nursing service on the basis of complexity alone *(*e.g., intravenous and intramuscular injections or insertion of catheters*)* and*,* if reasonable and necessary to the treatment of the patient's illness or injury, would be covered on that basis. *If a service can be safely and effectively performed (or self-administered) by an unskilled person, without the direct supervision of a nurse, the service cannot be regarded as a skilled nursing service although a nurse actually provides the service.* However, in some cases, the condition of the patient may cause a service that would ordinarily be considered unskilled to be considered a skilled nursing service. This would occur when the patient's condition is such that the service can be safely and effectively provided only by a nurse. *A service is not considered a skilled nursing service merely because it is performed by or under the supervision of a nurse. The unavailability of a competent person to provide a non-skilled service, regardless of the importance of the service to the patient, does not make it a skilled service when a nurse provides the service.*

A service that, by its nature, requires the skills of a nurse to be provided safely and effectively continues to be a skilled service even if it is taught to the patient, the patient's family, or other caregivers.

The skilled nursing service must be reasonable and necessary to the diagnosis and treatment of the patient's illness or injury within the context of the patient's unique medical condition. To be considered reasonable and necessary for the diagnosis or treatment of the patient's illness or injury, the services must be consistent with the nature and severity of the illness or injury, the patient's particular medical needs, and accepted standards of medical and nursing practice. The determination of whether the services are reasonable and necessary should be made in consideration that a physician has determined that the services ordered are reasonable and necessary. The services must, therefore, be viewed from the perspective of the condition of the patient when the services were ordered and what was, at that time, reasonably expected to be appropriate treatment for the illness or injury throughout the certification period.

A patient's overall medical condition, without regard to whether the illness or injury is acute, chronic, terminal, or expected to extend over a long period of time, should be

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considered in deciding whether skilled services are needed. A patient's diagnosis should never be the sole factor in deciding that a service the patient needs is either skilled or not skilled. Skilled care may, depending on the unique condition of the patient, continue to be necessary for patients whose condition is stable.

As is outlined in home health regulations, as part of the home health agency (HHA) Conditions of Participation (CoPs), the clinical record of the patient must contain progress and clinical notes. Additionally, in Pub. 100-04, Medicare Claims Processing Manual, Chapter 10; "Home Health Agency Billing", instructions specify that for each claim, HHAs are required to report all services provided to the beneficiary during each episode, which includes reporting each visit in line-item detail. As such, it is expected that the home health records for every visit will reflect the need for the skilled medical care provided. These clinical notes are also expected to provide important communication among all members of the home care team regarding the development, course and outcomes of the skilled observations, assessments, treatment and training performed. Taken as a whole then, the clinical notes are expected to tell the story of the patient's achievement towards his/her goals as outlined in the Plan of Care. In this way, the notes will serve to demonstrate why a skilled service is needed.

Therefore the home health clinical notes must document as appropriate:

- *the history and physical exam pertinent to the day's visit, (including the response or changes in behavior to previously administered skilled services) and the skilled services applied on the current visit, and*
- *the patient/caregiver's response to the skilled services provided, and*
- *the plan for the next visit based on the rationale of prior results,*
- *a detailed rationale that explains the need for the skilled service in light of the patient's overall medical condition and experiences,*
- *the complexity of the service to be performed, and*
- *any other pertinent characteristics of the beneficiary or home*

Clinical notes should be written so that they adequately describe the reaction of a patient to his/her skilled care. Clinical notes should also provide a clear picture of the treatment, as well as "next steps" to be taken. Vague or subjective descriptions of the patient's care should not be used. For example terminology such as the following would not adequately describe the need for skilled care:

- *Patient tolerated treatment well*
- *Caregiver instructed in medication management*
- *Continue with POC*

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Objective measurements of physical outcomes of treatment should be provided and/or a clear description of the changed behaviors due to education programs should be recorded in order that all concerned can follow the results of the applied services.

EXAMPLE 1:

The presence of a plaster cast on an extremity generally does not indicate a need for skilled nursing care. However, the patient with a preexisting peripheral vascular or circulatory condition might need skilled nursing care to observe for complications, monitor medication administration for pain control, and teach proper skin care to preserve skin integrity and prevent breakdown. *The documentation must support the severity of the circulatory condition that requires skilled care. The clinical notes for each home health visit should document the patient's skin and circulatory examination as well as the patient and/or caregiver application of the educational principles taught since the last visit. The plan for the next visit should describe the skilled services continuing to be required.*

EXAMPLE 2:

The condition of a patient, who has irritable bowel syndrome or is recovering from rectal surgery, may be such that he or she can be given an enema safely and effectively only by a nurse. If the enema were necessary to treat the illness or injury, then the visit would be covered as a skilled nursing visit. *The documentation must support the skilled need for the enema, and the plan for future visits based on this information.*

EXAMPLE *3*:

Giving a bath does not ordinarily require the skills of a nurse and, therefore, would not be covered as a skilled nursing service unless the patient's condition is such that the bath could be given safely and effectively only by a nurse (as discussed in §30.1 above).

EXAMPLE *4*:

A patient with a well-established colostomy absent complications may require assistance changing the colostomy bag because they cannot do it themselves and there is no one else to change the bag. Notwithstanding the need for the routine colostomy care, *changing* the *colostomy bag* does not become a skilled nursing service when the nurse provides it.

EXAMPLE *5*:

A patient was discharged from the hospital with an open draining wound that requires irrigation, packing, and dressing twice each day. The HHA has taught the family to perform the dressing changes. The HHA continues to see the patient for the wound care that is needed during the time that the family is not available and willing to provide the dressing changes. The wound care continues to be skilled nursing care, notwithstanding

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that the family provides it part of the time, and may be covered as long as the patient requires it.

EXAMPLE *6*:

A physician has ordered skilled nursing visits for a patient with a hairline fracture of the hip. *The home health record must document the reason skilled services are required and why the* nursing visits *are* reasonable and necessary for treatment of the patient's hip injury.

EXAMPLE *7*:

A physician has ordered skilled nursing visits for teaching of self-administration and self-management of the medication regimen for a patient*, newly diagnosed,* with diabetes mellitus *in* the *home health plan of care. Each visit's documentation must describe the patient's progress in this activity*.

EXAMPLE *8*:

Following a cerebrovascular accident (CVA), a patient has an in-dwelling Foley catheter because of urinary incontinence, and is expected to require the catheter for a long and indefinite period. *The medical condition of the patient must be described and documented to support the need for nursing skilled services in the home health plan of care.* Periodic visits to change the catheter as needed, treat the symptoms of catheter malfunction, and teach proper *catheter* care would be covered as long as they are reasonable and necessary, although the patient is stable*, even if* there is an expectation that the care will be needed for a long and indefinite period. *However, at every home health visit, the patient's current medical condition must be described and there must be documentation to support the need for continued skilled nursing services.*

EXAMPLE *9*:

A patient with advanced multiple sclerosis undergoing an exacerbation of the illness needs skilled teaching of medications, measures to overcome urinary retention, and the establishment of a program designed to minimize the adverse impact of the exacerbation. *The clinical notes for each home health visit must describe why skilled nursing services were required.* The skilled nursing care *received by* the patient would be covered despite the chronic nature of the illness.

EXAMPLE *10*:

A patient with malignant melanoma is terminally ill, and requires skilled observation, assessment, teaching, and treatment. The patient has not elected coverage under Medicare's hospice benefit. *The documentation should describe the goal of the skilled nursing intervention, and at each visit the services provided should support that goal.* The skilled nursing care that the patient requires would be covered, notwithstanding that

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the condition is terminal, because the *documentation and description must support that the needed* services *required* the skills of a nurse.

40.1.2 - Application of the Principles to Skilled Nursing Services

(Rev. 1, 10-01-03)
A3-3118.1.B, HHA-205.1.B

The following discussion of skilled nursing services applies the foregoing principles to specific skilled nursing services about which questions are most frequently raised.

40.1.2.1 - Observation and Assessment of the Patient's Condition When Only the Specialized Skills of a Medical Professional Can Determine Patient's Status

(Rev. 179, Issued: 01-14-14, Effective: 01-07-14, Implementation: 01-07-14)

Observation and assessment of the patient's condition by a nurse are reasonable and necessary skilled services where there is a reasonable potential for change in a patient's condition that requires skilled nursing personnel to identify and evaluate the patient's need for possible modification of treatment or initiation of additional medical procedures until the patient's *clinical condition and/or* treatment regimen *has* stabilized. Where a patient was admitted to home health care for skilled observation because there was a reasonable potential of a complication or further acute episode, but did not develop a further acute episode or complication, the skilled observation services are still covered for 3 weeks or so long as there remains a reasonable potential for such a complication or further acute episode.

Information from the patient's *home health record must document the rationale that demonstrates that* there is a reasonable potential for a future complication or acute episode and, therefore, may justify the need for continued skilled observation and assessment beyond the 3-week period. *Such signs and symptoms* as abnormal/fluctuating vital signs, weight changes, edema, symptoms of drug toxicity, abnormal/fluctuating lab values, and respiratory changes on auscultation may justify skilled observation and assessment. Where these *signs and symptoms* are such that there is a reasonable potential that skilled observation and assessment by a licensed nurse will result in changes to the treatment of the patient, then the services would be covered. However, observation and assessment by a nurse is not reasonable and necessary *for* the treatment of the illness or injury where *fluctuating signs and symptoms* are part of a longstanding pattern of the patient's condition which *has* not *previously required a* change *in* the *prescribed* treatment.

EXAMPLE 1:

A patient with atherosclerotic heart disease with congestive heart failure requires observation by skilled nursing personnel for signs of decompensation or adverse effects resulting from *newly* prescribed medication. Skilled observation is needed to determine whether the *new* drug regimen should be modified or whether other therapeutic measures

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should be considered until the patient's *clinical condition and/or* treatment regimen *has* stabilized. *The clinical notes for each home health visit should reflect the deliberations and their outcome.*

EXAMPLE 2:

A patient has undergone peripheral vascular disease treatment including a revascularization procedure (bypass). The incision area is showing signs of potential infection, (e.g., heat, redness, swelling, drainage) and the patient has elevated body temperature. *For each home health visit, the clinical notes must demonstrate that the skilled* observation and monitoring is required.

EXAMPLE 3:

A patient was hospitalized following a heart attack. *Following* treatment *he was* discharged home. Because it is not known whether *increasing* exertion will exacerbate the heart disease, skilled observation is reasonable and necessary as mobilization is initiated *in the patient's home. The patient's necessity for skilled observation must be documented at each home health visit* until the patient's *clinical condition and/or* treatment regimen *has* stabilized.

EXAMPLE 4:

A frail 85-year old man was hospitalized for pneumonia. The infection was resolved, but the patient, who had previously maintained adequate nutrition, will not eat or eats poorly. The patient is discharged to the HHA for monitoring of fluid and nutrient intake and assessment of the need for tube feeding. Observation and monitoring by skilled nurses of the patient's oral intake, output and hydration status is required to determine what further treatment or other intervention is needed. *The patient's necessity for skilled observation and treatment must be documented at each home health visit, until the patient's clinical condition and/or treatment regimen has stabilized.*

EXAMPLE 5:

A patient with glaucoma and a cardiac condition has a cataract extraction. Because of the interaction between the eye drops for the glaucoma and cataracts and the beta-blocker for the cardiac condition, the patient is at risk for serious cardiac arrhythmia. Skilled observation and monitoring of the drug actions is reasonable and necessary until the patient's condition is stabilized. *The patient's necessity for skilled observation must be documented at each home health visit, until the clinical condition and/or patient's treatment regimen has stabilized.*

EXAMPLE 6:

A patient with hypertension suffered dizziness and weakness. The physician found that the blood pressure was too low and discontinued the hypertension medication. Skilled

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observation and monitoring of the patient's blood pressure and medication regimen is required until the blood pressure remains stable and in a safe range. *The patient's necessity for skilled observation must be documented at each home health visit, until the patient's clinical condition and/or treatment regimen has stabilized.*

EXAMPLE 7:

A patient has chronic non-healing skin ulcers, Diabetes Mellitus Type I, and spinal muscular atrophy. In the past, the patient's wounds have deteriorated, requiring the patient to be hospitalized. Previously, a skilled nurse has trained the patient's wife to perform wound care. The treating physician orders a new episode of skilled care, at a frequency of one visit every 2 weeks to perform observation and assessment of the patient's skin ulcers to make certain that they are not worsening. This order is reasonable and necessary because, although the unskilled family caregiver has learned to care for the wounds, the skilled nurse can use observation and assessment to determine if the condition is worsening.

40.1.2.2 - Management and Evaluation of a Patient Care Plan

(Rev. 179, Issued: 01-14-14, Effective: 01-07-14, Implementation: 01-07-14)

A3-3118.1.B.2, HHA-205.1.B.2

Skilled nursing visits for management and evaluation of the patient's care plan are also reasonable and necessary where underlying conditions or complications require that only a registered nurse can ensure that essential *unskilled* care is achieving its purpose. For skilled nursing care to be reasonable and necessary for management and evaluation of the patient's plan of care, the complexity of the necessary unskilled services that are a necessary part of the medical treatment must require the involvement of skilled nursing personnel to promote the patient's recovery and medical safety in view of the patient's overall condition.

EXAMPLE 1:

An aged patient with a history of diabetes mellitus and angina pectoris is recovering from an open reduction of the neck of the femur. He requires, among other services, careful skin care, appropriate oral medications, a diabetic diet, a therapeutic exercise program to preserve muscle tone and body condition, and observation to notice signs of deterioration in his condition or complications resulting from his restricted, but increasing mobility. Although a properly instructed person could perform any of the required services, that person would not have the capability to understand the relationship among the services and their effect on each other. Since the combination of the patient's condition, age, and immobility create a high potential for serious complications, such an understanding is essential to ensure the patient's recovery and safety. The management of this plan of care requires skilled nursing personnel until *nursing visits are not needed to observe and assess the effects of the non-skilled services being provided to treat the illness or injury until the patient recovers. Where nursing visits are not needed to observe and assess the effects of the non-skilled services being provided to treat the illness or injury, skilled*

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nursing care would not be considered reasonable and necessary, and the management and evaluation of the care plan would not be considered a skilled service.

EXAMPLE 2:

An aged patient with a history of mild dementia is recovering from pneumonia which has been treated at home. The patient has had an increase in disorientation, has residual chest congestion, decreased appetite, and has remained in bed, immobile, throughout the episode with pneumonia. While the residual chest congestion and recovery from pneumonia alone would not represent a high risk factor, the patient's immobility and increase in confusion could create a high probability of a relapse. In this situation, skilled oversight of the *unskilled* services would be reasonable and necessary pending the elimination of the chest congestion and resolution of the persistent disorientation to ensure the patient's medical safety. *For this determination to be made, the home health documentation must describe the complexity of the unskilled services that are a necessary part of the medical treatment and which require the involvement of a registered nurse in order to ensure that essential unskilled care is achieving its purpose.* Where visits by a licensed nurse are not needed to observe and assess the effects of the *unskilled* services being provided to treat the illness or injury, skilled nursing care would not be considered reasonable and necessary to treat the illness or injury.

EXAMPLE 3:

A physician orders one skilled nursing visit every 2 weeks and three home health aide visits each week for bathing and washing hair for a patient whose recovery from a CVA has left him with residual weakness on the left side. The cardiovascular condition is stable and the patient has reached the maximum restoration potential. There are no underlying conditions that would necessitate the skilled supervision of a licensed nurse in assisting with bathing or hair washing. The skilled nursing visits are not necessary to manage and supervise the home health aide services and would not be covered.

40.1.2.3 - Teaching and Training Activities

(Rev. 179, Issued: 01-14-14, Effective: 01-07-14, Implementation: 01-07-14)

A3-3118.1.B.3, HHA-205.1.B.3

Teaching and training activities that require skilled nursing personnel to teach a patient, the patient's family, or caregivers how to manage the treatment regimen would constitute skilled nursing services. Where the teaching or training is reasonable and necessary to the treatment of the illness or injury, skilled nursing visits for teaching would be covered. The test of whether a nursing service is skilled relates to the skill required to teach and not to the nature of what is being taught. Therefore, where skilled nursing services are necessary to teach an unskilled service, the teaching may be covered. Skilled nursing visits for teaching and training activities are reasonable and necessary where the teaching or training is appropriate to the patient's functional loss, illness, or injury.

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Where it becomes apparent after a reasonable period of time that the patient, family, or caregiver will not or is not able to be trained, then further teaching and training would cease to be reasonable and necessary. ***The reason why the training was unsuccessful should be documented in the record.*** Notwithstanding that the teaching or training was unsuccessful, the services for teaching and training would be considered to be reasonable and necessary prior to the point that it became apparent that the teaching or training was unsuccessful, as long as such services were appropriate to the patient's illness, functional loss, or injury.

In determining the reasonable and necessary number of teaching and training visits, consideration must be given to whether the teaching and training provided constitutes reinforcement of teaching provided previously in an institutional setting or in the home or whether it represents initial instruction. Where the teaching represents initial instruction, the complexity of the activity to be taught and the unique abilities of the patient are to be considered. Where the teaching constitutes reinforcement, an analysis of the patient's retained knowledge and anticipated learning progress is necessary to determine the appropriate number of visits. Skills taught in a controlled institutional setting often need to be reinforced when the patient returns home. Where the patient needs reinforcement of the institutional teaching, additional teaching visits in the home are covered.

Re-teaching or retraining for an appropriate period may be considered reasonable and necessary where there is a change in the procedure or the patient's condition that requires re-teaching, or where the patient, family, or caregiver is not properly carrying out the task. The medical record should document the reason that the re-teaching or retraining is required and the patient/caregiver response to the education.

EXAMPLE 1:

A physician has ordered skilled nursing care for teaching a diabetic who has recently become insulin dependent. The physician has ordered teaching of self-injection and management of insulin, signs, and symptoms of insulin shock, and actions to take in emergencies. The *education is* reasonable and necessary to the treatment of the illness or injury*, and the teaching services and the patient/caregiver responses must be documented.*

EXAMPLE 2:

A physician has ordered skilled nursing care to teach a patient to follow a new medication regimen in which there is a significant probability of adverse drug reactions due to the nature of the drug and the patient's condition*, to recognize* signs and symptoms of adverse reactions to new medications, and *to follow the* necessary dietary restrictions. After it becomes apparent that the patient remains unable to take the medications properly, cannot demonstrate awareness of potential adverse reactions, and is not following the necessary dietary restrictions, skilled nursing care for further teaching would not be reasonable and necessary, since the patient has demonstrated an inability to

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be taught. *The documentation must thoroughly describe all efforts that have been made to educate the patient/caregiver, and their responses. The health record should also describe the reason for the failure of the educational attempts.*

EXAMPLE 3:

A physician has ordered skilled nursing visits to teach self-administration of insulin to a patient who has been self-injecting insulin for 10 years and there is no change in the patient's physical or mental status that would require re-teaching. The skilled nursing visits would not be considered reasonable and necessary since the patient has a longstanding history of being able to perform the service.

EXAMPLE 4:

A physician has ordered skilled nursing visits to teach self-administration of insulin to a patient who has been self-injecting insulin for 10 years because the patient has recently lost the use of the dominant hand and must be retrained to use the other hand. Skilled nursing visits to re-teach self-administration of the insulin would be reasonable and necessary. *The patient's response to teaching must be documented at each home health visit, until the patient has learned how to self-administer.*

EXAMPLE 5:

A patient recovering from pneumonia is being sent home requiring I.V. infusion of antibiotics four times per day. The patient's spouse has been shown how to administer the drug during the hospitalization and has been told the signs and symptoms of infection. The physician has ordered home health services for a nurse to teach the administration of the drug and the signs and symptoms requiring immediate medical attention.

EXAMPLE 6:

A spouse who has been taught to perform a dressing change for a post-surgical patient may need to be re-taught wound care if the spouse demonstrates improper performance of wound care. *The medical record should document the reason that the re-teaching or retraining is required and the patient/caregiver response to the education.*

NOTE: There is no requirement that the patient, family or other caregiver be taught to provide a service if they cannot or choose not to provide the care.

Teaching and training activities that require the skills of a licensed nurse include, but **are not limited to**, the following:

1. Teaching the self-administration of injectable medications, or a complex range of medications;

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2. Teaching a newly diagnosed diabetic or caregiver all aspects of diabetes management, including how to prepare and to administer insulin injections, to prepare and follow a diabetic diet, to observe foot-care precautions, and to observe for and understand signs of hyperglycemia and hypoglycemia;

3. Teaching self-administration of medical gases;

4. Teaching wound care where the complexity of the wound, the overall condition of the patient or the ability of the caregiver makes teaching necessary;

5. Teaching care for a recent ostomy or where reinforcement of ostomy care is needed;

6. Teaching self-catheterization;

7. Teaching self-administration of gastrostomy or enteral feedings;

8. Teaching care for and maintenance of peripheral and central venous lines and administration of intravenous medications through such lines;

9. Teaching bowel or bladder training when bowel or bladder dysfunction exists;

10. Teaching how to perform the activities of daily living when the patient or caregiver must use special techniques and adaptive devices due to a loss of function;

11. Teaching transfer techniques, e.g., from bed to chair, that are needed for safe transfer;

12. Teaching proper body alignment and positioning, and timing techniques of a bed-bound patient;

13. Teaching ambulation with prescribed assistive devices (such as crutches, walker, cane, etc.) that are needed due to a recent functional loss;

14. Teaching prosthesis care and gait training;

15. Teaching the use and care of braces, splints and orthotics and associated skin care;

16. Teaching the preparation and maintenance of a therapeutic diet; and

17. Teaching proper administration of oral medication, including signs of side-effects and avoidance of interaction with other medications and food.

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18. Teaching the proper care and application of any special dressings or skin treatments, (for example, dressings or treatments needed by patients with severe or widespread fungal infections, active and severe psoriasis or eczema, or due to skin deterioration due to radiation treatments)

40.1.2.4 - Administration of Medications

(Rev. 1, 10-01-03)
A3-3118.1.B.4, HHA-205.1.B.4

Although drugs and biologicals are specifically excluded from coverage by the statute (§1861(m)(5) of the Act, the services of a nurse that are required to administer the medications safely and effectively may be covered if they are reasonable and necessary to the treatment of the illness or injury.

A. Injections

Intravenous, intramuscular, or subcutaneous injections and infusions, and hypodermoclysis or intravenous feedings require the skills of a licensed nurse to be performed (or taught) safely and effectively. Where these services are reasonable and necessary to treat the illness or injury, they may be covered. For these services to be reasonable and necessary, the medication being administered must be accepted as safe and effective treatment of the patient's illness or injury, and there must be a medical reason that the medication cannot be taken orally. Moreover, the frequency and duration of the administration of the medication must be within accepted standards of medical practice, or there must be a valid explanation regarding the extenuating circumstances to justify the need for the additional injections.

1. Vitamin B-12 injections are considered specific therapy only for the following conditions:

- Specified anemias: pernicious anemia, megaloblastic anemias, macrocytic anemias, fish tapeworm anemia;

- Specified gastrointestinal disorders: gastrectomy, malabsorption syndromes such as sprue and idiopathic steatorrhea, surgical and mechanical disorders such as resection of the small intestine, strictures, anastomosis and blind loop syndrome, and

- Certain neuropathies: posterolateral sclerosis, other neuropathies associated with pernicious anemia, during the acute phase or acute exacerbation of a neuropathy due to malnutrition and alcoholism.

For a patient with pernicious anemia caused by a B-12 deficiency, intramuscular or subcutaneous injection of vitamin B-12 at a dose of from 100 to 1000 micrograms no more frequently than once monthly is the accepted reasonable and necessary dosage schedule for maintenance treatment. More frequent injections would be appropriate

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in the initial or acute phase of the disease until it has been determined through laboratory tests that the patient can be sustained on a maintenance dose.

2. Insulin Injections

Insulin is customarily self-injected by patients or is injected by their families. However, where a patient is either physically or mentally unable to self-inject insulin and there is no other person who is able and willing to inject the patient, the injections would be considered a reasonable and necessary skilled nursing service.

EXAMPLE: A patient who requires an injection of insulin once per day for treatment of diabetes mellitus, also has multiple sclerosis with loss of muscle control in the arms and hands, occasional tremors, and vision loss that causes inability to fill syringes or self-inject insulin. If there weren't an able and willing caregiver to inject her insulin, skilled nursing care would be reasonable and necessary for the injection of the insulin.

The prefilling of syringes with insulin (or other medication that is self-injected) does not require the skills of a licensed nurse and, therefore, is not considered to be a skilled nursing service. If the patient needs someone only to prefill syringes (and therefore needs no skilled nursing care on an intermittent basis, physical therapy, or speech-language pathology services), the patient, therefore, does not qualify for any Medicare coverage of home health care. Prefilling of syringes for self-administration of insulin or other medications is considered to be assistance with medications that are ordinarily self-administered and is an appropriate home health aide service. (See §50.2.) However, where State law requires that a licensed nurse prefill syringes, a skilled nursing visit to prefill syringes is paid as a skilled nursing visit (if the patient otherwise needs skilled nursing care, physical therapy, or speech-language pathology services), but is not considered to be a skilled nursing service.

B. Oral Medications

The administration of oral medications by a nurse is not reasonable and necessary skilled nursing care except in the specific situation in which the complexity of the patient's condition, the nature of the drugs prescribed, and the number of drugs prescribed require the skills of a licensed nurse to detect and evaluate side effects or reactions. The medical record must document the specific circumstances that cause administration of an oral medication to require skilled observation and assessment.

C. Eye Drops and Topical Ointments

The administration of eye drops and topical ointments does not require the skills of a nurse. Therefore, even if the administration of eye drops or ointments is necessary to the treatment of an illness or injury and the patient cannot self-administer the drops, and there is no one available to administer them, the visits cannot be covered as a skilled

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nursing service. This section does not eliminate coverage for skilled nursing visits for observation and assessment of the patient's condition. (See §40.2.1.)

EXAMPLE 1:

A physician has ordered skilled nursing visits to administer eye drops and ointments for a patient with glaucoma. The administration of eye drops and ointments does not require the skills of a nurse. Therefore, the skilled nursing visits cannot be covered as skilled nursing care, notwithstanding the importance of the administration of the drops as ordered.

EXAMPLE 2:

A physician has ordered skilled nursing visits for a patient with a reddened area under the breast. The physician instructs the patient to wash, rinse, and dry the area daily and apply vitamin A and D ointment. Skilled nursing care is not needed to provide this treatment and related services safely and effectively.

40.1.2.5 - Tube Feedings

(Rev. 1, 10-01-03)
A3-3118.1.B.5, HHA-205.1.B.5

Nasogastric tube, and percutaneous tube feedings (including gastrostomy and jejunostomy tubes), and replacement, adjustment, stabilization. and suctioning of the tubes are skilled nursing services, and if the feedings are required to treat the patient's illness or injury, the feedings and replacement or adjustment of the tubes would be covered as skilled nursing services.

40.1.2.6 - Nasopharyngeal and Tracheostomy Aspiration

(Rev. 1, 10-01-03)
A3-4118.1.B.6, HHA-205.1.B.6

Nasopharyngeal and tracheostomy aspiration are skilled nursing services and, if required to treat the patient's illness or injury, would be covered as skilled nursing services.

40.1.2.7 - Catheters

(Rev. 179, Issued: 01-14-14, Effective: 01-07-14, Implementation: 01-07-14)
A3-3118.1.B.7, HHA-205.1.B.7

Insertion and sterile irrigation and replacement of catheters, care of a suprapubic catheter, and in selected patients, urethral catheters, are considered to be skilled nursing services. Where the catheter is necessitated by a permanent or temporary loss of bladder control, skilled nursing services that are provided at a frequency appropriate to the type of catheter in use would be considered reasonable and necessary. Absent complications, Foley catheters generally require skilled care once approximately every 30 days and silicone catheters generally require skilled care once every 60-90 days and this frequency

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of service would be considered reasonable and necessary. However, where there are complications that require more frequent skilled care related to the catheter, such care would, with adequate documentation, be covered.

EXAMPLE: A patient who has a Foley catheter due to loss of bladder control because of multiple sclerosis has a history of frequent plugging of the catheter and urinary tract infections. The physician has ordered skilled nursing visits once per month to change the catheter, and has left a "PRN" order for up to three additional visits per month for skilled observation and evaluation and/or catheter changes if the patient or caregiver reports signs and symptoms of a urinary tract infection or a plugged catheter. During the certification period, the patient's family contacts the HHA because the patient has an elevated temperature, abdominal pain, and scant urine output. The nurse visits the patient and determines that the catheter is plugged and there are symptoms of a urinary tract infection. The nurse changes the catheter and contacts the physician to report findings and discuss treatment. The skilled nursing visit to change the catheter and to evaluate the patient would be reasonable and necessary to the treatment of the illness or injury. *The need for the skilled services must be documented.*

40.1.2.8 - Wound Care

(Rev. 179, Issued: 01-14-14, Effective: 01-07-14, Implementation: 01-07-14)

A3-3118.1.B.8, HHA-205.1.B.8

Care of wounds, (including, but not limited to, ulcers, burns, pressure sores, open surgical sites, fistulas, tube sites, and tumor erosion sites) when the skills of a licensed nurse are needed to provide safely and effectively the services necessary to treat the illness or injury, is considered to be a skilled nursing service. For skilled nursing care to be reasonable and necessary to treat a wound, the size, depth, nature of drainage (color, odor, consistency, and quantity), and condition and appearance of the skin surrounding the wound must be documented in the clinical findings so that an assessment of the need for skilled nursing care can be made. Coverage or denial of skilled nursing visits for wound care may not be based solely on the stage classification of the wound, but rather must be based on all of the documented clinical findings. Moreover, the plan of care must contain the specific instructions for the treatment of the wound. Where the physician has ordered appropriate active treatment (e.g., sterile or complex dressings, administration of prescription medications, etc.) of wounds with the following characteristics, the skills of a licensed nurse are usually reasonable and necessary:

- Open wounds which are draining purulent or colored exudate or have a foul odor present or for which the patient is receiving antibiotic therapy;

- Wounds with a drain or T-tube with requires shortening or movement of such drains;

- Wounds which require irrigation or instillation of a sterile cleansing or medicated solution into several layers of tissue and skin and/or packing with sterile gauze;

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- Recently debrided ulcers;
- Pressure sores (decubitus ulcers) with the following characteristics:
  - There is partial tissue loss with signs of infection such as foul odor or purulent drainage; or
  - There is full thickness tissue loss that involves exposure of fat or invasion of other tissue such as muscle or bone.

    NOTE: Wounds or ulcers that show redness, edema, and induration, at times with epidermal blistering or desquamation do not ordinarily require skilled nursing care.
- Wounds with exposed internal vessels or a mass that may have a proclivity for hemorrhage when a dressing is changed (e.g., post radical neck surgery, cancer of the vulva);
- Open wounds or widespread skin complications following radiation therapy, or which result from immune deficiencies or vascular insufficiencies;
- Post-operative wounds where there are complications such as infection or allergic reaction or where there is an underlying disease that has a reasonable potential to adversely affect healing (e.g., diabetes);
- Third degree burns, and second degree burns where the size of the burn or presence of complications causes skilled nursing care to be needed;
- Skin conditions that require application of nitrogen mustard or other chemotherapeutic medication that present a significant risk to the patient;
- Other open or complex wounds that require treatment that can only be provided safely and effectively by a licensed nurse.

EXAMPLE 1:

A patient has a second-degree burn with full thickness skin damage on the back. The wound is cleansed, followed by an application of Sulfamylon. While the wound requires skilled monitoring for signs and symptoms of infection or complications, the dressing change requires skilled nursing services. *The home health record at each visit must document the need for the skilled nursing services.*

EXAMPLE 2:

A patient experiences a decubitus ulcer where the full thickness tissue loss extends through the dermis to involve subcutaneous tissue. The wound involves necrotic tissue

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with a physician's order to apply a covering of a debriding ointment following vigorous irrigation. The wound is then packed loosely with wet to dry dressings or continuous moist dressing and covered with dry sterile gauze. Skilled nursing care is necessary for proper treatment. *The home health record at each visit must document the need for the skilled nursing services.*

NOTE: This section relates to the direct, hands on skilled nursing care provided to patients with wounds, including any necessary dressing changes on those wounds. While a wound might not require this skilled nursing care, the wound may still require skilled monitoring for signs and symptoms of infection or complication (See §40.1.2.1) or skilled teaching of wound care to the patient or the patient's family. (See §40.1.2.3.)

40.1.2.9 - Ostomy Care

(Rev. 179, Issued: 01-14-14, Effective: 01-07-14, Implementation: 01-07-14)
A3-3118.1.B.9, HHA-205.1.B.9

Ostomy care during the post-operative period and in the presence of associated complications where the need for skilled nursing care is clearly documented is a skilled nursing service. Teaching ostomy care remains skilled nursing care regardless of the presence of complications. *The teaching services and the patient/caregiver responses must be documented.*

40.1.2.10 - Heat Treatments

(Rev. 1, 10-01-03)
A3-3118.1.B.10, HHA-205.1.B.10

Heat treatments that have been specifically ordered by a physician as part of active treatment of an illness or injury and require observation by a licensed nurse to adequately evaluate the patient's progress would be considered a skilled nursing service.

40.1.2.11 - Medical Gases

(Rev. 1, 10-01-03)
A3-3118.1.B.11, HHA-205.1.B.11

Initial phases of a regimen involving the administration of medical gases that are necessary to the treatment of the patient's illness or injury, would require skilled nursing care for skilled observation and evaluation of the patient's reaction to the gases, and to teach the patient and family when and how to properly manage the administration of the gases.

40.1.2.12 - Rehabilitation Nursing

(Rev. 1, 10-01-03)
A3-3118.1.B.12, HHA-205.1.B.12

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Rehabilitation nursing procedures, including the related teaching and adaptive aspects of nursing that are part of active treatment (e.g., the institution and supervision of bowel and bladder training programs) would constitute skilled nursing services.

40.1.2.13 - Venipuncture

(Rev. 179, Issued: 01-14-14, Effective: 01-07-14, Implementation: 01-07-14)
A3-3118.1.B.13, HHA-205.1.B.13

Effective February 5, 1998, venipuncture for the purposes of obtaining a blood sample can no longer be the sole reason for Medicare home health eligibility. However, if a beneficiary qualifies for home health eligibility based on a skilled need other than solely venipuncture (e.g., eligibility based on the skilled nursing service of wound care and meets all other Medicare home health eligibility criteria), medically reasonable and necessary venipuncture coverage may continue during the 60-day episode under a home health plan of care.

Sections 1814(a)(2)(C) and 1835(a)(2)(A) of the Act specifically exclude venipuncture, as a basis for qualifying for Medicare home health services if this is the sole skilled service the beneficiary requires. However, the Medicare home health benefit will continue to pay for a blood draw if the beneficiary has a need for another qualified skilled service and meets all home health eligibility criteria. This specific requirement applies to home health services furnished on or after February 5, 1998.

For venipuncture to be reasonable and necessary:

1. The physician order for the venipuncture for a laboratory test should be associated with a specific symptom or diagnosis, or the documentation should clarify the need for the test when it is not diagnosis/illness specific. In addition, the treatment must be recognized (in the Physician's Desk Reference, or other authoritative source) as being reasonable and necessary to the treatment of the illness or injury for venipuncture and monitoring the treatment must also be reasonable and necessary.

2. The frequency of testing should be consistent with accepted standards of medical practice for continued monitoring of a diagnosis, medical problem, or treatment regimen. Even where the laboratory results are consistently stable, periodic venipuncture may be reasonable and necessary because of the nature of the treatment.

3. *The home health record must document the rationale for the blood draw as well as the results.*

   Examples of reasonable and necessary venipuncture for stabilized patients include, but are not limited to those described below.

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a. Captopril may cause side effects such as leukopenia and agranulocytosis and it is standard medical practice to monitor the white blood cell count and differential count on a routine basis (every 3 months) when the results are stable and the patient is asymptomatic.

b. In monitoring phenytoin (e.g., Dilantin) administration, the difference between a therapeutic and a toxic level of phenytoin in the blood is very slight and it is therefore appropriate to monitor the level on a routine basis (every 3 months) when the results are stable and the patient is asymptomatic.

c. Venipuncture for fasting blood sugar (FBS)

- An unstable insulin dependent or noninsulin dependent diabetic would require FBS more frequently than once per month if ordered by the physician.

- Where there is a new diagnosis or where there has been a recent exacerbation, but the patient is not unstable, monitoring once per month would be reasonable and necessary.

- A stable insulin or noninsulin dependent diabetic would require monitoring every 2-3 months.

d. Venipuncture for prothrombin

- Where the documentation shows that the dosage is being adjusted, monitoring would be reasonable and necessary as ordered by the physician.

- Where the results are stable within the therapeutic ranges, monthly monitoring would be reasonable and necessary.

- Where the results *remain* within nontherapeutic ranges, there must be *specific* documentation of *the* factors *that* indicate why continued monitoring is reasonable and necessary.

EXAMPLE: A patient with coronary artery disease was hospitalized with atrial fibrillation and subsequently discharged to the HHA with orders for anticoagulation therapy *as well as other skilled nursing care. If indicated,* monthly venipuncture to report prothrombin (protime) levels to the physician *would be reasonable and necessary even though* the patient's prothrombin time tests indicate essential stability. *The home health record must document the rationale for the blood draw as well as the results*.

40.1.2.14 - Student Nurse Visits

(Rev. 179, Issued: 01-14-14, Effective: 01-07-14, Implementation: 01-07-14)

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A3-3118.1.B.14, HHA-205.1.B.14

Visits made by a student nurse may be covered as skilled nursing care when the HHA participates in training programs that utilize student nurses enrolled in a school of nursing to perform skilled nursing services in a home setting. To be covered, the services must be reasonable and necessary skilled nursing care and must be performed under the general supervision of a registered or licensed nurse. The supervising nurse need not accompany the student nurse on each visit. *All documentation requirements must be fulfilled by student nurses.*

40.1.2.15 - Psychiatric Evaluation, Therapy, and Teaching

(Rev. 179, Issued: 01-14-14, Effective: 01-07-14, Implementation: 01-07-14)

A3-3118.1.B.15, HHA-205.1.B.15

The evaluation, psychotherapy, and teaching needed by a patient suffering from a diagnosed psychiatric disorder that requires active treatment by a psychiatrically trained nurse and the costs of the psychiatric nurse's services may be covered as a skilled nursing service. Psychiatrically trained nurses are nurses who have special training and/or experience beyond the standard curriculum required for a registered nurse. The services of the psychiatric nurse are to be provided under a plan of care established and reviewed by a physician.

Because the law precludes agencies that primarily provide care and treatment of mental diseases from participating as HHAs, psychiatric nursing must be furnished by an agency that does not primarily provide care and treatment of mental diseases. If a substantial number of an HHA's patients attend partial hospitalization programs or receive outpatient mental health services, the intermediary will verify whether the patients meet the eligibility requirements specified in §30 and whether the HHA is primarily engaged in care and treatment of mental disease.

Services of a psychiatric nurse would not be considered reasonable and necessary to assess or monitor use of psychoactive drugs that are being used for nonpsychiatric diagnoses or to monitor the condition of a patient with a known psychiatric illness who is on treatment but is considered stable. A person on treatment would be considered stable if their symptoms were absent or minimal or if symptoms were present but were relatively stable and did not create a significant disruption in the patient's normal living situation.

EXAMPLE 1:

A patient is homebound for medical conditions, but has a psychiatric condition for which he has been receiving medication. The patient's psychiatric condition has not required a change in medication or hospitalization for over 2 years. During a visit by the nurse, the patient's spouse indicates that the patient is awake and pacing most of the night and has begun ruminating about perceived failures in life. The nurse observes that the patient does not exhibit an appropriate level of hygiene and is dressed inappropriately for the

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season. The nurse comments to the patient about her observations and tries to solicit information about the patient's general medical condition and mental status. The nurse advises the physician about the patient's general medical condition and the new symptoms and changes in the patient's behavior. The physician orders the nurse to check blood levels of medication used to treat the patient's medical and psychiatric conditions. The physician then orders the psychiatric nursing service to evaluate the patient's mental health and communicate with the physician about whether additional intervention to deal with the patient's symptoms and behaviors is warranted. *The home health record at each visit should document the need for the psychiatric skilled nursing services and treatment. The home health record must also reflect the patient/caregiver response to any interventions provided.*

EXAMPLE 2:

A patient is homebound after discharge following hip replacement surgery and is receiving skilled therapy services for range of motion exercise and gait training. In the past, the patient had been diagnosed with clinical depression and was successfully stabilized on medication. There has been no change in her symptoms. The fact that the patient is taking an antidepressant does not indicate a need for psychiatric nursing services.

EXAMPLE 3:

A patient was discharged after 2 weeks in a psychiatric hospital with a new diagnosis of major depression. The patient remains withdrawn; in bed most of the day, and refusing to leave home. The patient has a depressed affect and continues to have thoughts of suicide, but is not considered to be suicidal. Psychiatric *skilled* nursing *services are* necessary for supportive interventions until antidepressant blood levels are reached and the suicidal thoughts are diminished further, to monitor suicide ideation, ensure medication compliance and patient safety, perform suicidal assessment, and teach crisis management and symptom management to family members. *The home health record at each visit should document the need for the psychiatric skilled nursing services and treatment. The home health record must also reflect the patient/caregiver response to any interventions provided.*

40.1.3 - Intermittent Skilled Nursing Care

(Rev. 1, 10-01-03)
A3.3118.1.C, HHA-205.1.C

The law, at §1861(m) of the Act defines intermittent, for the purposes of §§1814(a)(2) and 1835(a)(2)(A), as skilled nursing care that is either provided or needed on fewer than 7 days each week, or less than 8 hours each day for periods of 21 days or less (with extensions in exceptional circumstances when the need for additional care is finite and predictable.)

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To meet the requirement for "intermittent" skilled nursing care, a patient must have a medically predictable recurring need for skilled nursing services. In most instances, this definition will be met if a patient requires a skilled nursing service at least once every 60 days. The exception to the intermittent requirement is daily skilled nursing services for diabetics unable to administer their insulin (when there is no able and willing caregiver).

Since the need for "intermittent" skilled nursing care makes the patient eligible for other covered home health services, the intermediary should evaluate each claim involving skilled nursing services furnished less frequently than once every 60 days. In such cases, payment should be made only if documentation justifies a recurring need for reasonable, necessary, and medically predictable skilled nursing services. The following are examples of the need for infrequent, yet intermittent, skilled nursing services:

1. The patient with an indwelling **silicone** catheter who generally needs a catheter change only at 90-day intervals;

2. The patient who experiences a fecal impaction (i.e., loss of bowel tone, restrictive mobility, and a breakdown in good health habits) and must receive care to manually relieve the impaction. Although these impactions are likely to recur, it is not possible to pinpoint a specific timeframe; or

3. The blind diabetic who self-injects insulin may have a medically predictable recurring need for a skilled nursing visit at least every 90 days. These visits, for example, would be to observe and determine the need for changes in the level and type of care which have been prescribed thus supplementing the physician's contacts with the patient.

There is a possibility that a physician may order a skilled visit less frequently than once every 60 days for an eligible beneficiary if there exists an extraordinary circumstance of anticipated patient need that is documented in the patient's plan of care in accordance with 42 CFR 409.43(b). A skilled visit frequency of less than once every 60 days would only be covered if it is specifically ordered by a physician in the patient's plan of care and is considered to be a reasonable, necessary, and medically predictable skilled need for the patient in the individual circumstance.

Where the need for "intermittent" skilled nursing visits is medically predictable but a situation arises after the first visit making additional visits unnecessary, e.g., the patient is institutionalized or dies, the one visit would be paid at the wage-adjusted LUPA amount for that discipline type. However, a one-time order; e.g., to give gamma globulin following exposure to hepatitis, would not be considered a need for "intermittent" skilled nursing care since a recurrence of the problem that would require this service is not medically predictable.

Although most patients require services no more frequently than several times a week, Medicare will pay for part-time (as defined in §50.7) medically reasonable and necessary skilled nursing care seven days a week for a short period of time (two to three weeks).

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There may also be a few cases involving unusual circumstances where the patient's prognosis indicates the medical need for daily skilled services will extend beyond three weeks. As soon as the patient's physician makes this judgment, which usually should be made before the end of the 3-week period, the HHA must forward medical documentation justifying the need for such additional services and include an estimate of how much longer daily skilled services will be required.

A person expected to need more or less full-time skilled nursing care over an extended period of time, i.e., a patient who requires institutionalization, would usually not qualify for home health benefits.

40.2 - Skilled Therapy Services

(Rev. 179, Issued: 01-14-14, Effective: 01-07-14, Implementation: 01-07-14)
A3-3118.2, HHA-205.2

To be covered as skilled therapy, the services must require the skills of a qualified therapist and must be reasonable and necessary for the treatment of the patient's illness or injury as discussed below. Coverage does not turn on the presence or absence of an individual's potential for improvement, but rather on the beneficiary's need for skilled care.

40.2.1 - General Principles Governing Reasonable and Necessary Physical Therapy, Speech-Language Pathology Services, and Occupational Therapy

(Rev. 179, Issued: 01-14-14, Effective: 01-07-14, Implementation: 01-07-14)

The service of a physical therapist, speech-language pathologist, or occupational therapist is a skilled therapy service if the inherent complexity of the service is such that it can be performed safely and/or effectively only by or under the general supervision of a skilled therapist. To be covered*, assuming all other eligibility and coverage criteria have been met*, the skilled services must also be reasonable and necessary to the treatment of the patient's illness or injury or to the restoration or maintenance of function affected by the patient's illness or injury. It is necessary to determine whether individual therapy services are skilled and whether, in view of the patient's overall condition, skilled management of the services provided is needed.

The development, implementation, management, and evaluation of a patient care plan based on the physician's orders constitute skilled therapy services when, because of the patient's *clinical* condition, those activities require the *specialized* skills*, knowledge, and judgment* of a qualified therapist to ensure the effectiveness of the treatment goals and ensure medical safety. Where the *specialized* skills*, knowledge, and judgment* of a therapist are needed to manage and periodically reevaluate the appropriateness of a maintenance program, such services would be covered, even if the skills of a therapist were not needed to carry out the activities performed as part of the maintenance program.

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While a patient's particular medical condition is a valid factor in deciding if skilled therapy services are needed, a patient's diagnosis or prognosis should never be the sole factor in deciding that a service is or is not skilled. The key issue is whether the skills of a therapist are needed to treat the illness or injury, or whether the services can be carried out by *unskilled* personnel.

A service that is ordinarily considered *unskilled* could be considered a skilled therapy service in cases *where* there is clear documentation that, because of special medical complications, skilled rehabilitation personnel are required to perform the service. However, the importance of a particular service to a patient or the frequency with which it must be performed does not, by itself, make *an unskilled* service into a skilled service.

Assuming all other eligibility and coverage criteria have been met, the skilled therapy services must be reasonable and necessary to the treatment of the patient's illness or injury within the context of the patient's unique medical condition. To be considered reasonable and necessary for the treatment of the illness or injury:

a. The services must be consistent with the nature and severity of the illness or injury, the patient's particular medical needs, including the requirement that the amount, frequency, and duration of the services must be reasonable; and

b. The services must be considered, under accepted standards of medical practice, to be specific, safe, and effective treatment for the patient's condition, meeting the standards noted below. *The home health record must specify the purpose of the skilled service provided.*

1. Assessment, Measurement and Documentation of Therapy Effectiveness

To ensure therapy services are effective, at defined points during a course of treatment, for each therapy discipline for which services are provided, a qualified therapist (instead of an assistant) must perform the ordered therapy service. During this visit, the therapist must assess the patient using a method which allows for objective measurement of function and successive comparison of measurements. The therapist must document the measurement results in the clinical record. Specifically:

i. <u>Initial Therapy Assessment</u>

- For each therapy discipline for which services are provided, a qualified therapist (instead of an assistant) must assess the patient's function using a method which objectively measures activities of daily living such as, but not limited to, eating, swallowing, bathing, dressing, toileting, walking, climbing stairs, using assistive devices, and mental and cognitive factors. The measurement results must be documented in the clinical record.

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- Where more than one discipline of therapy is being provided, a qualified therapist from each of the disciplines must functionally assess the patient. The therapist must document the measurement results which correspond to the therapist's discipline and care plan goals in the clinical record.

ii. <u>Reassessment at least every 30 days (performed in conjunction with an ordered therapy service)</u>

- At least once every 30 days, for each therapy discipline for which services are provided, a qualified therapist (instead of an assistant) must provide the ordered therapy service, functionally reassess the patient, and compare the resultant measurement to prior assessment measurements. The therapist must document in the clinical record the measurement results along with the therapist's determination of the effectiveness of therapy, or lack thereof. The 30-day clock begins with the first therapy service (of that discipline) and the clock resets with each therapist's visit/assessment/measurement/documentation (of that discipline).

- Where more than one discipline of therapy is being provided, at least once every 30 days, a qualified therapist from each of the disciplines must provide the ordered therapy service, functionally reassess the patient, and compare the resultant measurement to prior assessment measurements. The therapist must document in the clinical record the measurement results along with the therapist's determination of the effectiveness of therapy, or lack thereof. In multi-discipline therapy cases, the qualified therapist would reassess functional items (and measure and document) those which correspond to the therapist's discipline and care plan goals. In cases where more than one discipline of therapy is being provided, the 30-day clock begins with the first therapy service (of that discipline) and the clock resets with each therapist's visit/assessment/measurement/documentation (of that discipline).

iii. <u>Reassessment prior to the 14th and 20th therapy visit</u>

- If a patient's course of therapy treatment reaches 13 therapy visits, for each therapy discipline for which services are provided, a qualified therapist (instead of an assistant) must provide the ordered 13th therapy service, functionally reassess the patient, and compare the resultant measurement to prior measurements. The therapist must document in the clinical record the measurement results along with the therapist's determination of the effectiveness of therapy, or lack thereof.

  - Similarly, if a patient's course of therapy treatment reaches 19 therapy visits, a qualified therapist (instead of an assistant) must provide the ordered 19th therapy service, functionally reassess, measure and document the effectiveness of therapy, or lack thereof.

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- When the patient resides in a rural area or when documented circumstances outside the control of the therapist prevent the qualified therapist's visit at exactly the 13th visit, the qualified therapist's visit can occur after the 10th therapy visit but no later than the 13th visit. Similarly, in rural areas or if documented exceptional circumstances exist, the qualified therapist's visit can occur after the 16th therapy visit but no later than the 19th therapy visit.

- Where more than one discipline of therapy is being provided, a qualified therapist from each of the disciplines must provide the ordered therapy service and functionally reassess, measure, and document the effectiveness of therapy or lack thereof close to but no later than the 13th and 19th therapy visit. The 13th and 19th therapy visit timepoints relate to the sum total of therapy visits from all therapy disciplines. In multi-discipline therapy cases, the qualified therapist would reassess functional items and measure those which correspond to the therapist's discipline and care plan goals.

- Therapy services provided after the 13th and 19th visit (sum total of therapy visits from all therapy disciplines), are not covered until:

    - The qualified therapist(s) completes the assessment/measurement/documentation requirements.

    - The qualified therapist(s) determines if the goals of the plan of care have been achieved or if the plan of care may require updating. If needed, changes to therapy goals or an updated plan of care is sent to the physician for signature or discharge.

    - If the measurement results do not reveal progress toward therapy goals and/or do not indicate that therapy is effective, but therapy continues, the qualified therapist(s) must document why the physician and therapist have determined therapy should be continued.

c. Services involving activities for the general welfare of any patient, e.g., general exercises to promote overall fitness or flexibility and activities to provide diversion or general motivation do not constitute skilled therapy. *Unskilled* individuals without the supervision of a therapist can perform those services.

d. Assuming all other eligibility and coverage requirements have been met, in order for therapy services to be covered, one of the following three conditions must be met:

1. The skills of a qualified therapist are needed to restore patient function:

- To meet this coverage condition, therapy services must be provided with the expectation, based on the assessment made by the physician of the patient's restorative potential that the condition of the patient will improve materially in a reasonable and generally predictable period of time. Improvement is evidenced by objective successive measurements.

- Therapy is not considered reasonable and necessary under this condition if the patient's expected restorative potential would be insignificant in relation to the extent and duration of therapy services required to reach such potential.

- Therapy is not required to effect improvement or restoration of function where a patient suffers a transient or easily reversible loss of function (such as temporary weakness following surgery) which could reasonably be expected to improve spontaneously as the patient gradually resumes normal activities. Therapy in such cases is not considered reasonable and necessary to treat the patient's illness or injury, under this condition. However, if the criteria for maintenance therapy described in (3) below is met, therapy could be covered under that condition.

2. The patient's *clinical* condition requires *the specialized skills, knowledge, and judgment of* a qualified therapist to establish *or design* a maintenance program, *related to the patient's illness or injury, in order to ensure the safety of the patient and the effectiveness of the program, to the extent provided by regulation,*

   - *For patients receiving rehabilitative/restorative therapy services, if the specialized skills, knowledge, and judgment of a qualified therapist are required to develop a maintenance program, the expectation is that the development of that maintenance program would occur during* the last visit(s) for *rehabilitative/*restorative treatment. The goals of a maintenance program would be to maintain *the patient's current* functional status or to prevent *or slow further deterioration*.

   - *Necessary periodic* reevaluations *by a qualified therapist* of the beneficiary and maintenance program *are* covered if the specialized skills*, knowledge, and judgment* of a qualified therapist *are required*.

   - Where a maintenance program is not established until after the rehabilitative*/restorative* therapy program has been completed, or where there was no rehabilitative*/restorative therapy* program*, and the specialized skills, knowledge, and judgment of a qualified therapist are required to develop a maintenance program, such services* would be considered reasonable and necessary for the treatment of the patient's condition *in order to ensure the effectiveness of the treatment goals and ensure medical safety. When the development of a maintenance program*

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could not be accomplished during the last visits(s) of rehabilitative/restorative treatment, the therapist must document why the maintenance program could not be developed during those last rehabilitative/restorative treatment visit(s).

- When designing or establishing a maintenance program, the qualified therapist must teach the patient or the patient's family or caregiver's necessary techniques, exercises or precautions as necessary to treat the illness or injury. *The instruction of the beneficiary or appropriate caregiver by a qualified therapist regarding a maintenance program is covered if the specialized skills, knowledge, and judgment of a qualified therapist are required.* However, visits made by skilled therapists to a patient's home solely to train other HHA staff (e.g., home health aides) are not billable as visits since the HHA is responsible for ensuring that its staff is properly trained to perform any service it furnishes. The cost of a skilled therapist's visit for the purpose of training HHA staff is an administrative cost to the agency.

3. The skills of a qualified therapist *(not an assistant)* are needed to perform maintenance therapy:

   Coverage of therapy services to perform a maintenance program is not determined solely on the presence or absence of a beneficiary's potential for improvement from the therapy, but rather on the beneficiary's need for skilled care. Assuming all other eligibility and coverage requirements are met, skilled therapy services are covered when an individualized assessment of the patient's clinical condition demonstrates that the specialized judgment, knowledge, and skills of a qualified therapist ("skilled care") are necessary for the performance of a safe and effective maintenance program. Such a maintenance program to maintain the patient's current condition or to prevent or slow further deterioration is covered so long as the beneficiary requires skilled care for the safe and effective performance of the program. When, however, the individualized assessment does not demonstrate such a necessity for skilled care, including when the performance of a maintenance program does not require the skills of a therapist because it could safely and effectively be accomplished by the patient or with the assistance of non-therapists, including unskilled caregivers, such maintenance services will not be covered.

   Further, under the standard set forth in the previous paragraph, skilled care is necessary for the performance of a safe and effective maintenance program only when (a) the particular patient's special medical complications require the skills of a qualified therapist to perform a therapy service that would otherwise be considered non-skilled; or (b) the

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needed therapy procedures are of such complexity that the skills of a qualified therapist are required to perform the procedure.

e. The amount, frequency, and duration of the services must be reasonable.

As is outlined in home health regulations, as part of the home health agency (HHA) Conditions of Participation (CoPs), the clinical record of the patient must contain progress and clinical notes. Additionally, in Pub. 100-04, Medicare Claims Processing Manual, Chapter 10; "Home Health Agency Billing", instructions specify that for each claim, HHAs are required to report all services provided to the beneficiary during each episode, this includes reporting each visit in line-item detail. As such, it is expected that the home health records for every visit will reflect the need for the skilled medical care provided. These clinical notes are also expected to provide important communication among all members of the home care team regarding the development, course and outcomes of the skilled observations, assessments, treatment and training performed. Taken as a whole then, the clinical notes are expected to tell the story of the patient's achievement towards his/her goals as outlined in the Plan of Care. In this way, the notes will serve to demonstrate why a skilled service is needed.

Therefore the home health clinical notes must document as appropriate:

- *the history and physical exam pertinent to the day's visit , (including the response or changes in behavior to previously administered skilled services) and*
- *the skilled services applied on the current visit, and*
- *the patient/caregiver's immediate response to the skilled services provided, and*
- *the plan for the next visit based on the rationale of prior results.*

Clinical notes should be written such that they adequately describe the reaction of a patient to his/her skilled care. Clinical notes should also provide a clear picture of the treatment, as well as "next steps" to be taken. Vague or subjective descriptions of the patient's care should not be used. For example terminology such as the following would not adequately describe the need for skilled care:

- *Patient tolerated treatment well*
- *Caregiver instructed in medication management*
- *Continue with POC*

Objective measurements of physical outcomes of treatment should be provided and/or a clear description of the changed behaviors due to education programs should be recorded in order that all concerned can follow the results of the applied services.

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When the skilled service is being provided to either maintain the patient's condition or prevent or slow further deterioration, the clinical notes must also describe:

- *A detailed rationale that explains the need for the skilled service in light of the patient's overall medical condition and experiences,*
- *the complexity of the service to be performed, and*
- *any other pertinent characteristics of the beneficiary or home.*

40.2.2 - Application of the Principles to Physical Therapy Services

(Rev. 179, Issued: 01-14-14, Effective: 01-07-14, Implementation: 01-07-14)

The following discussion of skilled physical therapy services applies the principles in §40.2.1 to specific physical therapy services about which questions are most frequently raised.

A. Assessment

Assuming all other eligibility and coverage requirements have been met, the skills of a physical therapist to assess and periodically reassess a patient's rehabilitation needs and potential or to develop and/or implement a physical therapy program are covered when they are reasonable and necessary because of the patient's condition. Skilled rehabilitation services concurrent with the management of a patient's care plan include objective tests and measurements such as, but not limited to, range of motion, strength, balance, coordination, endurance, or functional ability.

As described in section 40.2.1(b), at defined points during a course of therapy, the qualified physical therapist (instead of an assistant) must perform the ordered therapy service visit, assess the patient's function using a method which allows for objective measurement of function and comparison of successive measurements, and document the results of the assessments, corresponding measurements, and effectiveness of the therapy in the patient's clinical record. Refer to §40.2.1(b) for specific timing and documentation requirements associated with these requirements.

B. Therapeutic Exercises

Therapeutic exercises, which require the skills of a qualified physical therapist to ensure the safety of the beneficiary and the effectiveness of the treatment constitute skilled physical therapy, when the criteria in §40.2.1(d) above are met.

C. Gait Training

Gait evaluation and training furnished to a patient whose ability to walk has been impaired by neurological, muscular or skeletal abnormality require the skills of a

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qualified physical therapist and constitute skilled physical therapy and are considered reasonable and necessary if they can be expected to materially improve *or maintain* the patient's ability to walk *or prevent or slow further deterioration of the patient's ability to walk*. Gait evaluation and training which is furnished to a patient whose ability to walk has been impaired by a condition other than a neurological, muscular, or skeletal abnormality would nevertheless be covered where physical therapy is reasonable and necessary to restore *or maintain* function *or to prevent or slow further deterioration*. Refer to §40.2.1(d)(1) for the reasonable and necessary coverage criteria associated with restoring patient function.

EXAMPLE 1:

A physician has ordered gait evaluation and training for a patient whose gait has been materially impaired by scar tissue resulting from burns. Physical therapy services to evaluate the beneficiary's gait, establish a gait training program, and provide the skilled services necessary to implement the program would be covered. *The patient's response to therapy must be documented. At appropriate intervals (see above), the qualified therapist must assess the patient with objective measurements of function.*

EXAMPLE 2:

A patient who has had a total hip replacement is ambulatory but demonstrates weakness and is unable to climb stairs safely. Physical therapy would be reasonable and necessary to teach the patient to climb and descend stairs safely. *Once the patient has reached the goal of climbing and descending stairs safely, additional therapy services are no longer required, and thus would not be covered.*

EXAMPLE 3:

A patient who has received gait training has reached their maximum restoration potential, and the physical therapist is teaching the patient and family how to safely perform the activities that are a part of the maintenance program. The visits by the physical therapist to demonstrate and teach the activities (which by themselves do not require the skills of a therapist) would be covered since they are needed to establish the program (refer to §40.2.1(d)(2)). *The patient's and caregiver's understanding and implementation of the maintenance program must be documented. After the establishment of the maintenance program, any further visits would need to document why the skilled services of a physical therapist are still required.*

D. Range of Motion

Only a qualified physical therapist may perform range of motion tests and, therefore, such tests are skilled physical therapy.

Range of motion exercises constitute skilled physical therapy only if they are part of an active treatment for a specific disease state, illness, or injury that has resulted in a loss or

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restriction of mobility (as evidenced by physical therapy notes showing the degree of motion lost and the degree to be restored). *Unskilled* individuals may provide range of motion exercises unrelated to the restoration of a specific loss of function often safely and effectively. Passive exercises to maintain range of motion in paralyzed extremities that can be carried out by *unskilled* persons do not constitute skilled physical therapy.

However, if the criteria in §40.2.1(d)(3) are met, where there is clear documentation that, because of special medical complications (e.g., susceptible to pathological bone fractures), the skills of a therapist are needed to provide services which ordinarily do not need the skills of a therapist, and then the services would be covered.

E. Maintenance Therapy

Where services that are required to maintain *the patient's current* function *or to prevent or slow further deterioration are of such complexity* and *sophistication that* the *skills* of a *qualified* therapist *are* required *to perform* the *procedure* safely and effectively, the services would be covered physical therapy services. *Further, where the particular patient's special medical complications require the skills of a qualified therapist to perform a therapy service safely and effectively that would otherwise be considered unskilled, such services would be covered physical therapy services.* Refer to §40.2.1(d)(3).

EXAMPLE 4:

Where there is an unhealed, unstable fracture that requires regular exercise to maintain function until the fracture heals, the skills of a physical therapist would be needed to ensure that the fractured extremity is maintained in proper position and alignment during maintenance range of motion exercises.

EXAMPLE 5:

A Parkinson's patient or a patient with rheumatoid arthritis who has not been under a restorative physical therapy program may require the services of a physical therapist to determine what type of exercises are required to maintain the patient's present level of function *or to prevent or slow further deterioration.* The initial evaluation of the patient's needs, the designing of a maintenance program appropriate to *the patient's* capacity and tolerance and *to* the treatment objectives of the physician, the instruction of the patient, family or caregivers to carry out the program safely and effectively, and such reevaluations as may be required by the patient's condition, would constitute skilled physical therapy. *Each component of this process must be documented in the home health record.*

While a patient is under a restorative physical therapy program, the physical therapist should regularly reevaluate the patient's condition and adjust any exercise program the patient is expected to carry out alone or with the aid of supportive personnel to maintain the function being restored. Consequently, by the time it is determined that no further

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restoration is possible (i.e., by the end of the last restorative session) the physical therapist will already have designed the maintenance program required and instructed the patient or caregivers in carrying out the program.

F. Ultrasound, Shortwave, and Microwave Diathermy Treatments

These treatments must always be performed by or under the supervision of a qualified physical therapist and are skilled therapy.

G. Hot Packs, Infra-Red Treatments, Paraffin Baths and Whirlpool Baths

Heat treatments and baths of this type ordinarily do not require the skills of a qualified physical therapist. However, the skills, knowledge, and judgment of a qualified physical therapist might be required in the giving of such treatments or baths in a particular case, e.g., where the patient's condition is complicated by circulatory deficiency, areas of desensitization, open wounds, fractures, or other complications. *There must be clear documentation in the home health record, of the special medical complications that describe the need for the skilled services provided by the therapist.*

H. Wound Care Provided Within Scope of State Practice Acts

If wound care falls within the auspice of a physical therapist's State Practice Act, then the physical therapist may provide the specific type of wound care services defined in the State Practice Act. However, such visits in this specific situation would be a covered therapy service *when there is documentation in the home health record that* the skills of a therapist are required to perform the service*. The patient's response to therapy must be documented*.

40.2.3 - Application of the General Principles to Speech-Language Pathology Services

(Rev. 179, Issued: 01-14-14, Effective: 01-07-14, Implementation: 01-07-14)

The following discussion of skilled speech-language pathology services applies the principles to specific speech-language pathology services about which questions are most frequently raised. *Coverage of speech-language pathology services is not determined solely on the presence or absence of a beneficiary's potential for improvement from the therapy, but rather on the beneficiary's need for skilled care. Assuming all other eligibility and coverage requirements have been met, skilled speech-language pathology services are covered when the individualized assessment of the patient's clinical condition demonstrates that the specialized judgment, knowledge, and skills of a qualified speech-language pathologist are necessary.*

As described in §40.2.1(b), at defined points during a course of therapy, the qualified speech-language pathologist must perform the ordered therapy service visit, assess the patient's function using a method which allows for objective measurement of function and comparison of successive measurements, and document the results of the

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assessments, corresponding measurements, and effectiveness of therapy in the patient's clinical record. Refer to §40.2.1(b) for specific timing and documentation requirements associated with these requirements.

1. The skills of a speech-language pathologist are required for the assessment of a patient's rehabilitation needs (including the causal factors and the severity of the speech and language disorders), and rehabilitation potential. Reevaluation would be considered reasonable and necessary only if the patient exhibited:

    - A change in functional speech or motivation;
    - Clearing of confusion; or
    - The remission of some other medical condition that previously contraindicated speech-language pathology services.

    Where a patient is undergoing restorative speech-language pathology services, routine reevaluations are considered to be a part of the therapy and cannot be billed as a separate visit.

2. The services of a speech-language pathologist would be covered if they are needed as a result of an illness or injury and are directed towards specific speech/voice production.

3. Speech-language pathology would be covered where *a skilled* service can only be provided by a speech-language pathologist and where it is reasonably expected that the *skilled* service will improve*, maintain, or prevent or slow further deterioration in* the patient's ability to carry out *communication or feeding* activities.

4. The services of a speech-language pathologist to establish a hierarchy of speech-voice-language communication tasks and cueing that directs a patient toward speech-language communication goals in the plan of care would be covered speech-language pathology.

5. The services of a speech-language pathologist to train the patient, family, or other caregivers to augment the speech-language communication, treatment, to establish an effective maintenance program*, or carry out a safe and effective maintenance program when the particular patient's special medical complications require the skills of a qualified therapist (not an assistant) to perform a therapy service that would otherwise be considered unskilled or the needed therapy procedures are of such complexity that the skills of a qualified therapist are required to perform the procedures,* would be covered speech-language pathology services.

6. The services of a speech-language pathologist to assist patients with aphasia in rehabilitation of speech and language skills are covered when needed by a patient.

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7. The services of a speech-language pathologist to assist patients with voice disorders to develop proper control of the vocal and respiratory systems for correct voice production are covered when needed by a patient.

40.2.4 - Application of the General Principles to Occupational Therapy

(Rev. 179, Issued: 01-14-14, Effective: 01-07-14, Implementation: 01-07-14)
A3-3118.2.D, HHA-205.2.D

The following discussion of skilled occupational therapy services applies the principles to specific occupational therapy services about which questions are most frequently raised. *Coverage of occupational therapy services is not determined solely on the presence or absence of a beneficiary's potential for improvement from the therapy, but rather on the beneficiary's need for skilled care. Assuming all other eligibility and coverage requirements have been met, skilled occupational therapy services are covered when the individualized assessment of the patient's clinical condition demonstrates that the specialized judgment, knowledge, and skills of a qualified occupational therapist are necessary.*

40.2.4.1 - Assessment

(Rev. 179, Issued: 01-14-14, Effective: 01-07-14, Implementation: 01-07-14)

Assuming all other eligibility and coverage requirements are met, the skills of an occupational therapist to assess and reassess a patient's rehabilitation needs and potential or to develop and/or implement an occupational therapy program are covered when they are reasonable and necessary because of the patient's condition.

As described in §40.2.1(b), at defined points during a course of therapy, the qualified occupational therapist (instead of an assistant) must perform the ordered therapy service visit, assess the *patient's* function using a method which allows for objective measurement of function and comparison of successive measurements, and document the results of the assessments, corresponding measurements, and effectiveness of therapy in the patient's clinical record. Refer to §40.2.1(b) for specific timing and documentation requirements associated with these requirements.

40.2.4.2 - Planning, Implementing, and Supervision of Therapeutic Programs

(Rev. 1, 10-01-03)
A3-3118.2.D.2, HHA-205.2.D.2

The planning, implementing, and supervision of therapeutic programs including, but not limited to those listed below are skilled occupational therapy services, and if reasonable and necessary to the treatment of the patient's illness or injury would be covered.

A. Selecting and Teaching Task Oriented Therapeutic Activities Designed to Restore Physical Function.

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EXAMPLE: Use of woodworking activities on an inclined table to restore shoulder, elbow, and wrist range of motion lost as a result of burns.

B. Planning, Implementing, and Supervising Therapeutic Tasks and Activities Designed to Restore Sensory-Integrative Function.

EXAMPLE: Providing motor and tactile activities to increase sensory output and improve response for a stroke patient with functional loss resulting in a distorted body image.

C. Planning, Implementing, and Supervising of Individualized Therapeutic Activity Programs as Part of an Overall "Active Treatment" Program for a Patient With a Diagnosed Psychiatric Illness.

EXAMPLE: Use of sewing activities that require following a pattern to reduce confusion and restore reality orientation in a schizophrenic patient.

D. Teaching Compensatory Techniques to Improve the Level of Independence in the Activities of Daily Living.

EXAMPLE: Teaching a patient who has lost use of an arm how to pare potatoes and chop vegetables with one hand.

EXAMPLE: Teaching a stroke patient new techniques to enable them to perform feeding, dressing, and other activities of daily living as independently as possible.

E. The Designing, Fabricating, and Fitting of Orthotic and Self-Help Devices.

EXAMPLE: Construction of a device which would enable a patient to hold a utensil and feed themselves independently.

EXAMPLE: Construction of a hand splint for a patient with rheumatoid arthritis to maintain the hand in a functional position.

F. Vocational and Prevocational Assessment and Training

Vocational and prevocational assessment and training that is directed toward the restoration of function in the activities of daily living lost due to illness or injury would be covered. Where vocational or prevocational assessment and training is related solely to specific employment opportunities, work skills, or work settings, such services would not be covered because they would not be directed toward the treatment of an illness or injury.

40.2.4.3 - Illustration of Covered Services

(Rev. 179, Issued: 01-14-14, Effective: 01-07-14, Implementation: 01-07-14)

A3-3118.2.D.3, HHA-205.2.D.3

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EXAMPLE 1:

A physician orders occupational therapy for a patient who is recovering from a fractured hip and who needs to be taught compensatory and safety techniques with regard to lower extremity dressing, hygiene, toileting, and bathing. The occupational therapist will establish goals for the patient's rehabilitation (to be approved by the physician), and will undertake teaching techniques necessary for the patient to reach the goals. Occupational therapy services would be covered at a duration and intensity appropriate to the severity of the impairment and the patient's response to treatment. *Such visits would be considered covered when the skills of a therapist are required to perform the services. The patient's needs in response to therapy must be documented.*

EXAMPLE 2:

A physician has ordered occupational therapy for a patient who is recovering from a CVA. The patient has decreased range of motion, strength, and sensation in both the upper and lower extremities on the right side. In addition, the patient has perceptual and cognitive deficits resulting from the CVA. The patient's condition has resulted in decreased function in activities of daily living (specifically bathing, dressing, grooming, hygiene, and toileting). The loss of function requires assistive devices to enable the patient to compensate for the loss of function and maximize safety and independence. The patient also needs equipment such as himi-slings to prevent shoulder subluxation and a hand splint to prevent joint contracture and deformity in the right hand. The services of an occupational therapist would be necessary to:

- Assess the patient's needs;
- Develop goals (to be approved by the physician);
- Manufacture or adapt the needed equipment to the patient's use;
- Teach compensatory techniques;
- Strengthen the patient as necessary to permit use of compensatory techniques; and
- Provide activities that are directed towards meeting the goals governing increased perceptual and cognitive function.

Occupational therapy services would be covered at a duration and intensity appropriate to the severity of the impairment and the patient's response to treatment. *Such visits would be considered covered therapy services when the skills of a therapist are required to perform the services. The patient's needs, course of therapy and response to therapy must be documented.*

50 - Coverage of Other Home Health Services

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(Rev. 1, 10-01-03)
A3-3119, HHA-206

50.1 - Skilled Nursing, Physical Therapy, Speech-Language Pathology Services, and Occupational Therapy

(Rev. 1, 10-01-03)
A3-3119.1, HHA-206.1

Where the patient meets the qualifying criteria in §30, Medicare covers skilled nursing services that meet the requirements of §§40.1 and 50.7, physical therapy that meets the requirements of §40.2, speech-language pathology services that meets the requirements of §40.2, and occupational therapy that meets the requirements of §40.2.

Home health coverage is not available for services furnished to a qualified patient who is no longer in need of one of the qualifying skilled services specified in §30. Therefore, dependent services furnished after the final qualifying skilled service are not covered under the home health benefit, except when the dependent service was followed by a qualifying skilled service as a result of the unexpected inpatient admission or death of the patient or due to some other unanticipated event.

50.2 - Home Health Aide Services

(Rev. 1, 10-01-03)
A3-3119.2, HHA-206.2

For home health aide services to be covered:

- The patient must meet the qualifying criteria as specified in §30;
- The services provided by the home health aide must be part-time or intermittent as discussed in §50.7;
- The services must meet the definition of home health aide services of this section; and
- The services must be reasonable and necessary to the treatment of the patient's illness or injury.

NOTE: A home health aide must be certified consistent the competency evaluation requirements.

The reason for the visits by the home health aide must be to provide hands-on personal care of the patient or services needed to maintain the patient's health or to facilitate treatment of the patient's illness or injury.

The physician's order should indicate the frequency of the home health aide services required by the patient. These services may include but are not limited to:

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A. Personal Care

Personal care means:

1. Bathing, dressing, grooming, caring for hair, nail, and oral hygiene which are needed to facilitate treatment or to prevent deterioration of the patient's health, changing the bed linens of an incontinent patient, shaving, deodorant application, skin care with lotions and/or powder, foot care, and ear care; and

2. Feeding, assistance with elimination (including enemas unless the skills of a licensed nurse are required due to the patient's condition, routine catheter care and routine colostomy care), assistance with ambulation, changing position in bed, assistance with transfers.

EXAMPLE 1:

A physician has ordered home health aide visits to assist the patient in personal care because the patient is recovering from a stroke and continues to have significant right side weakness that causes the patient to be unable to bathe, dress or perform hair and oral care. The plan of care established by the HHA nurse sets forth the specific tasks with which the patient needs assistance. Home health aide visits at an appropriate frequency would be reasonable and necessary to assist in these tasks.

EXAMPLE 2:

A physician ordered four home health aide visits per week for personal care for a multiple sclerosis patient who is unable to perform these functions because of increasing debilitation. The home health aide gave the patient a bath twice per week and washed hair on the other two visits each week. Only two visits are reasonable and necessary since the services could have been provided in the course of two visits.

EXAMPLE 3:

A physician ordered seven home health aide visits per week for personal care for a bed-bound, incontinent patient. All visits are reasonable and necessary because the patient has extensive personal care needs.

EXAMPLE 4:

A patient with a well established colostomy forgets to change the bag regularly and has difficulty changing the bag. Home health aide services at an appropriate frequency to change the bag would be considered reasonable and necessary to the treatment of the illness or injury.

B. Simple Dressing Changes That Do Not Require the Skills of a Licensed Nurse

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EXAMPLE 5:

A patient who is confined to the bed has developed a small reddened area on the buttocks. The physician has ordered home health aide visits for more frequent repositioning, bathing and the application of a topical ointment and a gauze 4x4. Home health aide visits at an appropriate frequency would be reasonable and necessary.

C. Assistance With Medications Which Are Ordinarily Self-Administered and Do Not Require the Skills of a Licensed Nurse to Be Provided Safely and Effectively

NOTE: Prefilling of insulin syringes is ordinarily performed by the diabetic as part of the self-administration of the insulin and, unlike the injection of the insulin, does not require the skill of a licensed nurse to be performed properly. Therefore, if HHA staff performs the prefilling of insulin syringes, it is considered to be a home health aide service. However, where State law precludes the provision of this service by other than a licensed nurse or physician, Medicare will make payment for this service, when covered, as though it were a skilled nursing service. Where the patient needs only prefilling of insulin syringes and does not need skilled nursing care on an intermittent basis, physical therapy, speech-language pathology services, or have a continuing need for occupational therapy, then Medicare cannot cover any home health services to the patient (even if State law requires that the insulin syringes be filled by a licensed nurse).

Home health aide services are those services ordered in the plan of care that the aide is permitted to perform under State law. Medicare coverage of the administration of insulin by a home health aide will depend on whether or not the agency is in compliance with all Federal and State laws and regulations related to this task. However, when the task of insulin administration has been delegated to the home health aide, the task must be considered and billed as a Medicare home health aide service. By a State allowing the delegation of insulin administration to home health aides, the State has extended the role of aides, not equated aide services with the services of a registered nurse.

D. Assistance With Activities which Are Directly Supportive of Skilled Therapy Services but Do Not Require the Skills of a Therapist to Be Safely and Effectively Performed Such as Routine Maintenance Exercises and Repetitive Practice of Functional Communication Skills to Support Speech-Language Pathology Services

E. Provision of Services Incidental to Personal Care Services not Care of Prosthetic and Orthotic Devices

When a home health aide visits a patient to provide a health related service as discussed above, the home health aide may also perform some incidental services which do not meet the definition of a home health aide service (e.g., light cleaning, preparation of a meal, taking out the trash, shopping, etc.) However, the purpose of a home health aide visit may not be to provide these incidental services since they are not health related services, but rather are necessary household tasks that must be performed by anyone to maintain a home.

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EXAMPLE 1:

A home health aide visits a recovering stroke patient whose right side weakness and poor endurance cause her to be able to leave the bed and chair only with extreme difficulty. The physician has ordered physical therapy and speech-language pathology services for the patient and home health aide services three or four times per week for personal care, assistance with ambulation as mobility increases, and assistance with repetitive speech exercises as her impaired speech improves. The home health aide also provides incidental household services such as preparation of meals, light cleaning and taking out the trash. The patient lives with an elderly frail sister who is disabled and who cannot perform either the personal care or the incidental tasks. The home health aide visits at a frequency appropriate to the performance of the health related services would be covered, notwithstanding the incidental provision of noncovered services (i.e., the household services) in the course of the visits.

EXAMPLE 2:

A physician orders home health aide visits three times per week. The only services provided are light housecleaning, meal preparation and trash removal. The home health aide visits cannot be covered, notwithstanding their importance to the patient, because the services provided do not meet Medicare's definition of "home health aide services."

50.3 - Medical Social Services

(Rev. 1, 10-01-03)
A3-3119.3, HHA-206.3

Medical social services that are provided by a qualified medical social worker or a social work assistant under the supervision of a qualified medical social worker may be covered as home health services where the beneficiary meets the qualifying criteria specified in §30, and:

1. The services of these professionals are necessary to resolve social or emotional problems that are or are expected to be an impediment to the effective treatment of the patient's medical condition or rate of recovery; and

2. The plan of care indicates how the services which are required necessitate the skills of a qualified social worker or a social work assistant under the supervision of a qualified medical social worker to be performed safely and effectively.

Where both of these requirements for coverage are met, services of these professionals which may be covered include, but are not limited to:

1. Assessment of the social and emotional factors related to the patient's illness, need for care, response to treatment and adjustment to care;

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2. Assessment of the relationship of the patient's medical and nursing requirements to the patient's home situation, financial resources and availability of community resources;

3. Appropriate action to obtain available community resources to assist in resolving the patient's problem (**NOTE:** Medicare does not cover the services of a medical social worker to complete or assist in the completion of an application for Medicaid because Federal regulations require the State to provide assistance in completing the application to anyone who chooses to apply for Medicaid.);

4. Counseling services that are required by the patient; and

5. Medical social services furnished to the patient's family member or caregiver on a short-term basis when the HHA can demonstrate that a brief intervention (that is, two or three visits) by a medical social worker is necessary to remove a clear and direct impediment to the effective treatment of the patient's medical condition or to the patient's rate of recovery. To be considered "clear and direct," the behavior or actions of the family member or caregiver must plainly obstruct, contravene, or prevent the patient's medical treatment or rate of recovery. Medical social services to address general problems that do not clearly and directly impede treatment or recovery as well as long-term social services furnished to family members, such as ongoing alcohol counseling, are not covered.

NOTE: Participating in the development of the plan of care, preparing clinical and progress notes, participating in discharge planning and in-service programs, and acting as a consultant to other agency personnel are appropriate administrative costs to the HHA.

EXAMPLE 1:

The physician has ordered a medical social worker assessment of a diabetic patient who has recently become insulin dependent and is not yet stabilized. The nurse, who is providing skilled observation and evaluation to try to restabilize the patient notices during her visits that the supplies left in the home for the patient's use appear to be frequently missing, and the patient is not compliant with the regimen although she refuses to discuss the matter. The assessment by a medical social worker would be reasonable and necessary to determine if there are underlying social or emotional problems impeding the patient's treatment.

EXAMPLE 2:

A physician ordered an assessment by a medical social worker for a multiple sclerosis patient who was unable to move anything but her head and who had an indwelling catheter. The patient had experienced recurring urinary tract infections and multiple infected ulcers. The physician ordered medical social services after the HHA indicated to him that the home was not well cared for, the patient appeared to be neglected much of the time, and the relationship between the patient and family was very poor. The

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physician and HHA were concerned that social problems created by family caregivers were impeding the treatment of the recurring infections and ulcers. The assessment and follow-up for counseling both the patient and the family by a medical social worker were reasonable and necessary.

EXAMPLE 3:

A physician is aware that a patient with atherosclerosis and hypertension is not taking medications as ordered and adhering to dietary restrictions because he is unable to afford the medication and is unable to cook. The physician orders several visits by a medical social worker to assist in resolving these problems. The visits by the medical social worker to review the patient's financial status, discuss options, and make appropriate contacts with social services agencies or other community resources to arrange for medications and meals would be a reasonable and necessary medical social service.

EXAMPLE 4:

A physician has ordered counseling by a medical social worker for a patient with cirrhosis of the liver who has recently been discharged from a 28-day inpatient alcohol treatment program to her home which she shares with an alcoholic and neglectful adult child. The physician has ordered counseling several times per week to assist the patient in remaining free of alcohol and in dealing with the adult child. The services of the medical social worker would be covered until the patient's social situation ceased to impact on her recovery and/or treatment.

EXAMPLE 5:

A physician has ordered medical social services for a patient who is worried about his financial arrangements and payment for medical care. The services ordered are to arrange Medicaid if possible and resolve unpaid medical bills. There is no evidence that the patient's concerns are adversely impacting recovery or treatment of his illness or injury. Medical social services cannot be covered.

EXAMPLE 6:

A physician has ordered medical social services for a patient of extremely limited income who has incurred large unpaid hospital and other medical bills following a significant illness. The patient's recovery is adversely affected because the patient is not maintaining a proper therapeutic diet, and cannot leave the home to acquire the medication necessary to treat their illness. The medical social worker reviews the patient's financial status, arranges meal service to resolve the dietary problem, arranges for home delivered medications, gathers the information necessary for application to Medicaid to acquire coverage for the medications the patient needs, files the application on behalf of the patient, and follows up repeatedly with the Medicaid State agency.

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The medical social services that are necessary to review the financial status of the patient, arrange for meal service and delivery of medications to the home, and arrange for the Medicaid State agency to assist the patient with the application for Medicaid are covered. The services related to the assistance in filing the application for Medicaid and the follow-up on the application are not covered since they must be provided by the State agency free of charge, and hence the patient has no obligation to pay for such assistance.

EXAMPLE 7:

A physician has ordered medical social services for an insulin dependent diabetic whose blood sugar is elevated because she has run out of syringes and missed her insulin dose for two days. Upon making the assessment visit, the medical social worker learns that the patient's daughter, who is also an insulin dependent diabetic, has come to live with the patient because she is out of work. The daughter is now financially dependent on the patient for all of her financial needs and has been using the patient's insulin syringes. The social worker assesses the patient's financial resources and determines that they are adequate to support the patient and meet her own medical needs, but are not sufficient to support the daughter. She also counsels the daughter and helps her access community resources. These visits would be covered, but only to the extent that the services are necessary to prevent interference with the patient's treatment plan.

EXAMPLE 8:

A wife is caring for her husband who is an Alzheimer's patient. The nurse learns that the wife has not been giving the patient his medication correctly and seems distracted and forgetful about various aspects of the patient's care. In a conversation with the nurse, the wife relates that she is feeling depressed and overwhelmed by the patient's illness. The nurse contacts the patient's physician who orders a social work evaluation. In her assessment visit, the social worker learns that the patient's wife is so distraught over her situation that she cannot provide adequate care to the patient. While there, the social worker counsels the wife and assists her with referrals to a support group and her private physician for evaluation of her depression. The services would be covered.

EXAMPLE 9:

The parent of a dependent disabled child has been discharged from the hospital following a hip replacement. Although arrangements for care of the disabled child during the hospitalization were made, the child has returned to the home. During a visit to the patient, the nurse observes that the patient is transferring the child from bed to a wheelchair. In an effort to avoid impeding the patient's recovery, the nurse contacts the patient's physician to order a visit by a social worker to mobilize family members or otherwise arrange for temporary care of the disabled child. The services would be covered.

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50.4 - Medical Supplies (Except for Drugs and Biologicals Other Than Covered Osteoporosis Drugs) and the Use of Durable Medical Equipment

(Rev.26, Issued 11-05-04, Effective: 01-01-05, Implementation: 04-04-05)

50.4.1 - Medical Supplies

(Rev. 1, 10-01-03)
A3-3119.4.A, HHA-206.4.A

Medical supplies are items that, due to their therapeutic or diagnostic characteristics, are essential in enabling HHA personnel to conduct home visits or to carry out effectively the care the physician has ordered for the treatment or diagnosis of the patient's illness or injury. All supplies which would have been covered under the cost-based reimbursement system are bundled under home health PPS. Payment for the cost of supplies has been incorporated into the per visit and episode payment rates. Supplies fit into two categories. They are classified as:

- **Routine -** because they are used in small quantities for patients during the usual course of most home visits; or

- **Nonroutine -** because they are needed to treat a patient's specific illness or injury in accordance with the physician's plan of care and meet further conditions discussed in more detail below.

All HHAs are expected to separately identify in their records the cost of medical and surgical supplies that are not routinely furnished in conjunction with patient care visits and the use of which are directly identifiable to an individual patient.

50.4.1.1 - The Law, Routine and Nonroutine Medical Supplies, and the Patient's Plan of Care

(Rev. 1, 10-01-03)
A3-3119.4A.2, HHA-206.4A3, 4, 5

A. The Law

The Medicare law governing the home health PPS is specific to the type of items and services bundled to the HHA and the time the services are bundled. Medical supplies are bundled while the patient is under a home health plan of care. If a patient is admitted for a condition which is related to a chronic condition that requires a medical supply (e.g., ostomy patient) the HHA is required to provide the medical supply while the patient is under a home health plan of care during an open episode. The physician orders in the plan of care must reflect all nonroutine medical supplies provided and used while the patient is under a home health plan of care during an open 60-day episode. The consolidated billing requirement is not superseded by the exclusion of certain medical supplies from the plan of care and then distinguishing between medical supplies that are

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related and unrelated to the plan of care. Failure to include medical supplies on the plan of care does not relieve HHAs from the obligation to comply with the consolidated billing requirements. The comprehensive nature of the current patient assessment and plan of care requirements looks at the totality of patient needs. However, there could be a circumstance where a physician could be uncomfortable with writing orders for a preexisting condition unrelated to the reason for home health care. In those circumstances, PRN orders for such supplies may be used in the plan of care by a physician.

Thus, all medical supplies are bundled while the patient is under a home health plan of care during an open 60-day episode. This includes, but is not limited to, the above listed medical supplies as well as the Part B items provided in the final PPS rule. The latter item lists are subsequently updated in accordance with the current process governing the deletion, replacement and revision of Medicare Part B codes. Parenteral and enteral nutrition, prosthetics, orthotics, DME and DME supplies are not considered medical supplies and therefore not subject to bundling while the patient is under a home health plan of care during an open episode. However, §1834(h)(4)(c) of the Act specifically excludes from the term "orthotics and prosthetics" medical supplies including catheters, catheter supplies, ostomy bags and supplies related to ostomy care furnished by an HHA under §1861(m) of the Act. Therefore, these items are bundled while a patient is under a home health plan of care.

B. Relationship Between Patient Choice and Veterans Benefits

For veterans, both Medicare and Veteran's Administration (VA) benefits are primary. Therefore, the beneficiary who is a veteran has some choices in cases where the benefits overlap. The beneficiary, however, must select one or the other program as primary when obtaining active care. If the VA is selected as primary for home health care, then Medicare becomes a secondary payer. An HHA must provide the medical supplies a Medicare beneficiary needs no matter the payer; it is not obligated to provide medical supplies that are not needed. If a patient has medical supplies provided by the VA because of the patient's preference, then the HHA must not duplicate the supplies under Medicare. The beneficiary's choice is controlling. The HHA may not require the beneficiary to obtain or use medical supplies covered by the primary payer from any other source, including the VA.

C. Medical Supplies Purchased by the Patient Prior to the Start of Care

A patient may have acquired medical supplies prior to his/her Medicare home health start of care date. If a patient prefers to use his or her own medical supplies after having been offered appropriate supplies by the HHA and it is determined by the HHA that the patient's medical supplies are clinically appropriate, then the patient's choice is controlling. The HHA is not required to duplicate the medical supplies if the patient elects to use his or her own medical supplies. However, if the patient prefers to have the HHA provide medical supplies while the patient is under a Medicare home health plan of care during an open episode, then the HHA must provide the medical supplies. The HHA

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may not require that the patient obtain or use medical supplies from any other source. Given the possibility of subsequent misunderstandings arising between the HHA and the patient on this issue, the HHA should document the beneficiary's decision to decline HHA furnished medical supplies and use their own resources.

50.4.1.2 - Routine Supplies (Nonreportable)

(Rev. 1, 10-01-03)
A3-3119.4.A.1, HHA-206.4.A.1

Routine supplies are supplies that are customarily used in small quantities during the course of most home care visits. They are usually included in the staff's supplies and not designated for a specific patient. These supplies are included in the cost per visit of home health care services. Routine supplies would not include those supplies that are specifically ordered by the physician or are essential to HHA personnel in order to effectuate the plan of care.

Examples of supplies which are usually considered routine include, but are not limited to:

A. Dressings and Skin Care

- Swabs, alcohol preps, and skin prep pads;
- Tape removal pads;
- Cotton balls;
- Adhesive and paper tape;
- Nonsterile applicators; and
- 4 x 4's.

B. Infection Control Protection

- Nonsterile gloves;
- Aprons;
- Masks; and
- Gowns.

C. Blood Drawing Supplies

- Specimen containers.

D. Incontinence Supplies

- Incontinence briefs and Chux Covered in the normal course of a visit. For example, if a home health aide in the course of a bathing visit to a patient

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determines the patient requires an incontinence brief change, the incontinence brief in this example would be covered as a routine medical supply.

E. Other

- Thermometers; and
- Tongue depressors.

There are occasions when the supplies listed in the above examples would be considered nonroutine and thus would be considered a billable supply, i.e., if they are required in quantity, for recurring need, and are included in the plan of care. Examples include, but are not limited to, tape, and 4x4s for major dressings.

50.4.1.3 - Nonroutine Supplies (Reportable)

(Rev. 1, 10-01-03)
A3-3119.4.A.2, HHA-206.4.A.2

Nonroutine supplies are identified by the following conditions:

1. The HHA follows a consistent charging practice for Medicare and other patients receiving the item;

2. The item is directly identifiable to an individual patient;

3. The cost of the item can be identified and accumulated in a separate cost center; and

4. The item is furnished at the direction of the patient's physician and is specifically identified in the plan of care.

All nonroutine supplies must be specifically ordered by the physician or the physician's order for services must require the use of the specific supplies to be effectively furnished.

The charge for nonroutine supplies is excluded from the per visit costs.

Examples of supplies that can be considered nonroutine include, but are not limited to:

1. Dressings/Wound Care

- Sterile dressings;
- Sterile gauze and toppers;
- Kling and Kerlix rolls;
- Telfa pads;

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- Eye pads;
- Sterile solutions, ointments;
- Sterile applicators; and
- Sterile gloves.

2. I.V. Supplies

3. Ostomy Supplies

4. Catheters and Catheter Supplies

   - Foley catheters; and
   - Drainage bags, irrigation trays.

5. Enemas and Douches

6. Syringes and Needles

7. Home Testing

   - Blood glucose monitoring strips; and
   - Urine monitoring strips.

Consider other items that are often used by persons who are not ill or injured to be medical supplies only where:

- The item is recognized as having the capacity to serve a therapeutic or diagnostic purpose in a specific situation; and

- The item is required as a part of the actual physician-prescribed treatment of a patient's existing illness or injury.

For example, items that generally serve a routine hygienic purpose, e.g., soaps and shampoos and items that generally serve as skin conditioners, e.g., baby lotion, baby oil, skin softeners, powders, lotions, are not considered medical supplies unless the particular item is recognized as serving a specific therapeutic purpose in the physician's prescribed treatment of the patient's existing skin (scalp) disease or injury.

Limited amounts of medical supplies may be left in the home between visits where repeated applications are required and rendered by the patient or other caregivers. These items must be part of the plan of care in which the home health staff is actively involved. For example, the patient is independent in insulin injections but the nurse visits once a day to change wound dressings. The wound dressings/irrigation solution may be left in

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the home between visits. Supplies such as needles, syringes, and catheters that require administration by a nurse should not be left in the home between visits.

50.4.2 - Durable Medical Equipment

(Rev. 1, 10-01-03)
A3-3119.4.B, HHA-206.4.B

Durable medical equipment which meets the requirements of the Medicare Benefit Policy Manuals, Chapter 6, "Hospital Services Covered Under Part B," §80, and Chapter 15, “Covered Medical and Other Health Services” §110, is covered under the home health benefit with the beneficiary responsible for payment of a 20 percent coinsurance.

50.4.3 – Covered Osteoporosis Drugs

(Rev. 26, Issued 11-05-04, Effective: 01-01-05, Implementation: 04-04-05)

Sections 1861(m) and 1861(kk) of the Act provide for coverage of FDA approved injectable drugs for the treatment of osteoporosis. These drugs are expected to be provided by an HHA to female beneficiaries who are currently receiving services under an open home health plan of care, who meet existing coverage criteria for the home health benefit and who meet the criteria listed below. These drugs are covered on a cost basis when provided by an HHA under the circumstances listed below.

The home health visit (i.e., the skilled nurse's visit) to administer the drug is covered under all fee-for-service Medicare (Part A or Part B) home health coverage rules (see section 30 above). Coverage of the drug is limited to female beneficiaries who meet each of the following criteria:

- The individual is eligible for Medicare Part B coverage of home health services (the nursing visit to perform the injection may be the individual's qualifying service);

- The individual sustained a bone fracture that a physician certifies was related to post-menopausal osteoporosis; and

- The individual's physician certifies that she is unable to learn the skills needed to self-administer the drug or is otherwise physically or mentally incapable of administering the drug, and that her family or caregivers are unable or unwilling to administer the drug.

This drug is considered part of the home health benefit under Part B. Therefore, Part B deductible and coinsurance apply regardless of whether home health visits for the administration of the drug are covered under Part A or Part B.

For instructions on billing for covered osteoporosis drugs, see Pub. 100-04, Medicare Claims Processing Manual, chapter 10, section 90.1.

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50.5 - Services of Interns and Residents

(Rev. 1, 10-01-03)
A3-3119.5, HHA-206.5

Home health services include the medical services of interns and residents-in-training under an approved hospital teaching program if the services are ordered by the physician who is responsible for the plan of care and the HHA is affiliated with or is under common control of a hospital furnishing the medical services. Approved means:

- Approved by the Accreditation Council for Graduate Medical Education;
- In the case of an osteopathic hospital, approved by the Committee on Hospitals of the Bureau of Professional Education of the American Osteopathic Association;
- In the case of an intern or resident-in-training in the field of dentistry, approved by the Council on Dental Education of the American Dental Association; or
- In the case of an intern or resident-in-training in the field of podiatry, approved by the Council on Podiatric Education of the American Podiatric Association.

50.6 - Outpatient Services

(Rev. 1, 10-01-03)
A3-3119.6, HHA-206.6

Outpatient services include any of the items or services described above which are provided under arrangements on an outpatient basis at a hospital, skilled nursing facility, rehabilitation center, or outpatient department affiliated with a medical school, and (1) which require equipment which cannot readily be made available at the patient's place of residence, or (2) which are furnished while the patient is at the facility to receive the services described in (1). The hospital, skilled nursing facility, or outpatient department affiliated with a medical school must all be qualified providers of services. However, there are special provisions for the use of the facilities of rehabilitation centers. The cost of transporting an individual to a facility cannot be reimbursed as home health services.

50.7 - Part-Time or Intermittent Home Health Aide and Skilled Nursing Services

(Rev. 1, 10-01-03)
A3-3119.7, HHA-206.7, A3-3119.7A, HHA-206.7A, A3-3119.7.B, HHA-206.7.B

Where a patient is eligible for coverage of home health services, Medicare covers either part-time or intermittent home health aide services or skilled nursing services subject to the limits below. The law at §1861(m) of the Act clarified: "the term "part-time or intermittent services" means skilled nursing and home health aide services furnished any number of days per week as long as they are furnished (combined) less than 8 hours each day and 28 or fewer hours each week (or, subject to review on a case-by-case basis as to the need for care, less than 8 hours each day and 35 or fewer hours each week).

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50.7.1 - Impact on Care Provided in Excess of "Intermittent" or "Part-Time" Care

(Rev. 1, 10-01-03)
A3-3119.7.C, HHA-206.7.C

Home health aide and/or skilled nursing care, in excess of the amounts of care that meet the definition of part-time or intermittent, may be provided to a home care patient or purchased by other payers without bearing on whether the home health aide and skilled nursing care meets the Medicare definitions of part-time or intermittent.

EXAMPLE: A patient needs skilled nursing care monthly for a catheter change and the home health agency also renders needed daily home health aide services 24 hours per day that will be needed for a long and indefinite period of time. The HHA bills Medicare for the skilled nursing and home health aide services, which were provided before the 35th hour of service each week, and bills the beneficiary (or another payer) for the remainder of the care. If the intermediary determines that the 35 hours of care are reasonable and necessary, Medicare would cover the 35 hours of skilled nursing and home health aide visits.

50.7.2 - Application of this Policy Revision

(Rev. 1, 10-01-03)
A3-3119.7.D, HHA-206.7.D

Additional care covered by other payers discussed in §50.7.1 does not affect Medicare coverage when the conditions listed below apply. A patient must meet the criteria for Medicare coverage of home health services, before this policy revision becomes applicable to skilled nursing services and/or home health aide services. The definition of "intermittent" with respect to the need for skilled nursing care where the patient qualifies for coverage based on the need for "skilled nursing care on an intermittent basis" remains unchanged. Specifically:

1. This policy revision always applies to home health aide services when the patient qualifies for coverage;

2. This policy revision applies to skilled nursing care only when the patient needs physical therapy or speech-language pathology services or continued occupational therapy, and also needs skilled nursing care; and

3. If the patient needs skilled nursing care but does not need physical therapy or speech-language pathology services or occupational therapy, the patient must still meet the longstanding and unchanged definition of "intermittent" skilled nursing care in order to qualify for coverage of any home health services.

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60 - Special Conditions for Coverage of Home Health Services Under Hospital Insurance (Part A) and Supplementary Medical Insurance (Part B)

(Rev. 1, 10-01-03)
A3-3122, HHA-212

60.1 - Post-Institutional Home Health Services Furnished During A Home Health Benefit Period - Beneficiaries Enrolled in Part A and Part B

(Rev. 1, 10-01-03)
A3-3122.1, HHA-212.1, A3-3122.1, HHA-212.2, PMs A-97-12, A-97-16, A-98-49

Section 1812(a)(3) of the Act provides post-institutional home health services for individuals enrolled in Part A and Part B and home health services for individuals who are eligible for Part A only. For beneficiaries who are enrolled in Part A and Part B, Part A finances post-institutional home health services furnished during a home health spell of illness for up to 100 visits during a spell of illness.

Part A finances up to 100 visits furnished during a home health spell of illness if the following criteria are met:

- Beneficiaries are enrolled in Part A **and** Part B and qualify to receive the Medicare home health benefit;

- Beneficiaries must have at least a three consecutive day stay in a hospital or rural primary care hospital; and

- Home health services must be initiated and the first covered home health visit must be rendered within 14 days of discharge from a 3 consecutive day stay in a hospital or rural primary care hospital or within 14 days of discharge from a skilled nursing facility in which the individual was provided post-hospital extended care services. If the first home health visit is not initiated within 14 days of discharge, then home health services are financed under Part B.

After an individual exhausts 100 visits of Part A post-institutional home health services, Part B finances the balance of the home health spell of illness. A home health spell of illness is a period of consecutive days beginning with the first day not included in a previous home health spell of illness on which the individual is furnished post-institutional home health services which occurs in a month the individual is entitled to Part A. The home health spell of illness ends with the close of the first period of 60 consecutive days in which the individual is neither an inpatient of a hospital or rural primary care hospital nor an inpatient of a skilled nursing facility (in which the individual was furnished post-hospital extended care services) nor provided home health services.

EXAMPLE 1:

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An individual is enrolled in Part A and Part B, qualifies for the Medicare home health benefit, has a three consecutive day stay in a hospital, and is discharged on May 1. On May 5, the individual receives the first skilled nursing visit under the plan of care. Therefore, post-institutional home health services have been initiated within 14 days of discharge. The individual is later hospitalized on June 2. Prior to the June 2 hospitalization, the individual received 12 home health visits. The individual stays in the hospital for four consecutive days, is discharged and receives home health services. That individual continues the May 5 home health spell of illness and would have 88 visits left under that home health spell of illness under Part A. That individual could not start another home health spell of illness (100 visits under Part A) until a 60-day consecutive period in which the individual was not an inpatient of a hospital, rural primary care hospital, an inpatient of a skilled nursing facility (in which the individual was furnished post-hospital extended care services), or provided home health services had passed.

EXAMPLE 2:

An individual is enrolled in Part A and Part B, qualifies for the Medicare home health benefit, has a three consecutive day stay in a hospital, and home health is initiated within 14 days of discharge. The individual exhausts the 100 visits under Part A post-institutional home health services, continues to need home health services, and receives home health services under Part B. The individual is then hospitalized for 4 consecutive days. The individual is again discharged and receives home health services. The individual cannot begin a new home health spell of illness because 60 days did not pass in which the individual was not an inpatient of a hospital or rural primary care hospital or an inpatient of a skilled nursing facility in which the individual was furnished post-hospital extended care services. The individual would be discharged and Part B would continue to finance the home health services.

60.2 - Beneficiaries Who Are Enrolled in Part A and Part B, but Do Not Meet Threshold for Post-Institutional Home Health Services

(Rev. 1, 10-01-03)
A3-3122.1, HHA-212.3

If beneficiaries are enrolled in Part A and Part B and are eligible for the Medicare home health benefit, but do not meet the three consecutive day stay requirement or the 14 day initiation of care requirement, then all of their home health services would be financed under Part B. For example, this situation would include, but is not limited to, beneficiaries enrolled in Part A and Part B who are coming from the community to a home health agency in need of home health services or who stay less than three consecutive days in a hospital and are discharged. Any home health services received after discharge would be financed under Part B.

60.3 - Beneficiaries Who Are Part A Only or Part B Only

(Rev. 1, 10-01-03)
A3-3122.1, HHA-212.4

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If a beneficiary is enrolled **only** in Part A and qualifies for the Medicare home health benefit, then all of the home health services are financed under Part A. The 100-visit limit does **not** apply to beneficiaries who are only enrolled in Part A. If a beneficiary is enrolled **only** in Part B and qualifies for the Medicare home health benefit, then all of the home health services are financed under Part B. There is no 100-visit limit under Part B. The new definition of post-institutional home health services provided during a home health spell of illness **only** applies to those beneficiaries who are enrolled in **both** Part A and Part B and qualify for the Medicare home health benefit.

60.4 - Coinsurance, Copayments, and Deductibles

(Rev. 1, 10-01-03)
A3-3122.1, HHA-212.5

There is no coinsurance, copayment, or deductible for home health services and supplies other than the following:

- coinsurance required for durable medical equipment (DME) covered as a home health service and

- deductible and coinsurance for the osteoporosis drug, which is part of the home health benefit only paid under Part B.

The coinsurance liability of the beneficiary for DME and osteoporosis drug furnished as a home health service is 20 percent of the fee schedule amount for the services.

70 - Duration of Home Health Services

(Rev. 1, 10-01-03)
A3-3123, HHA-215, A3-3123.1, HHA-215.1

70.1 - Number of Home Health Visits Under Supplementary Medical Insurance (Part B)

(Rev. 1, 10-01-03)
A3-3123.2, HHA-215.2

To the extent that all coverage requirements are met, payment may be made on behalf of eligible beneficiaries under Part B for an unlimited number of covered home health visits. The determination of Part A or Part B Trust Fund financing and coverage is made in accordance with the financing shift required by the BBA described above in §60.

70.2 - Counting Visits Under the Hospital and Medical Plans

(Rev. 1, 10-01-03)
A3-3124, HHA-218, A3-3124.1, HHA-218.1, A3-3124.2, HHA-218.2, A3-3124.3, HHA-218.3

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The number of visits are counted in the same way whether paid under the hospital (Part A) or supplemental medical (Part B) Medicare trust funds

A. Visit Defined

A visit is an episode of personal contact with the patient by staff of the HHA, or others under arrangements with the HHA, for the purpose of providing a covered home health service. Though visits are provided under the HH benefit as part of episodes, and episodes are unlimited, each visit must be uniquely billed as a separate line item on a Medicare HH claim, and data on visit charges is still used in formulating payment rates.

B. Counting Visits

Generally, one visit may be covered each time an HHA employee, or someone providing home health services under arrangements with the HHA, enters the patient's home and provides a covered service to a patient who meets the criteria in §30.

If the HHA furnishes services in an outpatient facility under arrangements with the facility, one visit may be covered for each type of service provided.

If two individuals are needed to provide a service, two visits may be covered. If two individuals are present, but only one is needed to provide the care, only one visit may be covered.

A visit is initiated with the delivery of covered home health services and ends at the conclusion of delivery of covered home health services. In those circumstances in which all reasonable and necessary home health services cannot be provided in the course of a single visit, HHA staff or others providing services under arrangements with the HHA may remain at the patient's home between visits (e.g., to provide noncovered services). However, if all covered services could be provided in the course of one visit, only one visit may be covered.

EXAMPLES:

1. If an occupational therapist and an occupational therapy assistant visit the patient together to provide therapy and the therapist is there to supervise the assistant, **one** visit is counted.

2. If a nurse visits the patient in the morning to dress a wound and later must return to replace a catheter, **two** visits are counted.

3. If the therapist visits the patient for treatment in the morning and the patient is later visited by the assistant for additional treatment, **two** visits are counted.

4. If an individual is taken to a hospital to receive outpatient therapy that could not be furnished in their own home (e.g., hydrotherapy) and, while at the hospital

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receives speech-language pathology services and other services, **two or more** visits would be charged.

5. Many home health agencies provide home health aide services on an hourly basis (ranging from 1 to 8 hours a day). However, in order to allocate visits properly against a patient's maximum allowable visits, home health aide services are to be counted in terms of visits. Thus, regardless of the number of continuous hours a home health aide spends in a patient's home on any given day, one "visit" is counted for each such day. If, in a rare situation, a home health aide visits a patient for an hour or two in the morning, and again for an hour or two in the afternoon, two visits are counted.

C. Evaluation Visits

The HHAs are required by regulations to have written policies concerning the acceptance of patients by the agency. These include consideration of the physical facilities available in the patient's place of residence, the homebound status, and the attitudes of family members for the purpose of evaluating the feasibility of meeting the patient's medical needs in the home health setting. When personnel of the agency make such an initial evaluation visit, the cost of the visit is considered an administrative cost of the agency and is not chargeable as a visit since at this point the patient has not been accepted for care. If, however, during the course of this initial evaluation visit, the patient is determined suitable for home health care by the agency, and is also furnished the first skilled service as ordered under the physician's plan of care, the visit would become the first billable visit in the 60-day episode.

The intermediary will cover an observation and evaluation (or reevaluation) visit made by a nurse (see §40.1.2.1 for a further discussion of skilled nursing observation and evaluation visits) or other appropriate personnel, ordered by the physician for the purpose of evaluating the patient's condition and continuing need for skilled services, as a skilled visit.

A supervisory visit made by a nurse or other appropriate personnel (as required by the conditions of participation) to evaluate the specific personal care needs of the patient or to review the manner in which the personal care needs of the patient are being met by the aide is an administrative function, not a skilled visit.

80 - Specific Exclusions From Coverage as Home Health Services

(Rev. 1, 10-01-03)
A3-3125, HHA-230.A

In addition to the general exclusions from coverage under health insurance listed in the Medicare Benefit Policy Manual, Chapter 16, "General Exclusions from Coverage," the following are also excluded from coverage as home health services:

80.1 - Drugs and Biologicals

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(Rev. 1, 10-01-03)
A3-3125.A, HHA-230.A

Drugs and biologicals are excluded from payment under the Medicare home health benefit.

A drug is any chemical compound that may be used on or administered to humans or animals as an aid in the diagnosis, treatment, prevention of disease or other condition, for the relief of pain or suffering, or to control or improve any physiological pathologic condition.

A biological is any medicinal preparation made from living organisms and their products including, but not limited to, serums, vaccines, antigens, and antitoxins. The one drug exception is the osteoporosis drug, which is part of the home health benefit, and home health agencies may provide services such as vaccines outside the home health benefit.

80.2 - Transportation

(Rev. 1, 10-01-03)
A3-3125.B, HHA-230.B

The transportation of a patient, whether to receive covered care or for other purposes, is excluded from home health coverage. Costs of transportation of equipment, materials, supplies, or staff may be allowable as administrative costs, but no separate payment is made.

80.3 - Services That Would Not Be Covered as Inpatient Services

(Rev. 1, 10-01-03)
A3-3125C, HHA-230.C

Services that would not be covered if furnished as inpatient hospital services are excluded from home health coverage.

80.4 - Housekeeping Services

(Rev. 1, 10-01-03)
A3-3125D, HHA-230D

Services for which the sole purpose is to enable the patient to continue residing in their home (e.g., cooking, shopping, Meals on Wheels, cleaning, laundry) are excluded from home health coverage.

80.5 - Services Covered Under End Stage Renal Disease (ESRD) Program

(Rev. 1, 10-01-03)
A3-3125.E, HHA-230.E

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Services that are covered under the ESRD program and are contained in the composite rate reimbursement methodology, including any service furnished to an ESRD beneficiary that is directly related to that individual's dialysis, are excluded from coverage under the Medicare home health benefit. However, to the extent a service is not directly related to a patient's dialysis, e.g., a nursing visit to furnish wound care for an abandoned shunt site, and other requirements for coverage are met, the visit would be covered. Within these restrictions, beneficiaries may simultaneously receive items and services under the ESRD program at home at the same time as receiving services under the home health benefit not related to ESRD.

80.6 - Prosthetic Devices

(Rev. 1, 10-01-03)
A3-3125F, HHA-230F

Prosthetic items are excluded from home health coverage. However, catheters, catheter supplies, ostomy bags, and supplies related to ostomy care are not considered prosthetic devices if furnished under a home health plan of care and are not subject to this exclusion from coverage but are bundled while a patient is under a HH plan of care.

80.7 - Medical Social Services Furnished to Family Members

(Rev. 1, 10-01-03)
A3-3125G, HHA-230G

Except as provided in §50.3, medical social services furnished solely to members of the patient's family and that are not incidental to covered medical social services being furnished to the patient are not covered.

80.8 - Respiratory Care Services

(Rev. 1, 10-01-03)
A3-3125.H, HHA-230.H

If a respiratory therapist is used to furnish overall training or consultative advice to HHA staff and incidentally furnishes respiratory therapy services to patients in their homes, the costs of the respiratory therapist's services are allowable only as administrative costs to the HHA. Visits by a respiratory therapist to a patient's home are not separately billable during a HH episode when a HH plan of care is in effect. However, respiratory therapy services furnished as part of a plan of care other than a home health plan of care by a licensed nurse or physical therapist and that constitute skilled care may be covered and separately billed as skilled visits when the beneficiary is not in a home health episode. Note that Medicare billing does not recognize respiratory therapy as a separate discipline, but rather sees the services in accordance with the revenue code used on the claims (i.e. 042x).

80.9 - Dietary and Nutrition Personnel

(Rev. 1, 10-01-03)
A3-3125.I, HHA-230.I

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If dieticians or nutritionists are used to furnish overall training or consultative advice to HHA staff and incidentally furnish dietetic or nutritional services to patients in their homes, the costs of these professional services are allowable only as administrative costs. Visits by a dietician or nutritionist to a patient's home are not separately billable.

90 - Medical and Other Health Services Furnished by Home Health Agencies

(Rev. 37, Issued: 08-12-05; Effective/Implementation: 09-12-05)

Payment may be made by intermediaries to a home health agency which furnishes either directly or under arrangements with others the following "medical and other health services" to beneficiaries with Part B coverage in accordance with Part B billing and payment rules other than when a home health plan of care is in effect.

1. Surgical dressings (for a patient who is not under a home health plan of care), and splints, casts, and other devices used for reduction of fractures and dislocations;

2. Prosthetic (Except for items excluded from the term "orthotics and prosthetics" in accordance with §1834(h)(4)(C) of the Act for patients who are under a home health plan of care);

3. Leg, arm, back, and neck braces, trusses, and artificial legs, arms, and eyes and adjustments to these items when ordered by a physician. (See the Medicare Benefit Policy Manual, Chapter 15);

4. Outpatient physical therapy, outpatient occupational therapy, and outpatient speech-language pathology services (for a patient not under a home health plan of care). (See the Medicare Benefit Policy Manual, Chapter 15); and

5. Rental and purchase of durable medical equipment. (See the Medicare Benefit Policy Manual, Chapter 15.) If a beneficiary meets all of the criteria for coverage of home health services and the HHA is providing home health care under the Hospital Insurance Program (Part A), any DME provided and billed to the intermediary by the HHA to that patient must also be provided under Part A. Where the patient meets the criteria for coverage of home health services and the HHA is providing the home health care under the Supplementary Medical Insurance Program (Part B) because the patient is not eligible for Part A, the DME provided by the HHA may, at the beneficiary's option, be furnished under the Part B home health benefit or as a medical and other health service. Irrespective of how the DME is furnished, the beneficiary is responsible for a 20 percent coinsurance.

6. Ambulance service. (See the Medicare Benefit Policy Manual, Chapter 10, Ambulance Services)

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7. Hepatitis B Vaccine. Hepatitis B vaccine and its administration are covered under Part B for patients who are at high or intermediate risk of contracting hepatitis B. High risk groups currently identified include: end-stage renal disease (ESRD) patients, hemophiliacs who receive factor VIII or IX concentrates, clients of institutions for the mentally retarded, persons who live in the same household as an hepatitis B virus carrier, homosexual men, illicit injectable drug users. Intermediate risk groups currently identified include staff in institutions for the mentally retarded, workers in health care professions who have frequent contact with blood or blood-derived body fluids during routine work. Persons in the above listed groups would not be considered at high or intermediate risk of contracting hepatitis B, however, if there is laboratory evidence positive for antibodies to hepatitis B. ESRD patients are routinely tested for hepatitis B antibodies as part of their continuing monitoring and therapy. The vaccine may be administered, upon the order of a doctor of medicine or osteopathy, by home health agencies.

8. Hemophilia clotting factors. Blood clotting factors for hemophilia patients competent to use such factors to control bleeding without medical or other supervision and items related to the administration of such factors are covered under Part B.

9. Pneumococcal and influenza vaccines. See Medicare Benefit Policy Manual, Chapter 15, “Covered Medical and Other Health Services,” §50.4.2 “Immunizations.”

10. Splints, casts. See the Medicare Benefit Policy Manual, Chapter 15, “Covered Medical and Other Health Services.”

11. Antigens. See the Medicare Benefit Policy Manual, Chapter 15, “Covered Medical and Other Health Services.”

100 - Physician Certification for Medical and Other Health Services Furnished by Home Health Agency (HHA)

(Rev. 1, 10-01-03)
A3-3128, HHA-224

A physician must certify that the medical and other health services covered by medical insurance, which were provided by (or under arrangements made by) the HHA, were medically required. This certification needs to be made only once where the patient may require over a period of time the furnishing of the same item or service related to one diagnosis. There is no requirement that the certification be entered on any specific form or handled in any specific way as long as the approach adopted by the HHA permits the intermediary to determine that the certification requirement is, in fact, met. A written physician's order designating the services required would also be an acceptable certification.

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110 - Use of Telehealth in Delivery of Home Health Services

(Rev. 1, 10-01-03)
PM A-01-02, HHA-201.13

Section 1895(e) of the Act governs the home health prospective payment system (PPS) and provides that telehealth services are outside the scope of the Medicare home health benefit and home health PPS.

This provision does not provide coverage or payment for Medicare home health services provided via a telecommunications system. The law does not permit the substitution or use of a telecommunications system to provide any covered home health services paid under the home health PPS, or any covered home health service paid outside of the home health PPS. As stated in 42 CFR 409.48(c), a visit is an episode of personal contact with the beneficiary by staff of the home health agency (HHA), or others under arrangements with the HHA for the purposes of providing a covered service. The provision clarifies that there is nothing to preclude an HHA from adopting telemedicine or other technologies that they believe promote efficiencies, but that those technologies will not be specifically recognized or reimbursed by Medicare under the home health benefit. This provision does not waive the current statutory requirement for a physician certification of a home health plan of care under current §§1814(a)(2)(C) or 1835(a)(2)(A) of the Act.

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Transmittals Issued for this Chapter

Rev #	Issue Date	Subject	Impl Date	CR#
R179BP	01/14/2014	Manual Updates to Clarify Skilled Nursing Facility (SNF), Inpatient Rehabilitation Facility (IRF), Home Health (HH), and Outpatient (OPT) Coverage Pursuant to Jimmo vs. Sebelius	01/07/2014	8458
R176BP	12/13/2013	Manual Updates to Clarify Skilled Nursing Facility (SNF), Inpatient Rehabilitation Facility (IRF), Home Health (HH), and Outpatient (OPT) Coverage Pursuant to Jimmo vs. Sebelius – Rescinded and replaced by Transmittal 179	01/07/2014	8458
R172BP	10/18/2013	Home Health - Clarification to Benefit Policy Manual Language on Confined to the Home Definition	11/19/2013	8444
R144BP	05/06/2011	Home Health Therapy Services	05/05/2011	7374
R142BP	04/15/2011	Home Health Therapy Services – Rescinded and replaced by Transmittal 144	05/05/2011	7374
R139BP	02/16/2011	Clarifications for Home Health Face-to Face Encounter Provisions	03/10/2011	7329
R37BP	08/12/2005	Conforming Changes for Change Request 3648 to Pub. 100-02	09/12/2005	3912
R26BP	11/05/2004	Inclusion of Forteo as a Covered Osteoporosis Drug and Clarification of Manual Instructions Regarding Osteoporosis Drugs	04/04/2004	3524
R1BP	10/01/2003	Introduction to the Benefit Policy Manual	N/A	N/A

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