

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-02 Medicare Benefit Policy	Centers for Medicare & Medicaid Services (CMS)
Transmittal 192	Date: August 1, 2014
	Change Request 8818

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

I. SUMMARY OF CHANGES: This instruction clarifies the definition of the patient as being "confined to the home" to more accurately reflect the definition as articulated at Section 1835(a) of the Social Security Act. In addition, vague terms, such as "generally speaking", have been removed to ensure clear and specific requirements of the definition. These changes present the requirements first and more closely align the policy manual with the Act. This will prevent confusion, promote a clearer enforcement of the statute, and provide more definitive guidance to HHAs in order to foster compliance.

EFFECTIVE DATE: September 2, 2014

**Unless otherwise specified, the effective date is the date of service.*

IMPLEMENTATION DATE: September 2, 2014

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)

R=REVISED, N=NEW, D=DELETED-Only One Per Row.

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	15/60.4.1/Definition of Homebound Patient Under the Medicare Home Health (HH) Benefit

III. FUNDING:

For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC statement of Work. The contractor is not obliged to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

Attachment - Business Requirements

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I. GENERAL INFORMATION

A. Background: In the calendar year 2012 Home Health Prospective Payment System (HH PPS) proposed rule published on July 12, 2011, CMS proposed its intent to provide clarification to the Benefit Policy Manual language regarding the definition of "confined to the home". In the calendar year 2012 HH PPS final rule published on November 4, 2011 (76 FR 68599-68600), this proposal was finalized. This clarification was recommended by the Office of Inspector General (OIG).

B. Policy: This instruction clarifies the definition of the patient as being "confined to the home" to more accurately reflect the definition as articulated at Sections 1814(a) and 1835(a) of the Social Security Act. In addition, vague terms, such as "generally speaking", have been removed to ensure clear and specific requirements of the definition. These changes present the requirements first and more closely align the policy manual with the Act. This will prevent confusion, promote a clearer enforcement of the statute, and provide more definitive guidance to HHAs in order to foster compliance.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			D M E M A C	Shared- System Maintainers				Other
		A	B	H H H		F I S S	M C S	V M S	C W F	
8818.1	Medicare contractors shall be aware of the clarification in the definition of "confined to the home" as stated in the revised Pub 100-02, Medicare Benefit Policy Manual, Chapter 15, section 60.4.1.		X							

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility			
		A/B MAC		D M E M A C	CEDI
		A	B		
8818.2	MLN Article: A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web sites and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in the contractor's next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.		X		

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
N/A	N/A

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Hillary Loeffler, 410-786-0456 or hillary.loeffler@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question

and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 0

60.4.1 - Definition of Homebound Patient Under the Medicare Home Health (HH) Benefit

(Rev. 192, Issued: 08-01-14, Effective: 09-02-14, Implementation: 09-02-14)

This definition applies to homebound for purposes of the Medicare home health benefit.

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;*

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;
- A *patient* who is blind or senile and requires the assistance of another person in leaving his or her *place of* residence;
- A *patient* who has lost the use of the upper extremities and, therefore, is unable to open doors, use handrails on stairways, etc., requires the assistance of another individual *to leave* his or her 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 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, his or her actions may be restricted by the physician to certain specified and limited activities such as getting out of bed only for a specified period of time, or walking stairs only once a day, etc.;
- A *patient* with arteriosclerotic heart disease of such severity that the beneficiary 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 he *or* she had 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 this reimbursement unless they *meet one of the above conditions* above.