

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-02 Medicare Benefit Policy	Centers for Medicare & Medicaid Services (CMS)
Transmittal 265	Date: January 10, 2020
	Change Request 11577

SUBJECT: Manual Updates Related to Calendar Year (CY) 2020 Home Health Payment Policy Changes, Maintenance Therapy, and Remote Patient Monitoring

I. SUMMARY OF CHANGES: This Change Request (CR) updates the Medicare Benefit Policy Manual, (Publication 100-02), Chapter 7, to reflect policy changes finalized in the CY 2019 and 2020 Home Health Prospective Payment System (HH PPS) Final Rules with comment period (83 FR 56406 and 84 FR 60478). Specifically, these manual updates reflect policies related to the implementation of the Patient-Driven Groupings Model, a change to a 30-day unit of payment, changes to split-percentage payments, changes to the provision of maintenance therapy, and the definition of remote patient monitoring.

EFFECTIVE DATE: January 1, 2020

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

IMPLEMENTATION DATE: February 11, 2020

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	7/Table of Contents
R	7/10/Home Health Prospective Payment System (HH PPS)
R	7/10.1/National 30-Day Period Payment Rate
R	7/10.2/Adjustments to the 30-Day Period Payment Rates
R	7/10.3/Continuous 60-Day Recertifications
R	7/10.4/Split Percentage Payment Approach to the 30-Day Period Unit of Payment
R	7/10.5/Physician Signature Requirements for the Split Percentage Payments
R	7/10.6/Low Utilization Payment Adjustment (LUPA)
R	7/10.7/Partial Payment Adjustment
R	7/10.8/Outlier Payments
R	7/10.9/Discharge Issues
R	7/10.10/Consolidated Billing
R	7/10.11/Change of Ownership Relationship to Periods Under HH PPS
R	7/30.1.1/Patient Confined to the Home
R	7/30.1.2/Patient's Place of Residence
R	7/30.2.2/Specificity of Orders
R	7/30.2.4/Timeliness of Signature
R	7/30.2.5/Use of Oral (Verbal) Orders
R	7/30.2.9/Termination of the Plan of Care-Qualifying Services
R	7/30.2.10/Sequence of Qualifying Services and Other Medicare Covered Home Health Services
R	7/30.5.1/Physician Certification
R	7/30.5.2/Physician Recertification
R	7/40.1.1/General Principles Governing Reasonable and Necessary Skilled Nursing Care
R	7/40.1.2.1/Observation and Assessment of the Patient's Condition When Only the Specialized Skills of a Medical Professional Can Determine Patient's Status
R	7/40.1.2.2/Management and Evaluation of a Patient Care Plan
R	7/40.1.2.13/Venipuncture
R	7/40.2.1/General Principles Governing Reasonable and Necessary Physical Therapy, Speech-Language Pathology Services, and Occupational Therapy
R	7/50.4.1/Medical Supplies

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	7/50.4.1.1/The Law, Routine and Nonroutine Medical Supplies, and the Patient's Plan of Care
R	7/50.4.4/Negative Pressure Wound Therapy Using a Disposable Device
R	7/70.2/Counting Visits Under the Hospital and Medical Plans
R	7/80.8/Respiratory Care Services
N	7/80.10/Remote Patient Monitoring
R	7/110/Use of Telehealth in the Delivery of Home Health Services

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 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.

IV. ATTACHMENTS:

**Business Requirements
Manual Instruction**

Attachment - Business Requirements

Pub. 100-02	Transmittal: 265	Date: January 10, 2020	Change Request: 11577
-------------	------------------	------------------------	-----------------------

SUBJECT: Manual Updates Related to Calendar Year (CY) 2020 Home Health Payment Policy Changes, Maintenance Therapy, and Remote Patient Monitoring

EFFECTIVE DATE: January 1, 2020

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

IMPLEMENTATION DATE: February 11, 2020

I. GENERAL INFORMATION

A. Background: The regulations at 42 Code of Federal Regulations (CFR) 484.205 set forth the basis of home health payment under a prospective payment system. Currently, HHAs are paid a prospective payment for a 60-day episode of care, adjusted for case-mix and area wage differences. In accordance with section 51001 of the Bipartisan Budget Act of 2018, CMS finalized policy changes to the home health unit of payment and the case-mix adjustment methodology in the CY 2019 HH PPS final rule with comment period (83 FR 56406).

As part of the HH PPS, home health agencies are paid a split percentage payment through the request for anticipated payment (RAP) at the start of each 60-day episode and the final claim at the end of each 60-day episode. In response to ongoing program integrity concerns, in the CY 2020 HH Prospective Payment System Final Rule with comment period (84 FR 60478), CMS finalized modifications to the split-percentage payment policies beginning in CY 2020.

While a therapist assistant is able to perform restorative therapy under the Medicare home health benefit, the regulations at § 409.44(c)(2)(iii)(C) state that only a qualified therapist, and not an assistant, can perform maintenance therapy. In the CY 2020 HH Prospective Payment System Final Rule with comment period (84 FR 60478), CMS finalized changes regarding the provision of maintenance therapy services.

Section 1895(e)(1)(A) of the Act prohibits payment for services furnished via a telecommunications system if such services substitute for in-person home health services ordered as part of a plan of care. However, the statute does not define the term “telecommunications system” as it relates to the provision of home health care. In the CY 2019 HH Prospective Payment System (PPS) Final Rule with comment period (83 FR 56406), CMS defined “remote patient monitoring” and finalized associated changes regarding allowed administrative costs on Medicare cost reports.

B. Policy: In the CY 2019 HH Prospective Payment System (PPS) Final Rule with comment period (83 FR 56406), CMS finalized a change in the unit of payment from 60-day episodes to 30-day periods for periods beginning on or after January 1, 2020. This 30-day payment amount is adjusted by a new case-mix adjustment methodology, the Patient-Driven Groupings Model (PDGM), also finalized in the CY 2019 HH PPS Final Rule. Payment under the PDGM is adjusted by patient characteristics and other information obtained from home health claims, other Medicare claims, and certain items from the Outcome and Assessment Information Item Set (OASIS). Specifically, home health 30-day payments will be adjusted by the principal and secondary diagnoses, timing of the period of care, admission source, and level of functional impairment.

In the CY 2020 HH Prospective Payment System (PPS) Final Rule with comment period (84 FR60478), CMS finalized a change to the split percentage payment approach, reducing the up-front payment amount to 20 percent in CY 2020 for all 30-day periods of care for home health agencies certified for participation in Medicare on or before December 31, 2018. HHAs will submit a Request for Anticipated Payment (RAP) at the beginning of each 30-day period and a final claim at the end of each 30-day period. As finalized in the CY 2019 HH Prospective Payment System (PPS) Final Rule with Comment Period (83 FR 56406), newly-enrolled HHAs (that is, HHAs certified for participation in Medicare on and after January 1, 2019) will not

receive split-percentage payments for 30-day periods beginning on or after January 1, 2020. Newly-enrolled HHAs will submit a “no-pay” RAP at the beginning of each 30-day period to establish the home health period of care and trigger consolidated billing edits in the Medicare claims processing system. Newly-enrolled HHAs will receive a full 30-day period payment rate (minus any adjustments) after submission of a final claim at the end-of each 30-day period.

As finalized in the CY 2020 HH Prospective Payment System (PPS) Final Rule with comment period (84 FR 60478), beginning in CY 2020, therapist assistants, and not just qualified therapists, can perform maintenance therapy under the Medicare home health benefit in accordance with individual state practice requirements.

And finally, in the CY 2019 HH Prospective Payment System (PPS) Final Rule with comment period (83 FR 56406), CMS defined remote patient monitoring under the Medicare home health benefit as “the collection of physiologic data (for example, ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient or caregiver or both to the home health agency.” Visits to a beneficiary’s home for the sole purpose of supplying, connecting, and/or training the patient on the remote patient monitoring equipment, without the provision of another skilled service are not separately billable. CMS also finalized to amend the regulations at 42 CFR 409.46 to include the costs of remote patient monitoring as an allowable administrative cost (that is, operating expense), if remote patient monitoring is used by the HHA to augment the care planning process.

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility									
		A/B MAC			D M E	Shared-System Maintainers				Other	
		A	B	H H H		F M V C	M C M W	S S S F			
11577.1	The contractors shall be aware of the revisions to Pub. 100-02, Chapter 7 related to the new policies in this CR.			X							

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility					
		A/B MAC			D M E	C E D I	
		A	B	H H H			M A C
11577.2	MLN Article: CMS will make available an MLN Matters provider education article that will be marketed through the MLN Connects weekly newsletter shortly after the CR is released. MACs shall follow IOM Pub. No. 100-09 Chapter 6, section 50.2.4.1, instructions for distributing MLN Connects information to providers, posting the article or a direct link to the article on your website, and including the article or a direct link to the article in your bulletin or newsletter. You may supplement MLN Matters articles with localized information benefiting your provider community in billing and administering the			X			

Number	Requirement	Responsibility				
		A/B MAC			D M E D I	C E D I
		A	B	H H H		
	Medicare program correctly. Subscribe to the “MLN Matters” listserv to get article release notifications, or review them in the MLN Connects weekly newsletter.					

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:

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

V. CONTACTS

Pre-Implementation Contact(s): Kelly Vontran, 410-786-0332 or kelly.vontran@cms.hhs.gov.

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

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

Medicare Benefit Policy Manual

Chapter 7 - Home Health Services

Table of Contents *(Rev. 265, Issued: 01-10-20)*

Transmittals for Chapter 7

- 10.1 - National 30-Day Period Payment Rate
- 10.2 - Adjustments to the 30-Day Period Payment Rates
- 10.3 – Continuous 60-Day Recertifications
- 10.4 - *Split Percentage Payment Approach to the 30-Day Unit of Payment*
- 10.5 - *Physician Signature Requirements for the Split Percentage Payments*
- 10.6 - *Low Utilization Payment Adjustment (LUPA)*
- 10.7 - *Partial Payment Adjustment*
- 10.8 - *Outlier Payments*
- 10.9 - *Discharge Issues*
- 10.10 - *Consolidated Billing*
- 10.11 - *Change of Ownership Relationship to Periods Under the HH PPS*

- 40.1.2.13 - *Venipuncture*

- 50.4.1 - *Medical Supplies*

- 80.10- Remote Patient Monitoring*

10 - Home Health Prospective Payment System (HH PPS)

(Rev. 265, Issued: 01-10-20, Effective: 01-01-20, Implementation: 02-11-20)

The unit of payment under the HH PPS is a national *30-day period* rate with applicable adjustments. The *periods*, rate, and adjustments to the rates are detailed in the following sections.

10.1 - National 30-Day Period Payment Rate

(Rev. 265, Issued: 01-10-20, Effective: 01-01-20, Implementation: 02-11-20)

A. Services Included

The law requires the *30-day period* to include all covered home health services, including medical supplies, paid on a reasonable cost basis. That means the *30-day period payment* 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 *30-day period payment* 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 *30-day period payment* rate also includes amounts for nonroutine medical supplies and therapies that could have been unbundled to Part B prior to HH PPS. (See [§10.11.C](#) for those services.)

B. Excluded Services

The law specifically excludes durable medical equipment (DME) from the *30-day period payment* rate and consolidated billing requirements. DME continues to be paid the fee schedule *amounts or through the DME competitive bidding program* outside of the HH PPS rate.

Certain injectable osteoporosis drugs which *are* covered where *a woman is post-menopausal and has a bone fracture are* also excluded from the *30-day period payment* 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 *these* osteoporosis drugs. *These* osteoporosis drugs continue to be paid on a reasonable cost basis.

Negative pressure wound therapy (NPWT) using a disposable device that is an integrated system comprised of a non-manual vacuum pump, a receptacle for collecting exudate, and dressings for the purposes of wound therapy (in lieu of a conventional NPWT DME system), is also excluded from the *30-day period payment* 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 NPWT using a disposable device.

Furnishing NPWT using a disposable device means the application of a new applicable disposable device, as that term is defined in §1834 of the Social Security Act (the Act), which includes the professional services (specified by the assigned CPT code) that are provided.

10.2 - Adjustments to the 30-Day Period Payment Rate

(Rev. 265, Issued: 01-10-20, Effective: 01-01-20, Implementation: 02-11-20)

A. Case-Mix Adjustment

A case-mix methodology adjusts the *30-day* payment rate based on characteristics of the patient and his/her corresponding resource needs (e.g., *diagnoses, functional impairment level, and other factors*). The *30-day period payment rate* is adjusted by a case-mix methodology based on *information from home health claims, other Medicare claims, and data elements from the Outcome and Assessment Information Set (OASIS)*. *The claims information and OASIS data elements are used to group 30-day periods of care into their case-mix groups.*

The following case-mix variables are obtained from home health or other Medicare claims:

- **Admission Source**-Institutional (i.e., acute hospital, inpatient rehabilitation facility, skilled nursing facility, long-term care hospital, inpatient psychiatric facility) or Community;
- **Timing**-Early (the first 30-day period of care) or Late (all subsequent 30-day periods of care, unless there is a gap of more than 60-days between the end of one period of care and the start of another),
- **Clinical Group**-As determined by the principal diagnosis reported on home health claims; 30-day periods are assigned to one of 12 clinical groups describing the primary reason for the home health encounter:

Clinical Groups	The Primary Reason for the Home Health Encounter is to Provide:
Musculoskeletal Rehabilitation	Therapy (physical, occupational or speech) for a musculoskeletal condition
Neuro/Stroke Rehabilitation	Therapy (physical, occupational or speech) for a neurological condition or stroke
Wounds – Post-Op Wound Aftercare and Skin/Non-Surgical Wound Care	Assessment, treatment & evaluation of a surgical wound(s); assessment, treatment & evaluation of non-surgical wounds, ulcers, burns, and other lesions
Behavioral Health Care	Assessment, treatment & evaluation of psychiatric and substance abuse conditions
Complex Nursing Interventions	Assessment, treatment & evaluation of complex medical & surgical conditions including IV, TPN, enteral nutrition, ventilator, and ostomies
Medication Management, Teaching and Assessment (MMTA)	
MMTA –Surgical Aftercare	Assessment, evaluation, teaching, and medication management for surgical aftercare
MMTA – Cardiac/Circulatory	Assessment, evaluation, teaching, and medication management for cardiac or other circulatory related conditions
MMTA – Endocrine	Assessment, evaluation, teaching, and medication management for endocrine related conditions
MMTA – GI/GU	Assessment, evaluation, teaching, and medication management for gastrointestinal or genitourinary related conditions
MMTA – Infectious Disease/Neoplasms/Blood-forming Diseases	Assessment, evaluation, teaching, and medication management for conditions related to infectious diseases, neoplasms, and blood-forming diseases
MMTA –Respiratory	Assessment, evaluation, teaching, and medication management for respiratory related conditions
MMTA – Other	Assessment, evaluation, teaching, and medication management for a variety of medical and surgical conditions not classified in one of the previously listed groups

- **Comorbidity Adjustment**-As determined by certain secondary diagnoses reported on home health claims; a 30-day period of care can receive no comorbidity adjustment, a low comorbidity adjustment, or a high comorbidity adjustment.

The following case mix variable is determined from responses to certain items on the OASIS assessment:

- **Functional Impairment Level**-As determined by responses to certain OASIS items. A 30-day period of care can be assigned a low, medium, or high functional impairment level.

Each 30-day period is assigned into one of 432 case-mix groups based on the variables described above. Each group's case-mix weight reflects the predicted mean cost of the group relative to the overall average across all groups.

B. Labor Adjustments

The labor portion of the *30-day period payment rate* 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 HH 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 Recertifications

(Rev. 265, Issued: 01-10-20, Effective: 01-01-20, Implementation: 02-11-20)

While HH PPS payment is now made for each 30-day period, the home health PPS permits continuous 60-day recertifications for patients who continue to be eligible for the home health benefit. Medicare does not limit the number of continuous 60-day recertifications for beneficiaries who continue to be eligible for the home health benefit. Each 60-day certification can include two 30-day payment periods.

Recertification is required at least every 60 days when there is a need for continuous home health care after an initial 60-day certification. The recertification visit can be done during the prior certification period. With some minor exceptions, the Medicare Conditions of Participation at 42 CFR 484.55(d)(1), require that the recertification assessment be done during the last 5 days of the previous certification period (for example, during the initial 60-day certification period, the recertification visit is required to be done on days 56-60).

10.4 - Split Percentage Payment Approach to the 30-Day Period Unit of Payment

(Rev. 265, Issued: 01-10-20, Effective: 01-01-20, Implementation: 02-11-20)

The HH PPS has set forth a split percentage payment approach to the *30-day unit of payment in calendar year (CY) 2020 only. For each 30-day period in CY 2020, there will be a 20/80 split percentage payment. That is, there will be a split percentage payment of 20 percent at the beginning of each 30-day period and a final percentage payment of 80 percent at the end of each 30-day period, unless there is an applicable adjustment, such as a low-utilization payment adjustment (LUPA).*

For CY 2020, HHAs initially certified for participation in Medicare on or after January 1, 2019, do not receive split-percentage payments but will submit “no-pay” RAPs at the beginning of every 30-day period and will receive a final payment with a claim submission at the end of each 30-day period, unless there is an applicable adjustment.

See Pub. 100-04, Medicare Claims Processing Manual, Chapter 10, "Home Health Agency Billing" for requirements regarding split-percentage payments and RAP submissions.

10.5 - Physician Signature Requirements for the Split Percentage Payments *(Rev. 265, Issued: 01-10-20, Effective: 01-01-20, Implementation: 02-11-20)*

A. Initial Percentage Payment

If a physician-signed plan of care is not available at the beginning of the *30-day period*, 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 as required at §§484.60(b)(4) and 409.43(d).* 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 *30-day period of care* 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 30-day period of care* for services is submitted for the final percentage payment. Any changes in the plan of care must be signed and dated by a physician.

10.6- Low Utilization Payment Adjustment (LUPA) *(Rev. 265, Issued: 01-10-20, Effective: 01-01-20, Implementation: 02-11-20)*

The LUPA threshold varies for a 30-day period of care depending on the payment group to which it is assigned. For each payment group, the 10th percentile value of visits is used to create a payment group-specific LUPA threshold with a minimum threshold of at least 2 visits for each group. A 30-day period with visits less than the LUPA threshold for the payment group 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 periods that do not meet the LUPA threshold for the payment group are paid the wage-adjusted per visit amount for each of the visits rendered instead of the full 30-day period payment 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. To offset the full cost of longer, initial visits in some LUPA periods, the LUPA payment is increased by an add-on amount for LUPAs that occur as the only 30-day period or the initial 30-day period during a sequence of adjacent periods.

10.7 - Partial Payment Adjustment *(Rev. 265, Issued: 01-10-20, Effective: 01-01-20, Implementation: 02-11-20)*

A. Partial Payment Adjustment Criteria

An HHA receives a national, standardized 30-day payment of a predetermined rate for home health services unless CMS determines an intervening event warrants a new 30-day period for purposes of payment.

The partial payment adjustment is a proportion of the period payment and is based on the span of days including the start-of-care date (for example, the date of the first billable service) through and including the last billable service date under the original plan of care before the intervening event, defined as a—

- *Beneficiary elected transfer, or*
- *Discharge and return to home health that would warrant, for purposes of payment, a new OASIS assessment, physician certification of eligibility, and a new plan of care.*

When a new 30-day period begins due to an intervening event, the original 30-day period will be proportionally adjusted to reflect the length of time the beneficiary remained under the agency's care prior to the intervening event. The proportional payment is the partial payment adjustment.

B. Methodology Used to Calculate Partial Payment Adjustment

The *partial payment* adjustment for the original *30-day period* 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 partial payment adjustment will be calculated by using the span of days (first billable service date through and including the last billable service date) under the original plan of care as a proportion of the 30-day period. The proportion will then be multiplied by the original case-mix and wage index to produce the 30-day payment.*

C. Common Ownership Exception to Partial Payment Adjustment

The partial payment adjustment does not apply in situations of transfers among HHAs of common ownership. 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 *30-day period*. The common ownership exception to the transfer *partial payment* adjustment does not apply if the beneficiary moved out of their Metropolitan Statistical Area (MSA) or non-MSA during the *30-day period* before the transfer to the receiving HHA.

D. 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 484.50\(d\)](#). The receiving HHA must also document in the record that it accessed the Medicare contractor's 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 Medicare contractor 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 *partial payment* adjustment. If the receiving HHA cannot provide the appropriate documentation, the receiving HHA's RAP and/or final claim will be cancelled, and full *period* 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 Medicare contractor to resolve the dispute. The Medicare contractor is responsible for working with both HHAs to resolve the dispute.

10.8 - Outlier Payments

(Rev. 265, Issued: 01-10-20, Effective: 01-01-20, Implementation: 02-11-20)

When cases experience an unusually high level of services in a *30-day period*, Medicare systems will provide additional or "outlier" payments to the case-mix and wage-adjusted *30-day period* 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 *30-day period* payment amount for that group or the *partial payment* adjustment amount for the *30-day period*, 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 *30-day period* by first taking the national per-visit payment amounts for each discipline and calculating per-unit payment amounts (1 unit = 15 minutes). The per-unit amounts are then multiplied by the number of units in the discipline and computing the total imputed cost for all disciplines (summed across the six disciplines of care).

If the imputed cost for the *30-day period* is greater than the sum of the case-mix and wage-adjusted *30-day period* 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 *30-day period* payment.

The amount of the outlier payment is determined as follows:

1. Calculate the case-mix and wage-adjusted *30-day period* 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 *30-day period*;
3. Calculate the wage-adjusted imputed cost of the *30-day period* by first multiplying the total number of units for each home health discipline by the national per unit amounts, and wage-adjusting those amounts. Sum the per discipline wage-adjusted imputed amounts to yield the total wage-adjusted imputed cost for the *30-day period*;
4. Subtract the total imputed cost for the *30-day period* (total from Step 3) from the sum of the case-mix and wage-adjusted *30-day period* 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 *30-day period*.

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

10.9 - Discharge Issues

(Rev. 265, Issued: 01-10-20, Effective: 01-01-20, Implementation: 02-11-20)

A. Hospice Election Mid-Period

If a patient elects hospice before the end of the *30-day period* and there was no PEP or LUPA adjustment, the HHA will receive a full *30-day period* payment. *The 30-day period with visits less than the LUPA threshold for the payment group* 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 *30-day period* payment, unless the death occurred in a low utilization payment adjusted *30-day period*. Consistent with all episodes in which a patient receives four or fewer visits, if the patient's death occurred during *a low utilization adjusted 30-day*

payment period, the period would be paid at the low utilization payment adjusted amount. In the event of a patient's death during an adjusted *30-day period*, the total adjusted *period* would constitute the full *30-day period* payment.

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 visits *meeting the LUPA threshold for the payment group*, then the HHA would receive *the full 30-day period* payment. However, if the patient becomes subsequently eligible for the Medicare home health benefit during the same *30-day period* and transferred to another HHA or returned to the same HHA, then this would result in a *partial payment* 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 *visits meeting the LUPA threshold for the payment group*, then the HHA would receive full *period* payment unless the patient becomes subsequently eligible for the Medicare home health benefit during the same *30-day period* and transferred to another HHA or returned to the same HHA, then this would result in a PEP adjustment.

E. Patient Enrolls in Managed Care Mid-*Period*

If a patient's enrollment in a Medicare Advantage (MA) plan becomes effective mid *period*, the *30-day period* payment will be proportionally adjusted with a *partial payment* 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.

F. Submission of Final Claims Prior to the End of the *30-day Period*

The claim may be submitted upon discharge before the end of the *30-day period*. However, subsequent adjustments to any payments based on the claim may be made due to an intervening event resulting in a *partial payment* 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 HH PPS requires the HHA to provide all bundled home health services (except DME) either directly or under arrangement while a patient is under *an open* 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 *60-Day Recertifications*

1. If a patient is admitted to an inpatient facility and the inpatient stay overlaps into what would have been the subsequent *60-day recertification* and there is no recertification assessment of the patient, then the new certification begins with the new start of care date after inpatient discharge.
2. If a patient is admitted to an inpatient facility and the inpatient stay overlaps into what would have been the subsequent *60-day recertification* and there was a recertification assessment of the patient during days 56-60 and the patient returns home from the inpatient stay on day 61, if the home health resource group (HHRG) remains the same then the *30-day period of care following the inpatient stay* would be considered continuous and thus be considered a recertification. However, if the HHRG is different, this

would result in a new start of care OASIS and thus be considered a new certification and begins with the new start of care date after inpatient discharge.

3. If a patient is admitted to an inpatient facility and the inpatient stay overlaps into what would have been the subsequent *60-day recertification* and there was a recertification assessment of the patient during days 56-60 and the patient returns home from the inpatient stay after day 61 (after the first day of the next *60-day recertification* of care), then a new certification begins with the new start of care date after inpatient discharge.

10.10 - Consolidated Billing

(Rev. 265, Issued: 01-10-20, Effective: 01-01-20, Implementation: 02-11-20)

For individuals under a home health plan of care, payment for all services and supplies, with the exception of *certain injectable* osteoporosis drugs, DME, and furnishing NPWT using a disposable device is included in the HH PPS base payment rates. 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 the HH PPS are:

- Part-time or intermittent skilled nursing services;
- Part-time or intermittent home health aide services;
- 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;
- Furnishing NPWT using a disposable device as that term is defined in §1834 of the Act, which includes the professional services (specified by the assigned CPT code) that are provided;
- 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\(m\)](#) of the Act 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 that all medical supplies (routine and nonroutine) be provided by the HHA while the patient is under a home health plan of care. The agency that establishes the *30-day period* is the only entity that can bill and receive payment for medical supplies during *a 30-day period* 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 *30-day period*.

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 HH 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 into the HHA *30-day period* 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.

DME, including supplies covered as DME, are paid separately from the HH PPS and are excluded from the consolidated billing requirements governing the HH PPS. The determining factor is the medical classification of the supply, not the diagnosis of the patient.

Certain injectable osteoporosis drugs *are* included in consolidated billing under the home health benefit. However, payment is not bundled into the HH PPS payment rates. HHAs must bill for the osteoporosis drug in accordance with billing instructions. Payment is in addition to the HH PPS payment.

Furnishing NPWT using a disposable device is included in consolidated billing under the home health benefit. However, payment is not bundled into the HH PPS payment rates. HHAs must bill for NPWT using a disposable device in accordance with billing instructions. Payment is in addition to the HH PPS payment.

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 HH 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 HH 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 paid under the physician fee schedule are not recognized as home health services included in the PPS rates. Supplies incident to a physician service or related to a physician service billed to the Medicare contractor are not subject to the consolidated billing requirements. The physician would not be acting as a supplier billing the DME Medicare contractor 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 Healthcare Common Procedure Coding System (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 and cannot be separately billed to Part B during an open *30-day period of care*.

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 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 HH 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 *30-day period*. 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 physician orders) of the services provided by an entity during *a 30-day period* 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 *a 30-day period* 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 *a 30-day period* in an effort to resolve any misunderstanding and avoid such situations in the future.

10.11 - *Change of Ownership Relationship to Periods Under HH PPS* **(Rev. 265, Issued: 01-10-20, Effective: 01-01-20, Implementation: 02-11-20)**

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 *30-day periods* with applicable adjustments for existing patients under an established plan of care will continue on schedule through the change in ownership with assignment. The *30-day period* 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 payment 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 *30-day period* 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

30.1.1 - Patient Confined to the Home

(Rev. 265, Issued: 01-10-20, Effective: 01-01-20, Implementation: 02-11-20)

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. Criterion 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 criterion one conditions, then the patient must ALSO meet two additional requirements defined in criterion two below.

2. Criterion Two:

- There must exist a normal inability to leave home;

AND

- Leaving home must require a considerable and taxing effort.

To clarify, in determining whether the patient meets criterion two of the homebound definition, the clinician needs to take into account the illness or injury for which the patient met criterion one and consider the illness or injury in the context of the patient’s overall condition. The clinician is not required to include standardized phrases reflecting the patient’s condition (e.g., repeating the words “taxing effort to leave the home”) in the patient’s chart, nor are such phrases sufficient, by themselves, to demonstrate that criterion two has been met. For example, longitudinal clinical information about the patient’s health status is typically needed to sufficiently demonstrate a normal inability to leave the home and that leaving home requires a considerable and taxing effort. Such clinical information about the patient’s overall health status may include, but is not limited to, such factors as the patient’s diagnosis, duration of the patient’s condition, clinical course (worsening or improvement), prognosis, nature and extent of functional limitations, other therapeutic interventions and results, etc.

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 are listed below.

- 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 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 (meeting both criteria listed above) more frequently during a short period when the patient has multiple appointments with health care professionals and medical tests in 1 week. 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 because of the surgery 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.
- 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 *frailty* 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, 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 confined to home and meet both criteria listed above.

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

30.1.2 - Patient's Place of Residence

(Rev. 265, Issued: 01-10-20, Effective: 01-01-20, Implementation: 02-11-20)

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 *a period* 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 (i.e., the patient must meet both criteria listed in section 30.1.1 above).

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;
- 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 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

Per [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 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.

30.2.2 - Specificity of Orders

(Rev. 265, Issued: 01-10-20, Effective: 01-01-20, Implementation: 02-11-20)

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 *to home health patients under a home health plan of care*. 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.

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.

30.2.4 - Timeliness of Signature

(Rev. 265, Issued: 01-10-20, Effective: 01-01-20, Implementation: 02-11-20)

A. Initial Percentage Payment

If a physician signed plan of care is not available at the beginning of the *30-day period*, 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 *30-day period* 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. 265, Issued: 01-10-20, Effective: 01-01-20, Implementation: 02-11-20)

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 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 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.

Services that are provided in the subsequent 60-day 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 the 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 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.

EXAMPLE 2:

The patient is under a plan of care in which the physician orders I.V. medication administration every 2 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.

EXAMPLE 3:

The patient is under a plan of care in which the physician orders I.V. medication administration every 2 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 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.

Any increase in the frequency of services or addition of new services during a *60-day* certification must be authorized by a physician by way of a written or oral order prior to the provision of the increased or additional services

30.2.9 - Termination of the Plan of Care - Qualifying Services

(Rev. 265, Issued: 01-10-20, Effective: 01-01-20, Implementation: 02-11-20)

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 *certification* 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.

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

(Rev. 265, Issued: 01-10-20, Effective: 01-01-20, Implementation: 02-11-20)

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 *certification period* 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 not followed by a qualifying skilled service due to unexpected inpatient admission, death of the patient, or some other unanticipated event

30.5.1 - Physician Certification

(Rev. 265, Issued: 01-10-20, Effective: 01-01-20, Implementation: 02-11-20)

A certification (versus recertification) is considered to be anytime that a Start of Care OASIS is completed to initiate care. In such instances, a physician must certify (attest) that:

1. The home health services are or were needed because the patient is or was confined to the home as defined in §30.1.1;
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. 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, or as a signed addendum to the certification;
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/*periods* with starts of care beginning January 1, 2011 and later, in accordance with §30.5.1.1 below, a face-to-face encounter occurred no more than 90 days prior to or within 30 days after the start of the home health care, was related to the primary reason the patient requires home health services, and was performed by an allowed provider type. The certifying physician must also document the date of the encounter.

Example Certification Statement:

I certify that this patient is confined to his/her home and needs intermittent skilled nursing care, physical therapy and/or speech therapy or continues to need occupational therapy. The patient is under my care, and I have authorized services on this plan of care and will periodically review the plan. The patient had a face-to-face encounter with an allowed provider type on 11/01/2016 and the encounter was related to the primary reason for home health care.

Physician's Signature and Date Signed: **John Doe, MD 11/05/2016**

Physician's Name and Address

John Doe, MD
2121 Washington Pkwy
Suite 220
Washington, DC 20000

Note: This represents one example of a valid certification statement. Certification statements can be included in varying forms or formats as long as the content requirements (#1-5 above) for the certification are met.

If the patient is starting home health directly after discharge from an acute/post-acute care setting where the physician, with privileges, that cared for the patient in that setting is certifying the patient's eligibility for the home health benefit, but will not be following the patient after discharge, then the certifying physician must identify the community physician who will be following the patient after discharge. One of the criteria that must be met for a patient to be considered eligible for the home health benefit is that the patient must be under the care of a physician (number 4 listed above). Otherwise, the certification is not valid.

The certification must be complete prior to when an HHA bills Medicare for reimbursement; however, physicians should complete the certification when the plan of care is established, or as soon as possible thereafter. This is longstanding CMS policy as referenced in Pub 100-01, Medicare General Information, Eligibility, and Entitlement Manual, chapter 4, section 30.1. It is not acceptable for HHAs to wait until the end of a 60-day *certification period* to obtain a completed certification/recertification.

30.5.2 - Physician Recertification

(Rev. 265, Issued: 01-10-20, Effective: 01-01-20, Implementation: 02-11-20)

At the end of the 60-day *certification*, a decision must be made whether or not to recertify the patient for a subsequent 60-days. An eligible beneficiary who qualifies for a subsequent 60-day *certification* would start the subsequent 60-day *certification* 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:

- A beneficiary transfers to another HHA; or
- A discharge and return to home health during the 60-day *certification*.

For recertification of home health services, the physician must certify (attest) that:

1. The home health services are or were needed because the patient is or was confined to the home as defined in §30.1;
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 recertification, or as a signed addendum to the recertification;
3. A plan of care has been established and is periodically reviewed by a physician; and
4. The services are or were furnished while the patient is or was under the care of a physician.

Medicare does not limit the number of continuous *60-day* 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. Because the updated home health plan of care must include the frequency and duration

of visits to be made, the physician does not have to estimate how much longer skilled services will be needed for the recertification.

40.1.1 - General Principles Governing Reasonable and Necessary Skilled Nursing Care *(Rev. 265, Issued: 01-10-20, Effective: 01-01-20, Implementation: 02-11-20)*

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 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 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 *30-day period*, 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

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

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. 265, Issued: 01-10-20, Effective: 01-01-20, Implementation: 02-11-20)

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 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 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 *continuation* of skilled care *for a subsequent 60-day certification period*, 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. 265, Issued: 01-10-20, Effective: 01-01-20, Implementation: 02-11-20)

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 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 *period* 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.

40.1.2.13 - Venipuncture

(Rev. 265, Issued: 01-10-20, Effective: 01-01-20, Implementation: 02-11-20)

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 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.

- 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.

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

(Rev. 265, Issued: 01-10-20, Effective: 01-01-20, Implementation: 02-11-20)

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.

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.

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. **Initial Therapy Assessment**

- 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.
- 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. **Reassessment at least every 30 days (performed in conjunction with an ordered therapy service)**

- 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.
- For multi-discipline therapy cases, a qualified therapist from each of the disciplines must functionally reassess the patient. The therapist must document the measurement results which correspond to the therapist's discipline and care plan goals in the clinical record.
- 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).

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, *or by a qualified therapist assistant under the supervision 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 could not be accomplished during the last visit(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 or by a qualified therapist assistant under the supervision of a qualified therapist 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 *or by a qualified therapist assistant under the supervision 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 *or by a qualified therapist assistant under the supervision of a qualified 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 *or by a qualified therapist assistant under the supervision of a qualified therapist* to perform a therapy service that would otherwise be considered non-skilled; or (b) the 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 *30-day period*, 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.

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.

50.4.1 - Medical Supplies

(Rev. 265, Issued: 01-10-20, Effective: 01-01-20, Implementation: 02-11-20)

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 *30-day period* 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. 265, Issued: 01-10-20, Effective: 01-01-20, Implementation: 02-11-20)

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 *a 30-day period of care. 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.* 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 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. 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.* 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, then the HHA must provide the medical supplies.* The HHA 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.

50.4.4 - Negative Pressure Wound Therapy Using a Disposable Device

(Rev. 265, Issued: 01-10-20, Effective: 01-01-20, Implementation: 02-11-20)

Sections 1834 and 1861(m)(5) of the Act require a separate payment to an HHA for an applicable disposable device when furnished on or after January 1, 2017, to an individual who receives home health services for which payment is made under the Medicare home health benefit. Section 1834 of the Act defines an applicable device as a disposable NPWT device that is an integrated system comprised of a non-manual vacuum pump, a receptacle for collecting exudate, and dressings for the purposes of wound therapy used in lieu of a conventional NPWT DME system. As required by §1834 of the Act, the separate payment amount for a disposable NPWT device is to be set equal to the amount of the payment that would be made under the Medicare Hospital Outpatient Prospective Payment System (OPPS) using the Level I HCPCS code, otherwise referred to as Current Procedural Terminology (CPT) codes, for which the description for a professional service includes the furnishing of such a device.

Payment for HH visits related to wound care, but not requiring the furnishing of an entirely new disposable NPWT device, will be covered by the HH PPS *30-day period* payment and must be billed using the HH claim. Where a home health visit is exclusively for the purpose of furnishing NPWT using a disposable device, the HHA will submit only a type of claim that will be paid for separately outside the HH PPS (TOB 34x). Where, however, the home health visit includes the provision of other home health services in addition to, and separate from, furnishing NPWT using a disposable device, the HHA will submit both a home health claim and a TOB 34x—the home health claim for other home health services and the TOB 34x for furnishing NPWT using a disposable device.

EXAMPLE:

A patient requires NPWT for the treatment of a wound. On Monday, a nurse assesses a patient's wound, applies a new disposable NPWT device, and provides wound care education to the patient and family. The nurse returns on Thursday for wound assessment and replaces the fluid management system (or dressing) for the existing disposable NPWT, but does not replace the entire device. The nurse returns the following Monday, assesses the patient's condition and the wound, and replaces the device that had been applied on the previous Monday with a new disposable NPWT device. In this scenario, the billing procedures are as follows:

For both Monday visits, all the services provided by the nurse were associated with furnishing NPWT using a disposable device. The nurse did not provide any services that were not associated with furnishing NPWT using a disposable device. Therefore, all the nursing services for both Monday visits should be reported on TOB 34x with CPT code 97607 or 97608. None of the services should be reported on the HH claim.

For the Thursday visit, the nurse checked the wound, but did not apply a new disposable NPWT device, so even though the nurse provided care related to the wound, those services would not be considered furnishing NPWT using a disposable device. Therefore, the services should be reported on bill type 32x and no services should be reported on bill type 34x.

For instructions on billing for NPWT using a disposable device, see Pub. 100-04, Medicare Claims Processing Manual, chapter 10, Section 90.3 – Billing Instructions for Disposable Negative Pressure Wound Therapy Services.

70.2 - Counting Visits Under the Hospital and Medical Plans

(Rev. 265, Issued: 01-10-20, Effective: 01-01-20, Implementation: 02-11-20)

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 *30-day periods*, and *periods* 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 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 *30-day period*.

The Medicare contractor 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.

80.8 - Respiratory Care Services

(Rev. 265, Issued: 01-10-20, Effective: 01-01-20, Implementation: 02-11-20)

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 *period of care* 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 *period of care*. 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).

80.10 Remote Patient Monitoring

(Rev. 265, Issued: 01-10-20, Effective: 01-01-20, Implementation: 02-11-20)

Remote patient monitoring is the collection of physiologic data (for example, ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient or caregiver or both to the home health agency. Remote patient monitoring can be ordered as part of a home health plan of care but such services cannot be reported as a visit without the provision of another skilled service. Visits to a beneficiary's home for the sole purpose of supplying, connecting, and/or training the patient on the remote patient monitoring equipment, without the provision of another skilled service are not separately billable. However, HHAs may

include the costs of remote patient monitoring as an allowable administrative cost (that is, operating expense), if remote patient monitoring is used by the HHA to augment the care planning process.

110 - Use of Telehealth in Delivery of Home Health Services

(Rev. 265, Issued: 01-10-20, Effective: 01-01-20, Implementation: 02-11-20)

[Section 1895\(e\)](#) 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 there is no separate reimbursement for those technologies under the Medicare home health benefit. However, Medicare does recognize remote patient monitoring (see section 80.10) as an allowed administrative cost on Medicare cost reports if remote patient monitoring is used by the HHA to augment the care planning process.*

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.