

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
Centers for Medicare & Medicaid Services



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MLN Matters® Number: MM8818

Related Change Request (CR) #: CR 8818

Related CR Release Date: August 1, 2014

Effective Date: September 2, 2014

Related CR Transmittal #: R192BP

Implementation Date: September 2, 2014

## Clarification of the Confined to the Home Definition in Chapter 15, Covered Medical and Other Health Services, of the Medicare Benefit Policy Manual

### Provider Types Affected

This MLN Matters® Article is intended for physicians, home health agencies, and other providers that submit claims to Medicare Administrative Contractors (MACs) related to certifying or providing home health services to Medicare beneficiaries.

### Provider Action Needed



#### **STOP – Impact to You**

This article is based on Change Request (CR) 8818 which clarifies the definition of the patient as being "confined to the home" to more accurately reflect the definition as articulated in the Social Security Act (Sections 1814(a) and 1835(a)).



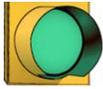
#### **CAUTION – What You Need to Know**

In addition to clarifying the definition of the patient as being "confined to the home", vague terms, such as "generally speaking", have been removed from Medicare's manual

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instructions to ensure clearer and more specific requirements of the definition. These changes present the requirements first and more closely align the Medicare Benefit Policy manual with the Social Security Act. This will help prevent confusion, promote a clearer enforcement of the statute, and provide more definitive guidance to Home Health Agencies (HHAs) in order to foster compliance.



### **GO – What You Need to Do**

See the Background and Additional Information Sections of this article for further details regarding these changes, and make sure that your billing staffs are aware of these changes.

## **Background**

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In the calendar year (CY) 2012 Home Health Prospective Payment System (HH PPS) proposed rule published on July 12, 2011, the Centers for Medicare & Medicaid Services (CMS) proposed its intent to provide clarification to the "Medicare Benefit Policy Manual" language regarding the definition of "confined to the home". In the CY 2012 HH PPS final rule published on November 4, 2011 (FR 76 68599-68600; see <http://www.gpo.gov/fdsys/pkg/FR-2011-11-04/pdf/2011-28416.pdf>), this proposal was finalized. This clarification was recommended by the Office of Inspector General (OIG).

CR 8818 revises the Medicare Benefit Policy Manual (Pub 100-02), Chapter 15 (Covered Medical and Other Health Services), Section 60.4.1 (Definition of Homebound Patient Under the Medicare Home Health (HH) Benefit), and it includes revised Section 60.4.1 as an attachment. The revised Section 60.4.1 is summarized as follows:

For a patient to be eligible to receive covered home health services, 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.

**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;

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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.

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 this reimbursement unless they meet one of the above conditions above.

The complete portion on the revised manual is attached to CR8818.

## Additional Information

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The official instruction, CR 8818 issued to your MAC regarding this change is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R192BP.pdf> on the CMS website.

If you have any questions, please contact your MAC at their toll-free number. That number is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Net/work-MLN/MLNMattersArticles/index.html> under - How Does It Work.

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