MEDICARE HOME HEALTH SELF HELP PACKET

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INTRODUCTION

Dear Medicare Patient:

The Center for Medicare Advocacy, in conjunction with the State of Connecticut Department of Social Services has produced this packet of materials to help you understand Medicare coverage and to file an appeal if it is necessary.

Medicare is the national health insurance program to which individuals are entitled under the Social Security Act. All too often, Medicare claims are erroneously denied. It is your right to appeal an unfair denial; we urge you to do so.

The materials enclosed include a Request for Redetermination form which has accompanying instructions for completing and filing. In order to appeal your Medicare denial, you must file the Request for Redetermination with the Medicare contractor. You will receive a Redetermination decision usually within one to three months after submitting the request.

Please do not hesitate to contact The Center for Medicare Advocacy at (800)262-4414 or (860)456-7790 if you have any questions.
HOW TO USE THIS PACKET

We’ve organized this packet so that it provides you with the information and forms necessary to enable you to evaluate your case and file a “Request for Redetermination,” the first level of administrative appeal. We suggest you take the following steps:

1. Read the “Brief Summary.” This summary will give you the background necessary to understand your case.

2. If your case has merit (that is, the coverage denial you have received is erroneous), you should complete the “Request for Redetermination” form, following the Instructions.

3. Send a copy of your “Request for Redetermination” to your Medicare contractor. Keep a copy of the form for your own records.

4. If you have questions when you receive the “Redetermination” decision, feel free to telephone the Center for Medicare Advocacy. The toll free number in Connecticut is 800-262-4414.
A BRIEF SUMMARY OF MEDICARE COVERAGE FOR HOME HEALTH CARE 
AND THE IMPROVEMENT MYTH

Medicare is the national health insurance program to which all Social Security recipients who are either at least 65 years old or are permanently disabled are entitled. In addition, individuals receiving Railroad Retirement benefits and individuals with End Stage Renal Disease (ESRD) or Amyotrophic Lateral Sclerosis (ALS) are eligible to receive Medicare benefits. Medicare was established in 1965 by Title 18 of the Social Security Act. 42 USC §1395 et seq.

Private Medicare plans are known as "Medicare Advantage" (MA) plans. Although the Medicare Advantage system is different from the original Medicare program, Medicare Advantage plan benefits are required to be identical to, or more generous than, those in the original program.

THE MEDICARE “IMPROVEMENT MYTH”

There is a long standing myth that Medicare coverage is not available for beneficiaries who have an underlying condition from which they will not improve. This is not true. In fact, the notion of "improvement" is only mentioned once in the Medicare Act – and it is not about coverage for home health care.

As an overarching principle, the Medicare Act states that no payment will be made except for items and services that are "reasonable and necessary for the diagnosis or treatment of an illness or injury, or to improve the functioning of a malformed body member." 42 USC §1395y(a)(1)(A). While it is not clear what a "malformed body member" is, clearly this language does not limit Medicare coverage only to services, diagnoses or treatments that will improve illness or injury. Yet, in practice, beneficiaries are often denied coverage on the grounds that they are not likely to improve, or are "stable" or "chronic," or require long-term care, or "maintenance services only." These are not legitimate reasons for Medicare denials. 42 CFR §409.44(b)(3)(ii); 42 CFR §409.44(c)(2)(iii)(B) or (C).

MEDICARE COVERAGE FOR HOME HEALTH CARE

Medicare coverage can be available for long term home health care if the qualifying criteria are met. There is no statutory or regulatory limit on the length of time for which home health coverage is available. Further, Medicare covers home health services in full, with no required deductible or co-payments from the beneficiary. Services must be reasonable and medically necessary and the following criteria must be met:

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A physician has signed or will sign a plan of care;

1. The patient is or will be "homebound." This criterion is met if leaving home requires a considerable and taxing effort which may be shown by the patient needing personal assistance, or the help of a wheelchair or crutches, etc. Occasional but infrequent "walks around the block" are allowable.
   42 USC §1395f(a)(2)(C); 42 USC §1395f(a)(8)
   CMS Policy Manual 100-02, Chapter 7, §30.1.1

2. The patient needs or will need physical or speech therapy, or intermittent skilled nursing (from once a day for periods of 21 days at a time if there is a predictable end to the need for daily nursing care, to once every 60 days).
   42 USC §1395f(a)(2)(C); 42 USC §1395x(m); 42 CFR §409.42(c)(1)
   CMS Policy Manual 100-02, Chapter 7, §40.1.3

3. The home health care is provided by, or under arrangement with, a Medicare-certified provider.
   42 USC §1395f(a)(2)(C); 42 USC §1395n(a)(2)(A); 42 USC §1395x(m); 42 CFR §409.42(c)

If the triggering conditions described above are met, the beneficiary is entitled to Medicare coverage for home health services. Home health services include:

- Part-time or intermittent nursing care provided by or under the supervision of a registered professional nurse
  For information about skilled nursing see, 42 CFR §409.33; 42 CFR §409.44(b)
- Physical, occupational, or speech therapy
  For information about skilled therapy see, 42 CFR §409.33; 42 CFR §409.44(c)
- Medical social services under the direction of a physician; and
- To the extent permitted in regulations, part-time or intermittent services of a home health aide.
  42 USC §1395x(m)(1) and (4)

Unfortunately, Medicare coverage is often denied to individuals who qualify under the law. In particular, beneficiaries are often denied coverage because they have certain chronic conditions such as Alzheimer's disease, Parkinson's disease, and multiple sclerosis, or because they need nursing or therapy "only" to maintain their condition. These are not legitimate reasons for Medicare denials.
42 CFR §409.44(a)

The question to ask is does the patient meet the qualifying criteria listed above and need skilled nursing and/or therapy – not does the patient have a particular disease or will s/he recover.
IMPORTANT ADVOCACY TIPS

1. Each person should get an individualized assessment regarding Medicare coverage based on his/her unique medical condition and need for care.
   42 CFR §409.44(a); 42 CFR §409.44(b)(3)(iii)

2. There is no legal limit to the duration of the Medicare home health benefit. Medicare coverage is available for necessary home care even if it is expected to last a long period of time.
   42 CFR §409.44(b)(3)(iii)

3. The restoration potential of a patient is not the deciding factor in determining whether skilled services are needed. Coverage can be available even if the illness or injury is chronic, terminal, or the patient’s condition is stable.
   42 CFR §409.32(c); 42 CFR §409.44(b)(3)(iii); 42 §CFR 409.44 (c)(2)(iii)(C); CMS Policy Manual 100-02, Chapter 8, §30.2.2 and 100-02, Chapter 7, §40.1.1

4. Medicare recognizes that skilled care can be required to maintain an individual’s condition or functioning, or to slow or prevent deterioration, including physical therapy to maintain the individual’s condition or function.
   42 CFR §409.42(c) and 42 CFR §409.44(c)(2)(C)(iii)

5. The doctor is the patient’s most important ally. Ask the doctor to help demonstrate that the standards described above are met. In particular, ask the individual’s doctor to state in writing that the individual is homebound and why the skilled care and other services are required.

If a home health agency or Medicare Advantage plan says Medicare coverage is not available and the patient seems to satisfy the criteria above, ask the home care agency to submit a claim for a formal Medicare coverage determination. The agency must submit a claim if the patient or representative requests.

CONCLUSION

Medicare coverage for home health care can be a long-term benefit if the individual meets the qualifying criteria. Unfortunately, however, coverage is often erroneously denied for individuals with chronic conditions, for people who are not improving, who need services for a long time and/or to maintain their condition.

**Medicare can be available for items and services needed to maintain the person’s condition or to arrest or retard further deterioration. It is not necessary for the individual’s underlying condition to improve to qualify for Medicare coverage!** The Medicare program has an appeal system to contest such denials. Beneficiaries and their advocates should use this system to appeal Medicare determinations that unfairly deny or limit coverage.

For more information about Medicare coverage, appeals, and related topics visit the Center for Medicare Advocacy’s web site at [www.medicareadvocacy.org](http://www.medicareadvocacy.org).

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Medicare Overview

Generally, coverage is available (except for hospice care) only when services are medically reasonable and necessary for treatment or diagnosis of illness or injury.

PART A
Coverage:
- Inpatient Hospital Services
- Inpatient Hospital Rehabilitation Services
- Inpatient Skilled Nursing Facility Services
- Home Health Services
- Hospice Services

PART B
Coverage:
- Physicians' Services
- Some Outpatient Services & Therapy
- Prosthetic Devices
- Ambulance Services
- Preventive Screenings such as: prostate cancer, bone mass, glaucoma
- Some Nutrition Therapy Services
- Flu and Pneumonia Vaccines
- Some Therapeutic Shoes

Appeals Process

1. Redetermination (by Quality Improvement Organization [QIO] or Medicare Contractor)

2. Reconsideration (by Qualified Independent Contractors [QIC])

3. Administrative Law Judge Hearing (U.S. Dept. of Health & Human Services) [If at least $130 in controversy]* [$200 for Hospital Case]

4. Medicare Appeals Council (MAC) (U.S. Dept. of Health and Human Services) [If at least $130 in controversy]* [$200 for Hospital Case]

5. Judicial Review (U.S. Dept. of Health and Human Services) [If at least $1,300 in controversy]* [$200 for Hospital Case]

* The amount in controversy is increased by the percentage increase in the medical care component price index.
MEDICARE PREMIUMS AND DEDUCTIBLES FOR 2011

Hospital Deductible: $1,132.00 / Benefit period

Hospital Coinsurance:

- Days 0-60: $0
- Days 61-90: $283 / Day
- Days 91-150: $566 / Day

Skilled Nursing Facility Coinsurance:

- Days 0-20: $0
- Days 21-100: $141.50 / Day

Part A Premium (For voluntary enrollees only)

- With 30-39 quarters of Social Security coverage: $248.00 / Month
- With 29 or fewer quarters of Social Security coverage: $450.00 / Month

Part B

- Deductible: $162.00 / Year
- Standard Premium: $115.40 / Month*

*Most people will continue to pay $96.40 in 2011.

PART B INCOME-RELATED PREMIUM

<table>
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<th>Beneficiaries who file an individual tax return with income:</th>
<th>Beneficiaries who file a joint tax return with income:</th>
<th>Income-related monthly adjustment amount</th>
<th>Total monthly premium amount</th>
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<td>Less than or equal to $170,000</td>
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<td>$115.40</td>
</tr>
<tr>
<td>Greater than $85,000 and less than or equal to $107,000</td>
<td>Greater than $170,000 and less than or equal to $214,000</td>
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<td>Greater than $107,000 and less than or equal to $160,000</td>
<td>Greater than $214,000 and less than or equal to $426,000</td>
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<td>$230.70</td>
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<td>Greater than $160,000 and less than or equal to $214,000</td>
<td>Greater than $320,000 and less than or equal to $400,000</td>
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<td>$299.90</td>
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<tr>
<td>Greater than $214</td>
<td>Greater than $426,000</td>
<td>$253.70</td>
<td>$369.10</td>
</tr>
</tbody>
</table>

(over)
PART B PREMIUM (cont.)

In addition, the monthly Part B premium rates to be paid by beneficiaries who are married, but file a separate return from their spouse and lived with their spouse at some time during the taxable year are:

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<tr>
<th>Beneficiaries who are married but file a separate tax return from their spouse:</th>
<th>Income-related monthly adjustment amount</th>
<th>Total monthly premium amount</th>
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<td>$115.40</td>
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<td>$299.90</td>
</tr>
<tr>
<td>Greater than $129,000</td>
<td>$253.70</td>
<td>$369.10</td>
</tr>
</tbody>
</table>

STANDARD PART D COST-SHARING FOR 2011

Deductible: $310.00
Initial Coverage Limit: $2,840.00
Out-of-pocket Threshold: $4,550.00
Catastrophic cost-sharing: Generic/Preferred Drug: $2.50*
Other Drugs: $6.30*

* or 5% whichever is higher

Low-Income Subsidy Co-Payments (LIS)

Full Benefit Dual Eligibles with-in Institutions: $0 after one full month for all drugs

Full Benefit Dual Eligibles with incomes ≤ 100% Federal Poverty Level
- Generic/Preferred Drugs: $1.10
- Other: $3.30
- Above Catastrophic Limit: $0.00

Full Benefit Duals with Incomes >100% Federal Poverty Level & Other Full-Subsidy Eligible Beneficiaries
- Deductible: $0
- Generic/preferred drugs: $2.50
- Other: $6.30
- Above Catastrophic Limit: $0.00

Partial Subsidy Eligible Beneficiaries
- Deductible: $63.00
- Co-insurance to Initial Coverage Limit: 15%
- Generics above catastrophic limit: $2.50
- Others above catastrophic limit: $6.30
REQUIRED NOTICES FROM HOME HEALTH AGENCY AND HOW TO HAVE A BILL SUBMITTED TO MEDICARE

The Home Health Agency makes the first decision as to whether or not the care they provide will be covered by the Medicare program. If a home health agency (HHA) decides that the services it provides will not be covered by Medicare, it is required by law to give the beneficiary or his/her representative a formal written notice to that effect. This notice of Medicare denial is known as a Home Health Advanced Beneficiary Notice (HHABN). To challenge the denial you must inform the HHA that you wish to appeal.

The HHABN notice must explain why the care being provided will not be covered by Medicare. It must also explain that to appeal this Medicare denial there must be a request that a bill be submitted to Medicare for the non-covered services, also known as a “demand bill.”

Demand billing is a procedure through which beneficiaries can request Medicare payment for services that the HHA advised (1) were not medically reasonable and necessary, or (2) the beneficiary failed to meet the homebound, intermittent or noncustodial care requirements, and therefore would not be reimbursed if billed. It is important to remember that if you do not object to the notification that care is ending and no bill is submitted to Medicare there can be no appeal.

Beneficiaries must pay for the services in question, but upon request of the beneficiary the HHA is required to bill Medicare for the disputed services. If, after its review, Medicare decides some or all the disputed services received on the “demand bill” are covered and pays for them, the HHA would refund the previously collected funds for these services. If the Medicare determination upholds the HHA’s judgment that the services were not medically reasonable and necessary, or that the beneficiary failed to meet the homebound or intermittent care requirements, the HHA keeps the funds collected, unless the appeal decision determines the HHABN notification was not properly executed, or
some other factor changed liability for payment of the disputed services back to the HHA.

The submission of a bill will result in a formal written determination by Medicare as to whether or not the care is covered. This determination notice will be sent to the beneficiary and/or the representative and can be appealed by a request for "redetermination."
REQUEST FOR PAYMENT FOR MEDICARE HOME HEALTH BENEFITS

Re: _____________________________________________ Health Insurance (Medicare) #: ____________________________

Beneficiary’s Name

__________________________________________

Street

__________________________________________

City State Zip

To: ____________________________________________ Dates of Service(s):

Home Health Agency

__________________________________________ From ______ through ________

Street

__________________________________________

City State Zip

I hereby request payment of authorized Medicare benefits for all services which you provided to me, or to the Medicare beneficiary named above. Please submit a claim for these services to your designated Medicare Contractor pursuant to 42 C.F.R. §424.32 et seq. and Medicare Claims Processing Manual, CMS Pub. 100-04, Ch. 10, §50. I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services. When you make the claim for coverage, you may wish to submit it as a “demand billing” and note that the claim is submitted at the request of the beneficiary.

SIGNED: ______________________________ DATE: ______________________________

Medicare Beneficiary/Representative

IMPORTANT: If anyone other than the claimant is signing this document, he/she should indicate his/her relationship to the claimant by checking the statement below:

The claimant is unable to sign this form due to illness. I am assisting him/her in his/her personal affairs. I am the claimant’s:

[ ] Son/Daughter  [ ] Brother/Sister
[ ] Spouse  [ ] Other____________________
[ ] Power of Attorney  (Please attach a copy of your Power of Attorney or Conservator form.)
[ ] Conservator
"Fast-track" or "expedited appeals" process in the Medicare appeals process is a service provided for beneficiaries who are experiencing severe financial hardship or whose health condition is deteriorating rapidly, and it allows for faster resolution of the appeal. Please contact the Center for Medicare Advocacy with questions about the

The amount in controversy is increased annually by the percentage increase in the medical care component price index.

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<td>Request For Claim</td>
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<tr>
<td>For Payment</td>
<td>For Payment</td>
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</tr>
</tbody>
</table>

(Appeals include claims for hospital, skilled nursing facility, home health & hospice)

MEDIACARE PART A APPEALS

Center for Medicare Advocacy Inc.

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INSTRUCTIONS FOR COMPLETING REDETERMINATION REQUEST FORM

Although most sections of the form are self-explanatory, a few sections may not be so clear. Below are instructions for completing those sections as well as instructions for submitting your Request for Redetermination. Remember to refer to the included Glossary of Terms if need be.

#2. Medicare Number- This number can be found in the upper right section of the “Medicare Summary Notice.” You can also use the Social Security number under which you receive benefits. Your Medicare Number can also be found on your Medicare card.

#5. My reasons are: - Fill in the following: “The services provided are coverable under the Medicare Act.” If you missed the 120 day appeal deadline, you will need to establish “good cause” for late filing of your Request Redetermination. Here are some acceptable “good cause” reasons.

#6. Date of the initial determination notice-The date can be found on the “Medicare Summary Notice” in a box in the upper Right hand corner.

If you received your initial determination notice more than 120 days ago, include your reason for late filing from the options below:

a. During the time in question, the patient suffered from (list illnesses), and thus was unable to attend to matters of personal business. Waiver is sought pursuant to 42 CFR §405.942(b)(i).

b. During the time in question, the patient had a death or serious illness in his/her immediate family. Waiver is sought pursuant to 42 CFR §405.942(b)(3)(iii).

c. Important records were destroyed or damaged by fire or other accidental cause. Waiver is sought pursuant to 42 CFR §405.942(b)(3)(iii).

d. The Medicare contractor did not give the patient correct or complete information about when or how to request a Redetermination. Waiver is sought pursuant to 42 CFR §405.942(b)(3)(iv).

e. The patient did not receive the initial determination. Waiver is sought pursuant to 42 CFR §405.942(b)(3)(v).
f. The patient sent the request to a government agency in good faith within the time limit but the request did not reach the appropriate contractor until after the time period had passed. Waiver is sought pursuant to 42 CFR §405.942(b)(3)(vi.)

If you are representing the beneficiary, have him/her sign the Appointment of Representative form included in this packet and attach a copy with the Request for Redetermination.

When completed, keep a copy for your records and deliver/mail* the original to the Medicare contractor. Attach a copy of the Medicare denial notice being appealed, and if appropriate, copies of your Appointment Representative form.

REMEMBER: KEEP THE ORIGINAL OR A COPY OF ALL PAPERS YOU SUBMIT.

*Name and Address of the Medicare Contractor can be found on the “Medicare Summary Notice”.
MEDICARE REDETERMINATION REQUEST FORM

1. Beneficiary's Name: ____________________________________________

2. Medicare Number: ____________________________________________

3. Description of Item or Service in Question: ________________________

4. Date the Service or Item was Received: __________________________

5. I do not agree with the determination of my claim. MY REASONS ARE:
   ____________________________________________________________________
   ____________________________________________________________________
   ____________________________________________________________________

6. Date of the initial determination notice
   (If you received your initial determination notice more than 120 days ago, include your reason for not making this request earlier.)
   ____________________________________________________________________
   ____________________________________________________________________
   ____________________________________________________________________

7. Additional Information Medicare Should Consider: ______________________
   ____________________________________________________________________
   ____________________________________________________________________
   ____________________________________________________________________

8. Requester's Name: ____________________________________________

9. Requester's Relationship to the Beneficiary: ________________________

10. Requester's Address: ____________________________________________

11. Requester's Telephone Number: _________________________________

12. Requester's Signature: _________________________________________

13. Date Signed: _________________________________________________

14. ☐ I have evidence to submit. (Attach such evidence to this form.)
    ☐ I do not have evidence to submit.

NOTICE: Anyone who misrepresents or falsifies essential information requested by this form may upon conviction be subject to fine or imprisonment under Federal Law.
# APPOINTMENT OF REPRESENTATIVE

## SECTION I: APPOINTMENT OF REPRESENTATIVE

To be completed by the beneficiary:

I appoint this individual: ____________________________ to act as my representative in connection with my claim or asserted right under Title XVIII of the Social Security Act (the "Act") and related provisions of Title XI of the Act. I authorize this individual to make any request; to present or to elicit evidence; to obtain appeals information; and to receive any notice in connection with my appeal, wholly in my stead. I understand that personal medical information related to my appeal may be disclosed to the representative indicated below.

<table>
<thead>
<tr>
<th>SIGNATURE OF BENEFICIARY</th>
<th>DATE</th>
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</thead>
</table>

<table>
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<th>STREET ADDRESS</th>
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</table>

<table>
<thead>
<tr>
<th>CITY</th>
<th>State</th>
<th>ZIP</th>
</tr>
</thead>
</table>

## SECTION II: ACCEPTANCE OF APPOINTMENT

To be completed by the representative:

I, ____________________________, hereby accept the above appointment. I certify that I have not been disqualified, suspended, or prohibited from practice before the Department of Health and Human Services; that I am not, as a current or former employee of the United States, disqualified from acting as the beneficiary’s representative; and that I recognize that any fee may be subject to review and approval by the Secretary.

I am a / an ____________________________ (PROFESSIONAL STATUS OR RELATIONSHIP TO THE PARTY, E.G. ATTORNEY, RELATIVE, ETC.)

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<thead>
<tr>
<th>SIGNATURE</th>
<th>DATE</th>
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<tr>
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<tr>
<th>CITY</th>
<th>State</th>
<th>ZIP</th>
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</table>

## SECTION III: WAIVER OF FEE FOR REPRESENTATION

Instructions: This form should be filled out if the representative waives a fee for such representation. (Note that providers or suppliers may not charge a fee for representation and thus, all providers or suppliers that furnished the items or services at issue must complete this section.)

I waive my right to charge and collect a fee for representing ____________________________ before the Secretary of the Department of Health and Human Services.

<table>
<thead>
<tr>
<th>SIGNATURE</th>
<th>DATE</th>
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</table>

## SECTION IV: WAIVER OF PAYMENT FOR ITEMS OR SERVICES AT ISSUE

Instructions: Providers or suppliers that furnished the items or services at issue must complete this section if the appeal involves a question of liability under section 1879(a)(2) of the Act. (Section 1879(a)(2) generally addresses whether a provider/supplier or beneficiary did not know, and could not reasonably be expected to know, that the items or services at issue would not be covered by Medicare.)

I waive my right to collect payment from the beneficiary for furnished items or services at issue involving 1879(a)(2) of the Act.

<table>
<thead>
<tr>
<th>SIGNATURE</th>
<th>DATE</th>
</tr>
</thead>
</table>
CHARGING OF FEES FOR REPRESENTING BENEFICIARIES BEFORE THE SECRETARY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

An attorney, or other representative for a beneficiary, who wishes to charge a fee for services rendered in connection with an appeal before the Department of Health and Human Services (DHHS) at the Administrative Law Judge (ALJ) or Medicare Appeals Council (MAC) level is required by law to obtain approval of the fee in accordance with 42 CFR §405.910(f). A claim that has been remanded by a court to the Secretary for further administrative proceedings is considered to be before the Secretary after the remand by the court.

The form, "Petition to Obtain Representative Fee" elicits the information required for a fee petition. It should be completed by the representative and filed with DHHS. Where a representative has rendered services in a claim before DHHS, the regulations require that the amount of the fee to be charged, if any, for services performed before the Secretary of DHHS be specified. If any fee is to be charged for such services, a petition for approval of that amount must be submitted.

An approval of a fee is not required where the appellant is a provider or supplier or where the fee is for services (1) rendered in an official capacity such as that of legal guardian, committee, or similar court-appointed office and the court has approved the fee in question; (2) in representing the beneficiary before the federal district court of above, or (3) in representing the beneficiary in appeals below the ALJ level. If the representative wishes to waive a fee, he or she may do so. Section III on the front of this form can be used for that purpose. In some instances, as indicated on the form, the fee must be waived for representation.

AUTHORIZATION OF FEE

The requirement for the approval of fees ensures that representative will receive fair value for the services performed before DHHS on behalf of a claimant while at the same time giving a measure of security to the beneficiaries. In approving a requested fee, the ALJ or MAC considers the nature and type of services performed, the complexity of the case, the level of skill and competence required in rendition of the services, the amount of time spent on the case, the results achieved, the level of administrative review to which the representative carried the appeal and the amount of the fee requested by the representative.

CONFLICT OF INTEREST

Sections 203, 205 and 207 of Title XVIII of the United States Code make it a criminal offense for certain officers, employees and former officers and employees of the United States to render certain services in matters affecting the Government or to aid or assist in the prosecution of claims against the United States. Individuals with a conflict of interest are excluded from being representatives of beneficiaries before DHHS.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0918-0920. The time required to prepare and distribute this collection is 15 minutes per notice, including the time to select the preprinted form, complete it and deliver it to the beneficiary. If you have comments concerning the accuracy of the time estimates or suggestions for improving this form, please write to CMS, PRA Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.
GLOSSARY OF TERMS

BENEFICIARY
An individual enrolled in the Medicare program.

CLAIMANT
An individual requesting reimbursement from Medicare for expenses incurred for medical care (or the individual requesting payment on behalf of a Medicare enrollee).

CO-INSURANCE
The amount a beneficiary must pay as his or her share of the cost of a given service. For example, a beneficiary must pay part of the cost of days 21 through 100 in a skilled nursing facility. There is also a co-insurance (20% of the reasonable charge) which must be paid for Part A or B services.

CMS (Centers for Medicare and Medicaid Services)
The federal agency which administers the Medicare program: part of the United States Department of Health and Human Services.

DEDUCTIBLE
The amount which a beneficiary must pay before Medicare (or other insurance program) will begin to cover the bill. Each calendar year a deductible must be paid before Medicare will cover hospital care under Part A, or physician visits and other services under Medicare Part B.

HEALTH INSURANCE CLAIM NUMBER
The Social Security number under which you receive benefits. This number is the number on your health insurance (Medicare) card.
INPATIENT

An individual admitted to a hospital, skilled nursing facility, or other health care institution for treatment

MEDICARE CLAIM DETERMINATION

The written notice of denial of Medicare coverage issued by the intermediary.

MEDICARE CONTRACTOR

An agent of the federal government, often an insurance company, which makes Part A Medicare claim determinations for skilled nursing facility and home health coverage, and issues payments to providers.

MEDIGAP

Private insurance which covers the "gaps" in Medicare (such as deductibles and co-insurance amounts). Significantly, these policies generally do not pay when Medicare refuses coverage.

SKILLED CARE

Care which requires the skill of technical or professional personnel in order to ensure its safety and effectiveness, and is furnished directly by, or under the supervision of, such personnel. (Nurses and physical or occupational therapists are examples of professional personnel.)

SKILLED NURSING FACILITY (SNF)

A skilled nursing facility, or "SNF," is a nursing home which delivers a relatively substantial degree of skilled nursing and rehabilitative care, and personal care. In order to receive Medicare coverage for nursing home care, a patient must receive daily skilled care in a Medicare-certified skilled nursing facility.

SPELL OF ILLNESS (BENEFIT PERIOD)

The name of the benefit period for Medicare Part A. The "spell of illness" begins on the first day a patient receives Medicare-covered inpatient hospital care and ends when the patient has spent 60 consecutive days outside the institution, or remains in the institution but does not receive Medicare-coverable care for 60 consecutive days.
MEDICARE ACT

42 U.S.C. §1395f(a)(8)
and
42 U.S.C. §1395n(2)

(Definition of "Homebound" for purposes of qualifying for Medicare Home Health Benefits)

For purposes of paragraph(2)(C), an individual shall be considered to be "confined to his home" if the individual has a condition, due to an illness or an injury, that restricts the ability of the individual to leave his or her home except with the assistance of another individual or the aid of a supportive devise (such as crutches, a cane, a wheelchair or a walker), or if the individual has a condition such that leaving his home is contraindicated. While an individual does not have to be bedridden to be considered "confined to home", the condition of the individual should be such that there exists a normal inability to leave home, that leaving home requires a considerable and taxing effort by the individual, and absences of the individual from home are infrequent or of relatively short duration, or are attributable to the need to receive medical treatment. 42 U.S.C. §1395f(a)(8) and §1395n(2).
Title 42: Public Health
PART 409—HOSPITAL INSURANCE BENEFITS
Subpart E—Home Health Services Under Hospital Insurance

§ 409.40 Basis, purpose, and scope.
This subpart implements sections 1814(a)(2)(C), 1835(a)(2)(A), and 1861(m) of the Act with respect to the requirements that must be met for Medicare payment to be made for home health services furnished to eligible beneficiaries.

[59 FR 65493, Dec. 20, 1994]

§ 409.41 Requirement for payment.
In order for home health services to qualify for payment under the Medicare program the following requirements must be met:

(a) The services must be furnished to an eligible beneficiary by, or under arrangements with, an HHA that—
   (1) Meets the conditions of participation for HHAs at part 484 of this chapter; and
   (2) Has in effect a Medicare provider agreement as described in part 489, subparts A, B, C, D, and E of this chapter.

(b) The physician certification and recertification requirements for home health services described in §424.22.

(c) All requirements contained in §§409.42 through 409.47.

[59 FR 65494, Dec. 20, 1994]

§ 409.42 Beneficiary qualifications for coverage of services.
To qualify for Medicare coverage of home health services, a beneficiary must meet each of the following requirements:

(a) Confined to the home. The beneficiary must be confined to the home or in an institution that is not a hospital, SNF or nursing facility as defined in section 1861(e)(1), 1819(a)(1) or 1919(a)(1) of the Act, respectively.

(b) Under the care of a physician. The beneficiary must be under the care of a physician who establishes the plan of care. A doctor of pediatric medicine may establish a plan of care only if that is consistent with the functions he or she is authorized to perform under State law.

(c) In need of skilled services. The beneficiary must need at least one of the following skilled services as certified by a physician in accordance with the physician certification and recertification requirements for home health services under §424.22 of this chapter.

(1) Intermittent skilled nursing services that meet the criteria for skilled services and the need for skilled services found in §409.32. (Also see §409.33(a) and (b) for a description of examples of skilled nursing and rehabilitation services.) These criteria are subject to the following limitations in the home health setting:
   (i) In the home health setting, management and evaluation of a patient care plan is considered a reasonable and necessary skilled service when underlying conditions or complications are such that only a registered nurse can ensure that essential non-skilled care is achieving its purpose. To be considered a skilled service, the complexity of the necessary unskilled services that are a necessary part of the medical treatment must require the involvement of licensed nurses to promote the patient's recovery and medical safety in view of the overall condition. 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. In some cases, the condition of the patient may cause a service that would originally be considered unskilled to be considered a skilled nursing service. This would occur when the patient's underlying condition or complication requires that only a registered nurse can ensure that essential non-skilled care is achieving its purpose. The registered nurse is ensuring that service is safely and effectively performed. However, a service is not considered a skilled nursing service merely because it is performed by or under the supervision of a licensed nurse. Where a service can be safely and effectively performed (or self administered) by non-licensed staff without the direct supervision of a nurse, the service cannot be regarded as a skilled service even if a nurse actually provides the service.
   (ii) In the home health setting, skilled education services are no longer needed if it becomes apparent, after a reasonable period of time, that the patient, family, or caregiver could not or would not be trained. Further teaching and training would cease to be reasonable and necessary in this case, and would cease to be considered a skilled service. Notwithstanding that the teaching or training was unsuccessful, the services for teaching and training would be considered to be reasonable and necessary prior to the point that it became apparent that the teaching or training was unsuccessful, as long as such services were appropriate to the patient's illness, functional loss, or injury.

(2) Physical therapy services that meet the requirements of §409.44(c).

(3) Speech-language pathology services that meet the requirements of §409.44(c).

(4) Continuing occupational therapy services that meet the requirements of §409.44(c) if the beneficiary's eligibility for home health services has been established by virtue of a prior need for
intermittent skilled nursing care, speech-language pathology services, or physical therapy in the current or prior certification period.

(d) Under a plan of care. The beneficiary must be under a plan of care that meets the requirements for plans of care specified in §409.43.

(e) By whom the services must be furnished. The home health services must be furnished by, or under arrangements made by, a participating HHA.


§ 409.43 Plan of care requirements.

(a) Contents. The plan of care must contain those items listed in §484.18(a) of this chapter that specify the standards relating to a plan of care that an HHA must meet in order to participate in the Medicare program.

(b) Physician's orders. The physician's orders for services in the plan of care must specify the medical treatments to be furnished as well as the type of home health discipline that will furnish the ordered services and at what frequency the services will be furnished. Orders for services to be provided "as needed" or "PRN" must be accompanied by a description of the beneficiary's medical signs and symptoms that would occasion the 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. Orders for care may indicate a specific range in frequency of visits to ensure that the most appropriate level of services is furnished. If a range of visits is ordered, the upper limit of the range is considered the specific frequency.

(c) Physician signature—(1) Request for Anticipated payment signature requirements. If the physician signed plan of care is not available at the time the HHA requests an anticipated payment of the initial percentage prospective payment in accordance with §484.205, the request for the anticipated payment must be based on—

(A) A physician’s verbal order that—

(B) Includes a description of the patient’s condition and the services to be provided by the home health agency;

(C) Includes an attestation (relating to the physician's orders and the date received) signed and dated by the registered nurse or qualified therapist (as defined in 42 CFR 484.4) responsible for furnishing or supervising the ordered services in the plan of care; and

(D) Is copied into the plan of care and the plan of care is immediately submitted to the physician;

(ii) A referral prescribing detailed orders for the services to be rendered that is signed and dated by a physician.

(2) Reduction or disapproval of anticipated payment requests. 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 as specified in paragraph (c)(1)(i) and/or a prescribing referral as specified in (c)(1)(ii) of this section 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 as defined in 42 U.S.C. 1320a-7a (i) (2)), the Civil False Claims Act (as defined in 31 U.S.C. 3729(c)), and the Criminal False Claims Act (18 U.S.C. 287)), the request for anticipated payment will be canceled and recovered unless the claim is submitted within the greater of 60 days from the end of the episode or 60 days from the issuance of the request for anticipated payment.

(3) Final percentage payment signature requirements. The plan of care must be signed and dated—

(i) By a physician as described who meets the certification and recertification requirements of §424.22 of this chapter; and

(ii) Before the claim for each episode for services is submitted for the final percentage prospective payment.

(4) Changes to the plan of care signature requirements. Any changes in the plan must be signed and dated by a physician.

(d) Oral (verbal) orders. If any services are provided based on a physician’s oral orders, the orders must be put in writing and be signed and dated with the date of receipt by the registered nurse or qualified therapist (as defined in §484.4 of this chapter) responsible for furnishing or supervising the ordered services. Oral orders may only be accepted by personnel authorized to do so by applicable State and Federal laws and regulations as well as by the HHA’s internal policies. The oral orders must also be countersigned and dated by the physician before the HHA bills for the care.

(e) Frequency of review. (1) The plan of care must be reviewed by the physician (as specified in §409.42(b)) in consultation with agency professional personnel at least every 60 days or more frequently when there is a—

(i) Beneficiary elected transfer;

(ii) Significant change in condition; or

(iii) Discharge and return to the same HHA during the 60-day episode.

(2) Each review of a beneficiary’s plan of care must contain the signature of the physician who reviewed it and the date of review.

(f) Termination of the plan of care. The plan of care is considered to be terminated if the beneficiary does not receive at least one covered skilled nursing,
physical therapy, speech-language pathology services, or occupational therapy visit in a 60-day period unless the physician documents that the interval without such care is appropriate to the treatment of the beneficiary's illness or injury.


§ 409.44 Skilled services requirements.

(a) General. The intermediary's decision on whether care is reasonable and necessary is based on information provided on the forms and in the medical record concerning the unique medical condition of the individual beneficiary. A coverage denial is not made solely on the basis of the reviewer's general inferences about patients with similar diagnoses or on data related to utilization generally but is based upon objective clinical evidence regarding the beneficiary's individual need for care.

(b) Skilled nursing care. (1) Skilled nursing care consists of those services that must, under State law, be performed by a registered nurse, or practical (vocational) nurse, as defined in §484.4 of this chapter, meet the criteria for skilled nursing services specified in §409.32, and meet the qualifications for coverage of skilled services specified in §409.42(c).

(ii) The skilled nursing care provided to the beneficiary must be reasonable within the context of the beneficiary's condition.

(iii) The determination of whether skilled nursing care is reasonable and necessary must be based solely upon the beneficiary's unique condition and individual needs, without regard to whether the illness or injury is acute, chronic, terminal, or expected to last a long time.

(c) Physical therapy, speech-language pathology services, and occupational therapy. To be covered, physical therapy, speech-language pathology services, and occupational therapy must satisfy the criteria in paragraphs (c)(1) through (4) of this section. Occupational therapy services initially qualify for home health coverage only if they are part of a plan of care that also includes intermittent skilled nursing care, physical therapy, or speech-language pathology services as follows:

(i) Speech-language pathology services and physical or occupational therapy services must relate directly and specifically to a treatment regimen (established by the physician, after any needed consultation with the qualified therapist) that is designed to treat the beneficiary's illness or injury. Services related to activities for the general physical welfare of beneficiaries (for example, exercises to promote overall fitness) do not constitute physical therapy, occupational therapy, or speech-language pathology services for Medicare purposes. To be covered by Medicare, all of the requirements apply as follows:

(ii) The patient's plan of care must describe a course of therapy treatment and therapy goals which are consistent with the evaluation of the patient's function, and both must be included in the clinical record. The therapy goals must be established by a qualified therapist in conjunction with the physician.

(ii) The patient's clinical record must include documentation describing how the course of therapy treatment for the patient's illness or injury is in accordance with accepted professional standards of clinical practice.

(iii) Therapy treatment goals described in the plan of care must be measurable, and must pertain directly to the patient's illness or injury, and the patient's resultant impairments.

(iv) The patient's clinical record must demonstrate that the method used to assess a patient's function included objective measurements of function in accordance with accepted professional standards of clinical practice enabling comparison of successive measurements to determine the effectiveness of therapy goals. Such objective measurements would be made by the qualified therapist using measurements which assess activities of daily living that may include but are not limited to eating, swallowing, bathing, dressing, toileting, walking,
climbing stairs, or using assistive devices, and mental and cognitive factors.

(2) Physical and occupational therapy and speech-language pathology services must be reasonable and necessary. To be considered reasonable and necessary, the following conditions must be met:

(i) The services must be considered under accepted standards of professional clinical practice, to be a specific, safe, and effective treatment for the beneficiary's condition. Each of the following requirements must also be met:

(A) The patient's function must be initially assessed and periodically reassessed by a qualified therapist, of the corresponding discipline for the type of therapy being provided, using a method which would include objective measurement as described in §409.44(c)(1)(iv). If more than one discipline of therapy is being provided, a qualified therapist from each of the disciplines must perform the assessment and periodic reassessments. The measurement results and corresponding effectiveness of the therapy, or lack thereof, must be documented in the clinical record.

(B) At least every 30 days a qualified therapist (instead of an assistant) must provide the needed therapy service and functionally reassess the patient in accordance with §409.44(c)(2)(i)(A). Where more than one discipline of therapy is being provided, a qualified therapist from each of the disciplines must provide the needed therapy service and functionally reassess the patient in accordance with §409.44(c)(2)(i)(A) at least every 30 days.

(C) If a patient is expected to require 13 therapy visits, a qualified therapist (instead of an assistant) must provide all of the therapy services on the 13th therapy visit and functionally reassess the patient in accordance with §409.44(c)(2)(i)(A). Exceptions to this requirement are as follows:

(I) The qualified therapist's visit can occur after the 10th therapy visit but no later than the 13th therapy visit when the patient resides in a rural area or when documented circumstances outside the control of the therapist prevent the qualified therapist's visit at the 13th therapy visit.

(2) Where more than one discipline of therapy is being provided, the qualified therapist from each discipline must provide all of the therapy services and functionally reassess the patient in accordance with §409.44(c)(2)(i)(A) during the visit associated with that discipline which is scheduled to occur close to but no later than the 13th therapy visit per the plan of care.

(D) If a patient is expected to require 19 therapy visits, a qualified therapist (instead of an assistant) must provide all of the therapy services on the 19th therapy visit and functionally reassess the patient in accordance with §409.44(c)(2)(A). Exceptions to this requirement are as follows:

(I) This required qualified therapist service can instead occur after the 16th therapy visit but no later than the 19th therapy visit when the patient resides in a rural area or documented circumstances outside the control of the therapist preclude the qualified therapist service at the 19th therapy visit.

(2) Where more than one discipline of therapy is being provided, the qualified therapist from each discipline must provide the therapy service and functionally reassess the patient in accordance with §409.44(c)(2)(i)(A) during the visit which would occur close to but before the 19th visit per the plan of care.

(E) Pursuant to the requirements described in paragraphs (c)(2)(i)(A)(B), (C), and (D) above, subsequent therapy visits will not be covered until the following conditions are met:

(I) The qualified therapist has completed the reassessment and objective measurement of the effectiveness of the therapy as it relates to the therapy goals.

(2) The qualified therapist has determined if goals have been achieved or require updating.

(3) The qualified therapist has documented measurement results and corresponding therapy effectiveness in the clinical record in accordance with §409.44(c)(2)(i)(H) of this section.

(F) If the criteria for maintenance therapy, described at §409.44(c)(2)(iii)(B) and (C) of this section are not met, the following criteria must also be met for subsequent therapy visits to be covered:

(I) If the measurement of the reassessment do not reveal progress toward goals, the qualified therapist together with the physician must determine whether the therapy is still effective or should be discontinued.

(2) If therapy is to be continued in accordance with §409.44(c)(2)(iv)(B) of this section, the clinical record must document with a clinically supportable statement why there is an expectation that the goals are attainable in a reasonable and generally predictable period of time.

(G) Clinical notes written by therapy assistants may supplement the clinical record, and if included, must include the date written, the signature, professional designation, and objective measurements or description of changes in status (if any) relative to each goal being addressed by treatment. Assistants may not make clinical judgments about why progress was or was not made, but must report the progress or the effectiveness of the therapy (or lack thereof) objectively.

(H) Documentation by a qualified therapist must include the following:

(I) The therapist's assessment of the effectiveness of the therapy as it relates to the therapy goals;

(2) Plans for continuing or discontinuing treatment with reference to evaluation results and or treatment plan revisions;
(3) Changes to therapy goals or an updated plan of care that is sent to the physician for signature or discharge;

(4) Documentation of objective evidence or a clinically supportable statement of expectation that the patient can continue to progress toward the treatment goals and is responding to therapy in a reasonable and generally predictable period of time; or in the case of maintenance therapy, the patient is responding to therapy and can meet the goals in a predictable period of time.

(ii) The services must be of such a level of complexity and sophistication or the condition of the beneficiary must be such that the services required can safely and effectively be performed only by a qualified physical therapist or by a qualified physical therapy assistant under the supervision of a qualified physical therapist, by a qualified speech-language pathologist, or by a qualified occupational therapist or a qualified occupational therapy assistant under the supervision of a qualified occupational therapist (as defined in §484.4 of this chapter). Services that do not require the performance or supervision of a physical therapist or an occupational therapist are not considered reasonable or necessary physical therapy or occupational therapy services, even if they are performed by or supervised by a physical therapist or occupational therapist. Services that do not require the skills of a speech-language pathologist are not considered to be reasonable and necessary speech-language pathology services even if they are performed by or supervised by a speech-language pathologist.

(iii) For therapy services to be covered in the home health setting, one of the following three criteria must be met:

(A) There must be an expectation that the beneficiary's condition will improve materially in a reasonable (and generally predictable) period of time based on the physician's assessment of the beneficiary's restoration potential and unique medical condition.

(1) Material improvement requires that the clinical record demonstrate that the patient is making improvement towards goals when measured against his or her condition at the start of treatment.

(2) If an individual's expected restorative potential would be insignificant in relation to the extent and duration of therapy services required to achieve such potential, therapy would not be considered reasonable and necessary, and thus would not be covered.

(3) When a patient suffers a transient and easily reversible loss or reduction of function which could reasonably be expected to improve spontaneously as the patient gradually resumes normal activities, because the services do not require the performance or supervision of a qualified therapist, those services are not to be considered reasonable and necessary covered therapy services.

(B) The unique clinical condition of a patient may require the specialized skills, knowledge, and judgment of a qualified therapist to design or establish a safe and effective maintenance program required in connection with the patient's specific illness or injury.

(1) If the services are for the establishment of a maintenance program, they must include the design of the program, the instruction of the beneficiary, family, or home health aides, and the necessary periodic reevaluations of the beneficiary and the program to the degree that the specialized knowledge and judgment of a physical therapist, speech-language pathologist, or occupational therapist is required.

(2) The maintenance program must be established by a qualified therapist (and not an assistant).

(C) The unique clinical condition of a patient may require the specialized skills of a qualified therapist to perform a safe and effective maintenance program required in connection with the patient's specific illness or injury. Where the clinical condition of the patient is such that the complexity of the therapy services required to maintain function involve the use of complex and sophisticated therapy procedures to be delivered by the therapist himself/herself (and not an assistant) or the clinical condition of the patient is such that the complexity of the therapy services required to maintain function must be delivered by the therapist himself/herself (and not an assistant) in order to ensure the patient's safety and to provide an effective maintenance program, then those reasonable and necessary services shall be covered.

(iv) The amount, frequency, and duration of the services must be reasonable and necessary, as determined by a qualified therapist and/or physician, using accepted standards of clinical practice.

(A) Where factors exist that would influence the amount, frequency or duration of therapy services, such as factors that may result in providing more services than are typical for the patient's condition, those factors must be documented in the plan of care and/or functional assessment.

(B) Clinical records must include documentation using objective measures that the patient continues to progress towards goals. If progress cannot be measured, and continued progress towards goals cannot be expected, therapy services cease to be covered except when—

(1) Therapy progress regresses or plateaus, and the reasons for lack of progress are documented to include justification that continued therapy treatment will lead to resumption of progress toward goals; or

(2) Maintenance therapy as described in 4109.44(c)(2)(iii)(B) or (C) is needed.

§ 409.45 Dependent services requirements.

(a) General. Services discussed in paragraphs (b) through (g) of this section may be covered only if the beneficiary needs skilled nursing care on an intermittent basis, as described in §409.44(b); physical therapy or speech-language pathology services as described in §409.44(c); or has a continuing need for occupational therapy services as described in §409.44(c) if the beneficiary's eligibility for home health services has been established by virtue of a prior need for intermittent skilled nursing care, speech-language pathology services, or physical therapy in the current or prior certification period; and otherwise meets the qualifying criteria (confined to the home, under the care of a physician, in need of skilled services, and under a plan of care) specified in §409.42. Home health coverage is not available for services furnished to a beneficiary who is no longer in need of one of the qualifying skilled services specified in this paragraph. Therefore, dependent services furnished after the final qualifying skilled service are not covered, except when the dependent service was not followed by a qualifying skilled service as a result of the unexpected inpatient admission or death of the beneficiary, or due to some other unanticipated event.

(b) Home health aide services. To be covered, home health aide services must meet each of the following requirements:

(1) The reason for the visits by the home health aide must be to provide hands-on personal care to the beneficiary or services that are needed to maintain the beneficiary's health or to facilitate treatment of the beneficiary's illness or injury. The physician's order must indicate the frequency of the home health aide services required by the beneficiary. These services may include but are not limited to:

(i) Personal care services such as bathing, dressing, grooming, caring for hair, nail and oral hygiene that are needed to facilitate treatment or to prevent deterioration of the beneficiary's health, changing the bed linens of an incontinent beneficiary, shaving, deodorant application, skin care with lotions and/or powder, foot care, ear care, feeding, assistance with elimination (including enemas unless the skills of a licensed nurse are required due to the beneficiary's condition, routine catheter care, and routine colostomy care), assistance with ambulation, changing position in bed, and assistance with transfers.

(ii) Simple dressing changes that do not require the skills of a licensed nurse.

(iii) Assistance with medications that are ordinarily self-administered and that do not require the skills of a licensed nurse to be provided safely and effectively.

(iv) Assistance with activities that are directly supportive of skilled therapy services but do not require the skills of a therapist to be safely and effectively performed, such as routine maintenance exercises and repetitive practice of functional communication skills to support speech-language pathology services.

(v) Routine care of prosthetic and orthotic devices.

(2) The services to be provided by the home health aide must be—

(i) Ordered by a physician in the plan of care; and

(ii) Provided by the home health aide on a part-time or intermittent basis.

(3) The services provided by the home health aide must be reasonable and necessary. To be considered reasonable and necessary, the services must—

(i) Meet the requirement for home health aide services in paragraph (b)(1) of this section;

(ii) Be of a type the beneficiary cannot perform for himself or herself; and

(iii) Be of a type that there is no able or willing caregiver to provide, or, if there is a potential caregiver, the beneficiary is unwilling to use the services of that individual.

(4) The home health aide also may perform services incidental to a visit that was for the provision of care as described in paragraphs (b)(3)(i) through (iii) of this section. For example, these incidental services may include changing bed linens, personal laundry, or preparing a light meal.

(c) Medical social services. Medical social services may be covered if the following requirements are met:

(1) The services are ordered by a physician and included in the plan of care.

(2)(i) The services are necessary to resolve social or emotional problems that are expected to be an impediment to the effective treatment of the beneficiary's medical condition or to his or her rate of recovery.

(ii) If these services are furnished to a beneficiary's family member or caregiver, they are furnished on a short-term basis and it can be demonstrated that the service is necessary to resolve a clear and direct impediment to the effective treatment of the beneficiary's medical condition or to his or her rate of recovery.

(3) The frequency and nature of the medical social services are reasonable and necessary to the treatment of the beneficiary's condition.

(4) The medical social services are furnished by a qualified social worker or qualified social work assistant under the supervision of a social worker as defined in §484.4 of this chapter.

(5) The services needed to resolve the problems that are impeding the beneficiary's recovery require the skills of a social worker or a social work assistant under the supervision of a social worker to be performed safely and effectively.

(d) Occupational therapy. Occupational therapy services that are not qualifying services under §409.44(c) are nevertheless covered as dependent services if the requirements of §409.44(c)(2)(i)
through (iv), as to reasonableness and necessity, are met.

(c) Durable medical equipment. Durable medical equipment in accordance with \$410.38 of this chapter, which describes the scope and conditions of payment for durable medical equipment under Part B, may be covered under the home health benefit as either a Part A or Part B service. Durable medical equipment furnished by an HHA as a home health service is always covered by Part A if the beneficiary is entitled to Part A.

(f) Medical supplies. Medical supplies (including catheters, catheter supplies, ostomy bags, and supplies relating to ostomy care but excluding drugs and biologicals) may be covered as a home health benefit. For medical supplies to be covered as a Medicare home health benefit, the medical supplies must be needed to treat the beneficiary's illness or injury that occasioned the home health care.

(g) Intern and resident services. The medical services of interns and residents in training under an approved hospital teaching program are covered if the services are ordered by the physician who is responsible for the plan of care and the HHA is affiliated with or under the common control of the hospital furnishing the medical services.

Approved means—

(1) Approved by the Accreditation Council for Graduate Medical Education;

(2) In the case of an osteopathic hospital, approved by the Committee on Hospitals of the Bureau of Professional Education of the American Osteopathic Association;

(3) In the case of an intern or resident-in-training in the field of dentistry, approved by the Council on Dental Education of the American Dental Association; or

(4) In the case of an intern or resident-in-training in the field of podiatry, approved by the Council on Podiatric Medical Education of the American Podiatric Medical Association.

[59 FR 65495, Dec. 20, 1994; 60 FR 39122, 39123, Aug. 1, 1995]
§ 409.33 Examples of skilled nursing and rehabilitation services.

(a) Services that could qualify as other skilled nursing or skilled rehabilitation services—(1) Overall management and evaluation of care plan. (1) When overall management and evaluation of care plan constitutes skilled services. The management and evaluation of a patient's physical or mental condition, those activities require the involvement of technical or professional personnel in order to meet the patient's needs, promote recovery, and ensure medical safety. Those activities include the management of a plan involving a variety of personal care services only when, in light of the patient's condition, the aggregate of those services requires the involvement of technical or professional personnel.

(b) Example. An aged patient with a history of diabetes mellitus and angina pectoris who is recovering from an open reduction of a fracture of the neck of the femur requires, among other services, careful skin care, appropriate oral medications, a diabetic diet, an exercise program to preserve muscle tone and body condition, and observation to detect signs of deterioration in his or her condition or complications resulting from restricted, but increasing, mobility. Although any of the required services could be performed by a properly instructed person, such a person would not have the ability to understand the relationship between the services and evaluate the ultimate effect of one service on the other. Since the nature 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. Under these circumstances, the management of the plan of care would require the skills of a nurse even though the individual services are not skilled. Skilled planning and management activities are not always specifically identified in the patient's clinical record. Therefore, if the patient's overall condition supports a finding that recovery and safety can be ensured...
§ 409.33

only if the total care is planned, managed, and evaluated by technical or professional personnel, it is appropriate to infer that skilled services are being provided. (2) Observation and assessment of the patient’s changing condition—(i) When observation and assessment constitute skilled services. Observation and assessment constitute skilled services when the skills of a technical or professional person are required to identify and evaluate the patient’s need for modification of treatment or for additional medical procedures until his or her condition is stabilized. (ii) Examples. A patient with congestive heart failure may require continuous close observation to detect signs of decompensation, abnormal fluid balance, or adverse effects resulting from prescribed medication(s) that serve as indicators for adjusting therapeutic measures. Similarly, surgical patients transferred from a hospital to an SNF while in the complicated, unstabilized preoperative period, for example, after hip prosthesis or cataract surgery, may need continued close skilled monitoring for postoperative complications and adverse reaction. Patients who, in addition to their physical problems, exhibit acute psychological symptoms such as depression, anxiety, or agitation, may also require skilled observation and assessment by technical or professional personnel to ensure their safety or the safety of others, that is, to observe for indications of suicidal or hostile behavior. The need for services of this type must be documented by physicians’ orders or nursing or therapy notes. (b) Patient education services—(1) When patient education services constitute skilled services. Patient education services are skilled services if the use of technical or professional personnel is necessary to teach a patient self-maintenance. (ii) Examples. A patient who has had a recent leg amputation needs skilled rehabilitation services provided by technical or professional personnel to provide gait training and to teach prosthesis care. Similarly, a patient newly diagnosed with diabetes requires instruction from technical or professional personnel to learn the self-ad-

ministration of insulin or foot-care precautions. (b) Services that qualify as skilled nursing services. (1) Intravenous or intramuscular injections and intravenous feeding; (2) Enteral feeding that comprises at least 26 per cent of the patient’s daily calorie requirements and provides at least 501 milliliters of fluid per day; (3) Nasopharyngeal and tracheostomy aspiration; (4) Insertion and sterile irrigation and replacement of suprapubic catheters; (5) Application of dressings involving prescription medications and aseptic techniques; (6) Treatment of extensive decubitus ulcers or other widespread skin disorders; (7) Heat treatments which have been specifically ordered by a physician as part of active treatment and which require observation by nurses to adequately evaluate the patient’s response; (8) Initial phases of a regimen involving administration of medical gases; (9) Rehabilitation nursing procedures, including the related teaching and adaptive aspects of nursing, that are part of active treatment, e.g., the institution and supervision of bowel and bladder training programs. (c) Services which would qualify as skilled rehabilitation services. (1) Ongoing assessment of rehabilitation needs and potential: Services concurrent with the management of a patient care plan, including, tests and measurements of range of motion, strength, balance, coordination, endurance, functional ability, activities of daily living, perceptual-deficits, speech and language or hearing disorders; (2) Therapeutic exercises or activities: Therapeutic exercises or activities which, because of the type of exercises employed or the condition of the patient, must be performed by or under the supervision of a qualified physical therapist or occupational therapist to ensure the safety of the patient and the effectiveness of the treatment; (3) Gait evaluation and training: Gait evaluation and training furnished to restore function in a patient whose ability to walk has been impaired by
neurological, muscular, or skeletal abnormality;

(4) Range of motion exercises: Range of motion exercises which are part of the active treatment of a specific disease state which has resulted in a loss of, or restriction of, mobility (as evidenced by a therapist's notes showing the degree of motion lost and the degree to be restored);

(5) Maintenance therapy: Maintenance therapy, when the specialized knowledge and judgment of a qualified therapist is required to design and establish a maintenance program based on an initial evaluation and periodic reassessment of the patient's needs, and consistent with the patient's capacity and tolerance. For example, a patient with Parkinson's disease who has not been under a rehabilitation regimen may require the services of a qualified therapist to determine what type of exercises will contribute the most to the maintenance of his present level of functioning.

(6) Ultrasound, short-wave, and microwave therapy treatment by a qualified physical therapist;

(7) Hot pack, hydrocollator, infrared treatments, paraffin baths, and whirlpool; Hot pack hydrocollator, infrared treatments, paraffin baths, and whirlpool in particular cases where the patient's condition is complicated by circulatory deficiency, areas of desensitization, open wounds, fractures, or other complications, and the skills, knowledge, and judgment of a qualified physical therapist are required; and

(8) Services of a speech pathologist or audiologist when necessary for the restoration of function in speech or hearing;

(9) Personal care services. Personal care services which do not require the skills of qualified technical or professional personnel are not skilled services except under the circumstances specified in §409.32(b). Personal care services include, but are not limited to, the following:

(1) Administration of routine oral medications, eye drops, and ointments;

(2) General maintenance care of colostomy and ileostomy;

(3) Routine services to maintain satisfactory functioning of indwelling bladder catheters;

(4) Changes of dressings for non-infected postoperative or chronic conditions;

(5) Prophylactic and palliative skin care, including bathing and application of creams, or treatment of minor skin problems;

(6) Routine care of the incontinent patient, including use of diapers and protective sheets;

(7) General maintenance care in connection with a plaster cast;

(8) Routine care in connection with braces and similar devices;

(9) Use of heat as a palliative and comfort measure, such as whirlpool and hydrocollator;

(10) Routine administration of medical gases after a regimen of therapy has been established;

(11) Assistance in dressing, eating, and going to the toilet;

(12) Periodic turning and positioning in bed; and

(13) General supervision of exercises which have been taught to the patient; including the actual carrying out of maintenance programs, i.e., the performance of the repetitive exercises required to maintain function do not require the skills of a therapist and would not constitute skilled rehabilitation services (see paragraph (c) of this section). Similarly, repetitious exercises to improve gait, maintain strength, or endurance, passive exercises to maintain range of motion in paralyzed extremities, which are not related to a specific loss of function, and assistive walking do not constitute skilled rehabilitation services.

30 - Conditions Patient Must Meet to Qualify for Coverage of Home Health Services  
(Rev. 1, 10-01-03)  
A3-3117, HHA-204, A-98-49  

To qualify for the Medicare home health benefit, under §§1814(a)(2)(C) and 1833(a)(2)(A) of the Act, a Medicare beneficiary must meet the following requirements:

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

For purposes of benefit eligibility, under §§1814(a)(2)(C) and 1833(a)(2)(A) of the Act, "intermittent" means skilled nursing care that is either provided or needed on fewer than 7 days each week or less than 8 hours of each day for periods of 21 days or less (with extensions in exceptional circumstances when the need for additional care is finite and predictable).

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

30.1 - Confined to the Home  
(Rev. 1, 10-01-03)  
A3-3117.1, HHA-204.1

30.1.1 - Patient Confined to the Home  
(Rev. 1, 10-01-03)  

In order 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. An individual does not have to be bedridden to be considered confined to the home. However, the condition of these patients should be such that there exists a normal inability to leave home and, consequently, leaving home would require a considerable and taxing effort.
If the patient does in fact leave the home, the patient may nevertheless be considered homebound if the absences from the home are infrequent or for periods of relatively short duration, or are attributable to the need to receive health care treatment. Absences attributable to the need to receive health care treatment include, but are not limited to:

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

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

Generally speaking, a patient will be considered to be homebound if they have a condition due to an illness or injury that restricts their ability to leave their place of residence except with the aid of: supportive devices such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the assistance of another person; or if leaving home is medically contraindicated.

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

- A patient paralyzed from a stroke who is confined to a wheelchair or requires the aid of crutches in order to walk;
- A patient who is blind or senile and requires the assistance of another person in leaving their place of residence;
- A patient who has lost the use of their upper extremities and, therefore, is unable to open doors, use handrails on stairways, etc., and requires the assistance of another individual to leave their place of residence;
• A patient in the late stages of ALS or neurodegenerative disabilities. In determining whether the patient has the general inability to leave the home and leaves the home only infrequently or for periods of short duration, it is necessary (as is the case in determining whether skilled nursing services are intermittent) to look at the patient’s condition over a period of time rather than for short periods within the home health stay. For example, a patient may leave the home (under the conditions described above, e.g., with severe and taxing effort, with the assistance of others) more frequently during a short period when, for example, the presence of visiting relatives provides a unique opportunity for such absences, than is normally the case. So long as the patient’s overall condition and experience is such that he or she meets these qualifications, he or she should be considered confined to the home.

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

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

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

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

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

If a question is raised as to whether a patient is confined to the home, the HHA will be requested to furnish the intermediary with the information necessary to establish that the patient is homebound as defined above.
30.1.2 - Patient's Place of Residence
(Rev. 1, 10-01-03)
A3-3117.1.B, HHA-204.1.B

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

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

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

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

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

- Diagnostic and therapeutic services for medical diagnosis;
- Treatment;
- Care of disabled or sick persons;
- Rehabilitation services for the rehabilitation of injured, disabled, or sick persons;
- Skilled nursing care or related services for patients who require medical or nursing care; or
- Rehabilitation services for the rehabilitation of injured, sick, or disabled persons.
If it is determined that the assisted living facility (also called personal care homes, group homes, etc.) in which the individuals reside are not primarily engaged in providing the above services, then Medicare will cover reasonable and necessary home health care furnished to these individuals.

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

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

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

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

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

C. State Licensure/Certification of Day Care Facilities

Section 1861(m) of the Act, an adult day care center must be either licensed or certified by the State or accredited by a private accrediting body. State licensure or certification as an adult day care facility must be based on State interpretations of its process. For example, several States do not license adult day care facilities as a whole, but do certify 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.
40.1.1 - General Principles Governing Reasonable and Necessary Skilled Nursing Care
(Rev. 1, 10-01-03)
A3-3118.1, HHA-205.1

A skilled nursing service is a service that must be provided by a registered nurse or a licensed practical (vocational) nurse under the supervision of a registered nurse to be safe and effective. In determining whether a service requires the skills of a nurse, the reviewer considers both the inherent complexity of the service, the condition of the patient and accepted standards of medical and nursing practice.

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. 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.

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.

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.

A service is not considered a skilled nursing service merely because it is performed by or under the direct supervision of a nurse. If a service can be safely and effectively performed (or self-administered) by a nonmedical 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. Similarly, the unavailability of a competent person to provide a nonskilled service, notwithstanding the importance of the service to the patient, does not make it a skilled service when a nurse provides the service.
EXAMPLE 1:

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 2:

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, the care does not become a skilled nursing service when the nurse provides it.

A service which, 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. Where the patient needs the skilled nursing care and there is no one trained, able and willing to provide it, the services of a nurse would be reasonable and necessary to the treatment of the illness or injury.

EXAMPLE 3:

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.

4. 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. A patient's overall medical condition is a valid factor 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.

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.
EXAMPLE 1:

A physician has ordered skilled nursing visits for a patient with a hairline fracture of the hip. In the absence of any underlying medical condition or illness, nursing visits would not be reasonable and necessary for treatment of the patient's hip injury.

EXAMPLE 2:

A physician has ordered skilled nursing visits for injections of insulin and teaching of self-administration and self-management of the medication regimen for a patient with diabetes mellitus. Insulin has been shown to be a safe and effective treatment for diabetes mellitus, and therefore, the skilled nursing visits for the injections and the teaching of self-administration and management of the treatment regimen would be reasonable and necessary.

The determination of whether a patient needs skilled nursing care should be based solely upon the patient's unique condition and individual needs, without regard to whether the illness or injury is acute, chronic, terminal, or expected to extend over a long period of time. In addition, skilled care may, depending on the unique condition of the patient, continue to be necessary for patients whose condition is stable.

EXAMPLE 3:

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. Periodic visits to change the catheter as needed, treat the symptoms of catheter malfunction, and teach proper patient care would be covered as long as they are reasonable and necessary, although the patient is stable and there is an expectation that the care will be needed for a long and indefinite period.

EXAMPLE 4:

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 skilled nursing care the patient needs for a short period would be covered despite the chronic nature of the illness.

EXAMPLE 5:

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 skilled nursing care that the patient requires would be covered, notwithstanding that the condition is terminal, because the services require the skills of a nurse.
40.1.2 - Application of the Principles to Skilled Nursing Services
(Rev. 1, 10-01-03)
A3-3118.1.B, HHA-205.1.B

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

40.1.2.1 - Observation and Assessment of the Patient's Condition When Only the Specialized Skills of a Medical Professional Can Determine Patient's Status
(Rev. 1, 10-01-03)
A3-3118.1.B.1, HHA-205.1.B.1

Observation and assessment of the patient's condition by a nurse are reasonable and necessary skilled services when the likelihood of change in a patient's condition 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 treatment regimen is essentially 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 three weeks or so long as there remains a reasonable potential for such a complication or further acute episode.

Information from the patient's medical history may support the likelihood of a future complication or acute episode and, therefore, may justify the need for continued skilled observation and assessment beyond 3-week period. Moreover, such indications 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 indications are such that it is likely 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. There are cases where patients who are stable continue to require skilled observation and assessment. (See examples below.) However, observation and assessment by a nurse is not reasonable and necessary to the treatment of the illness or injury where these indications are part of a longstanding pattern of the patient's condition, and there is no attempt to change the treatment to resolve them.

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 prescribed medication. Skilled observation is needed to determine whether the drug regimen should be modified or whether other therapeutic measures should be considered until the patient's treatment regimen is essentially stabilized.
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. Skilled observation and monitoring of the vascular supply of the legs and the incision site is required until the signs of potential infection have abated and there is no longer a reasonable potential of infection.

EXAMPLE 3:
A patient was hospitalized following a heart attack, and following treatment but before mobilization, is discharged home. Because it is not known whether exertion will exacerbate the heart disease, skilled observation is reasonable and necessary as mobilization is initiated until the patient’s treatment regimen is essentially 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.

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.

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.

40.1.2.2 - Management and Evaluation of a Patient Care Plan
(Rev. 1, 10-01-03)
A3-3118.1.B.2, HHA-205.1.B.2

Skilled nursing visits for management and evaluation of the patient's care plan are also reasonable and necessary where underlying conditions or complications require that only
a registered nurse can ensure that essential nonskilled 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 the patient's treatment regimen is essentially stabilized.

EXAMPLE 2:

An aged patient with a history of mild dementia is recovering from pneumonia which has been treated at home. The patient has had an increase in disorientation, has residual chest congestion, decreased appetite, and has remained in bed, immobile, throughout the episode with pneumonia. While the residual chest congestion and recovery from pneumonia alone would not represent a high risk factor, the patient's immobility and increase in confusion could create a high probability of a relapse. In this situation, skilled oversight of the nonskilled 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.

Where visits by a licensed nurse are not needed to observe and assess the effects of the nonskilled 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 two 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.
Medicare Benefit Policy Manual
Pub. 100-02, Ch. 7, §40.1.3

40.1.3 - Intermittent Skilled Nursing Care
(Rev. 1, 10-01-03)

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

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

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

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

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

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

There is a possibility that a physician may order a skilled visit less frequently than once every 60 days for an eligible beneficiary if there exists an extraordinary circumstance of anticipated patient need that is documented in the patient's plan of care in accordance with 42 CFR 409.43(b). A skilled visit frequency of less than once every 60 days would only be covered if it is specifically ordered by a physician in the patient's plan of care and is considered to be a reasonable, necessary, and medically predictable skilled need for the patient in the individual circumstance.
Where the need for "intermittent" skilled nursing visits is medically predictable but a situation arises after the first visit making additional visits unnecessary, e.g., the patient is institutionalized or dies, the one visit would be paid at the wage-adjusted LUPA amount for that discipline type. However, a one-time order; e.g., to give gamma globulin following exposure to hepatitis, would not be considered a need for "intermittent" skilled nursing care since a recurrence of the problem that would require this service is not medically predictable.

Although most patients require services no more frequently than several times a week, Medicare will pay for part-time (as defined in §50.7) medically reasonable and necessary skilled nursing care seven days a week for a short period of time (two to three weeks). There may also be a few cases involving unusual circumstances where the patient's prognosis indicates the medical need for daily skilled services will extend beyond three weeks. As soon as the patient's physician makes this judgment, which usually should be made before the end of the 3-week period, the HHA must forward medical documentation justifying the need for such additional services and include an estimate of how much longer daily skilled services will be required.

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