# Coverage Summary

## Home Health Services and Home Health Visits

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<td>Approved by:</td>
<td>UnitedHealthcare Medicare Benefit Interpretation Committee</td>
<td>Last Review Date: 08/21/2018</td>
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**Related Medicare Advantage Policy Guidelines:**

- Home Health Nurses' Visits to Patients Requiring Heparin Injection (NCD 290.2)
- Home Health Visits to a Blind Diabetic (290.1)

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The benefit information in this Coverage Summary is based on existing national coverage policy, however, Local Coverage Determinations (LCDs) may exist and compliance with these policies is required where applicable.

There are instances where this document may direct readers to a UnitedHealthcare Commercial Medical Policy, Medical Benefit Drug Policy, and/or Coverage Determination Guideline (CDG). In the absence of a Medicare National Coverage Determination (NCD), Local Coverage Determination (LCD), or other Medicare coverage guidance, CMS allows a Medicare Advantage Organization (MAO) to create its own coverage determinations, using objective evidence-based rationale relying on authoritative evidence. (Medicare IOM Pub. No. 100-16, Ch. 4, §90.5).

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## I. COVERAGE

**Coverage Statement:** Home health services are covered when Medicare coverage criteria are met.

**Guidelines/Notes:**

1. **a.** Home health services are covered when all of the following criteria are met:
   
   1) Member must be homebound or confined to an institution that is not a hospital or is not primarily engaged in providing skilled nursing or rehabilitation services. Refer to the Medicare Benefit Policy Manual, Chapter 7, §30.1 - Confined to the Home. (Accessed August 13, 2018)

   See Guideline #1.b for coverage information pertaining to homebound and Guideline #1.c for place of residence.

   2) The member must be in need skilled nursing care on an intermittent basis (other than solely venipuncture for the purposes of obtaining a blood sample), physical therapy, speech-language pathology services, or has continued need for occupational therapy. (See Section II for definitions of intermittent visit; part time or intermittent). Refer to


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### II. DEFINITIONS

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Note: Home health aide and/or skilled nursing care in excess of the amounts of care that meet these definitions of part-time or intermittent may be provided to a home care patient or purchased by other payers without bearing on whether the home health aide and skilled nursing care meets the definitions of part-time or intermittent. Refer to the Medicare Benefit Policy Manual, Chapter 7, § 50.7.1 - Impact on Care Provided in Excess of "Intermittent" or "Part-Time" Care. (Accessed August 13, 2018)

3) Member must be under the care of a physician in accordance with 42 CFR 424.22 and the home health care services must be furnished under a plan of care that is established, periodically reviewed and ordered by a physician.

A patient is expected to be under the care of the physician who signs the plan of care. It is expected that in most instances, the physician who certifies the patient’s eligibility for home health services, in accordance with §30.5 below, will be the same physician who establishes and signs the plan of care.

Refer to the Medicare Benefit Policy Manual, Chapter 7, § 30.3 - Under the Care of a Physician. (Accessed August 13, 2018)

Also see the Medicare Benefit Policy Manual, Chapter 7, § 30.5 - Physician Certification. (Accessed August 13, 2018)

b. Homebound (Confined to the Home)

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 shall be considered “confined to the home” (homebound) if the following two criteria are met:

1) Criterion One:
   - The patient must either:
     - Because of illness or injury, need the aid of supportive devices such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the assistance of another person in order to leave their place of residence; OR
     - Have a condition such that leaving his or her home is medically contraindicated.

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

2) Criterion Two:
   - There must exist a normal inability to leave home; AND
   - Leaving home must require a considerable and taxing effort.


c. Place of Residence

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. 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.
• **Assisted Living Facilities (also called Group Homes and Personal Care Homes)**
  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 these institutions when provision of such care is required of the facility under State licensure requirements, such services will be denied.

• **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 a home health agency (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.

*Refer to the Medicare Benefit Policy Manual, Chapter 7, §30.1.2 - Patient’s Place of Residence. (Accessed August 13, 2018)*

**d. Use of Utilization Screens and "Rules of Thumb"**

Medicare recognizes that determinations of whether home health services are reasonable and necessary must be based on an assessment of each beneficiary's individual care needs. Therefore, denial of services based on numerical utilization screens, diagnostic screens, diagnosis or specific treatment norms is not appropriate. *Refer to the Medicare Benefit Policy Manual, Chapter 7,§20.3 Use of Utilization Screens and "Rules of Thumb". (Accessed August 13, 2018)*

**e. Face-to-Face Home Health Certification Requirement**

As part of the certification of patient eligibility for the Medicare home health benefit, a face-to-face encounter with the patient must be performed by the certifying physician himself or herself, a physician that cared for the patient in the acute or post-acute care facility (with privileges who cared for the patient in an acute or post-acute care facility from which the patient was directly admitted to home health) or an allowed non-physician practitioner (NPP).

**Timeframe Requirements**

- The encounter must occur no more than 90 days prior to the home health start of care date or within 30 days after the start of care.
- In situations when a physician orders home health care for the patient based on a new condition that was not evident during a visit within the 90 days prior to start of care, the certifying physician or an allowed NPP must see the patient again within 30 days after admission. Specifically, if a patient saw the certifying physician or NPP within the 90 days prior to start of care, another encounter would be needed if the patient’s condition had changed to the extent that standards of practice would indicate that the physician or a non-physician practitioner should examine the patient in order to establish an effective treatment plan.
Note: UnitedHealthcare Medicare Advantage Plans follow these requirements.

See the Medicare Benefit Policy Manual, Chapter 7, §30.5.1.1 - 30.5.1.2 – Face-to-Face Encounter. (Accessed August 13, 2018)


f. Outpatient Services
The home health care services must be furnished on a per visit basis in the member’s place of residence. Services may be furnished on an outpatient basis in a hospital, SNF, or rehabilitation center if it is necessary to use equipment that is not available in the member’s place of residence. Refer to the Medicare Benefit Policy Manual, Chapter 7, §50.6. (Accessed August 13, 2018)

Note: The HHA that is providing the services to the patient has in effect a valid agreement to participate in the Medicare program. See the Medicare Benefit Policy Manual, Chapter 7, §20 - Conditions To Be Met for Coverage of Home Health Service. (Accessed August 13, 2018)

g. Frequency of Review of Plan of Care
The plan of care must be reviewed in consultation with home health agency (HHA) professional personnel, and signed by the physician who established the plan, at least every 60 days. See the Medicare Benefit Policy Manual, Chapter 7, §30.2.6. (Accessed August 13, 2018)

Note: The HHA that is providing the services to the patient has in effect a valid agreement to participate in the Medicare program. See the Medicare Benefit Policy Manual, Chapter 7, §20 - Conditions To Be Met for Coverage of Home Health Service. (Accessed August 13, 2018)

h. Physician Recertification
Medicare does not limit the number of continuous episode recertifications for beneficiaries who continue to be eligible for the home health benefit. The physician certification may cover a period less than but not greater than 60 days. For more detailed guidance, see the Medicare Benefit Policy Manual, Chapter 7, §30.5.2. (Accessed August 13, 2018)

i. Impact of Other Available Caregivers and Other Available Coverage on Medicare Coverage of Home Health Services
Where the Medicare criteria for coverage of home health services are met, patients are entitled by law to coverage of reasonable and necessary home health services. A patient is entitled to have the costs of reasonable and necessary services reimbursed by Medicare without regard to whether there is someone available to furnish the services. However, when a family member or other person is or will be providing services that adequately meet the patient’s needs, it would not be reasonable and necessary for HHA personnel to furnish such services.

Similarly, a patient is entitled to reasonable and necessary Medicare home health services even if the patient would qualify for institutional care (e.g., hospital care or skilled nursing facility care) and Medicare payment should be made for reasonable and necessary home health services where the patient is also receiving supplemental services that do not meet Medicare’s definition of skilled nursing care or home health aide services.

2. **Skilled Nursing Care**

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

For more detailed benefit information and examples, refer to the Medicare Benefit Policy Manual, Chapter 7, §40.1- Skilled Nursing Care. (Accessed August 13, 2018)

a. **General Principles Governing Reasonable and Necessary Skilled Nursing Care**

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

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

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, without regard to whether the illness or injury is acute, chronic, terminal, or expected to extend over a long period of time, should be considered in deciding whether skilled services are needed. A patient's diagnosis should never be the sole factor in deciding that a service the patient needs is either skilled or not skilled. Skilled care may, depending on the unique condition of the patient, continue to be necessary for patients whose condition is stable.

For more detailed benefit information and examples, refer to the Medicare Benefit Policy Manual, Chapter 7, §40.1.1 - General Principles Governing Reasonable and Necessary Skilled Nursing Care. (Accessed August 13, 2018)

b. **Application of the Principles to Skilled Nursing Services**
1) **Observation and assessment of the patient's condition when only the specialized skills of a medical professional can determine the patient's status**

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

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

*See the Medicare Benefit Policy Manual, Chapter 7, §40.1.2.1 - Observation and Assessment of the Patient's Condition When Only the Specialized Skills of a Medical Professional Can Determine Patient's Status. (Accessed August 13, 2018)*

2) **Management and Evaluation of a Patient Care Plan**

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

*For specific examples, refer to the Medicare Benefit Policy Manual, Chapter 7, §40.1.2.2 - Management and Evaluation of a Patient Care Plan. (Accessed August 13, 2018)*

3) **Teaching and Training Activities**

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

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

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

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

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

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

- Teaching the self-administration of injectable medications, or a complex range of medications;
- Teaching a newly diagnosed diabetic or caregiver all aspects of diabetes management, including how to prepare and to administer insulin injections, to prepare and follow a diabetic diet, to observe foot-care precautions, and to observe for and understand signs of hyperglycemia and hypoglycemia;
- Teaching self-administration of medical gases;
- Teaching wound care where the complexity of the wound, the overall condition of the patient or the ability of the caregiver makes teaching necessary;
- Teaching care for a recent ostomy or where reinforcement of ostomy care is needed;
- Teaching self-catheterization;
- Teaching self-administration of gastrostomy or enteral feedings;
- Teaching care for and maintenance of peripheral and central venous lines and administration of intravenous medications through such lines;
- Teaching bowel or bladder training when bowel or bladder dysfunction exists;
- Teaching how to perform the activities of daily living when the patient or caregiver must use special techniques and adaptive devices due to a loss of function;
- Teaching transfer techniques, e.g., from bed to chair, that are needed for safe transfer;
- Teaching proper body alignment and positioning, and timing techniques of a bed-bound patient;
- Teaching ambulation with prescribed assistive devices (such as crutches, walker, cane, etc.) that are needed due to a recent functional loss;
- Teaching prosthesis care and gait training;
- Teaching the use and care of braces, splints and orthotics and associated skin care;
- Teaching the preparation and maintenance of a therapeutic diet; and
- Teaching proper administration of oral medication, including signs of side-effects and avoidance of interaction with other medications and food.
- Teaching the proper care and application of any special dressings or skin treatments, (for example, dressings or treatments needed by patients with severe or widespread fungal infections, active and severe psoriasis or eczema, or due to skin deterioration due to radiation treatments).

For specific examples, refer to the Medicare Benefit Policy Manual, Chapter 7, §40.1.2.3 - Teaching and Training Activities. (Accessed August 13, 2018)

4) Administration of Medications
   a) Vitamin B-12 Injections
   Vitamin B-12 injections are considered specific therapy only for the following conditions:
   - Specified anemias: pernicious anemia, megaloblastic anemias, macrocytic anemias, fish tapeworm anemia;
   - Specified gastrointestinal disorders: gastrectomy, malabsorption syndromes such as sprue and idiopathic steatorrhea, surgical and mechanical disorders such as resection of the small intestine, strictures, anastomosis and blind loop syndrome, and
   - Certain neuropathies: posterolateral sclerosis, other neuropathies associated with pernicious anemia, during the acute phase or acute exacerbation of a neuropathy due to malnutrition and alcoholism.

Note: For a patient with pernicious anemia caused by a B-12 deficiency, intramuscular or subcutaneous injection of vitamin B-12 at a dose of from 100 to 1000 micrograms no more frequently than once monthly is the accepted reasonable and necessary dosage schedule for maintenance treatment. More frequent injections would be appropriate in the initial or acute phase of the disease until it has been determined through laboratory tests that the patient can be sustained on a maintenance dose.

See the Medicare Benefit Policy Manual, Chapter 7, §40.1.2.4 - Administration of Medications. (Accessed August 13, 2018)

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

See the *Medicare Benefit Policy Manual, Chapter 7, §40.1.2.4 - Administration of Medications.* (Accessed August 13, 2018)

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

See the *Medicare Benefit Policy Manual, Chapter 7, §40.1.2.4- Administration of Medications.* (Accessed August 13, 2018)

d) **Eye Drops and Topical Ointments**
The administration of eye drops and topical ointments does not require the skills of a nurse. Therefore, even if the administration of eye drops or ointments is necessary to the treatment of an illness or injury and the patient cannot self-administer the drops, and there is no one available to administer them, the visits cannot be covered as a skilled nursing service. This section does not eliminate coverage for skilled nursing visits for observation and assessment of the patient's condition.

See the *Medicare Benefit Policy Manual, Chapter 7 Home Health Services, §40.1.2.4 – Administration of Medications.* (Accessed August 13, 2018)

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

See the *Medicare Benefit Policy Manual, Chapter 7, §40.1.2.5 – Tube Feedings.* (Accessed August 13, 2018)

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

See the *Medicare Benefit Policy Manual, Chapter 7, §40.1.2.6 – Nasopharyngeal and Tracheostomy Aspiration.* (Accessed August 13, 2018)

7) **Catheters**
Insertion and sterile irrigation and replacement of catheters, care of a suprapubic catheter, and in selected patients, urethral catheters, are considered to be skilled nursing services. Where the catheter is necessitated by a permanent or temporary loss of bladder control, skilled nursing services that are provided at a frequency
appropriate to the type of catheter in use would be considered reasonable and necessary. Absent complications, Foley catheters generally require skilled care once approximately every 30 days and silicone catheters generally require skilled care once every 60-90 days and this frequency of service would be considered reasonable and necessary. However, where there are complications that require more frequent skilled care related to the catheter, such care would, with adequate documentation, be covered.

See the Medicare Benefit Policy Manual, Chapter 7, §40.1.2.7 - Catheters. (Accessed August 13, 2018)

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

- Open wounds which are draining purulent or colored exudate or have a foul odor present or for which the patient is receiving antibiotic therapy;
- Wounds with a drain or T-tube that requires shortening or movement of such drains;
- Wounds which require irrigation or instillation of a sterile cleansing or medicated solution into several layers of tissue and skin and/or packing with sterile gauze;
- Recently debrided ulcers;
- Pressure sores (decubitus ulcers) with the following characteristics:
  - There is partial tissue loss with signs of infection such as foul odor or purulent drainage; or
  - There is full thickness tissue loss that involves exposure of fat or invasion of other tissue such as muscle or bone.

  **Note:** Wounds or ulcers that show redness, edema, and induration, at times with epidermal blistering or desquamation do not ordinarily require skilled nursing care.

- Wounds with exposed internal vessels or a mass that may have a proclivity for hemorrhage when a dressing is changed (e.g., post radical neck surgery, cancer of the vulva);
- Open wounds or widespread skin complications following radiation therapy, or which result from immune deficiencies or vascular insufficiencies;
- Post-operative wounds where there are complications such as infection or allergic reaction or where there is an underlying disease
- Third degree burns, and second degree burns where the size of the burn or presence of complications causes skilled nursing care to be needed;
- Skin conditions that require application of nitrogen mustard or other chemotherapeutic medication that present a significant risk to the patient;
- Other open or complex wounds that require treatment that can only be provided safely and effectively by a licensed nurse.

**Note:** This section relates to the direct, hands on skilled nursing care provided to patients with wounds, including any necessary dressing changes on those wounds. While a wound might not require this skilled nursing care, the wound may still require skilled monitoring for signs and symptoms of infection or complication or for skilled teaching of wound care to the patient or the patient's family. For an example of when wound care is provided separately from the furnishing of NPWT using a disposable device, see Guideline 7.d NPWT Using a Disposable Device.

See the *Medicare Benefit Policy Manual, Chapter 7, §40.1.2.8 – Wound Care.* (Accessed August 13, 2018)

9) **Ostomy Care**
Ostomy care during the post-operative period and in the presence of associated complications where the need for skilled nursing care is clearly documented is a skilled nursing service. Teaching ostomy care remains skilled nursing care regardless of the presence of complications.

See the *Medicare Benefit Policy Manual, Chapter 7, §40.1.2.9 – Ostomy Care.* (Accessed August 13, 2018)

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

See the *Medicare Benefit Policy Manual, Chapter 7, §40.1.2.10 – Heat Treatments.* (Accessed August 8, 2018)

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

See the *Medicare Benefit Policy Manual, Chapter 7, §40.1.2.11- Medical Gases.* (Accessed August 13, 2018)

12) **Rehabilitation Nursing**
Rehabilitation nursing procedures, including the related teaching and adaptive aspects of nursing that are part of active treatment (e.g., the institution and supervision of bowel and bladder training programs) would constitute skilled nursing services. See the *Medicare Benefit Policy Manual, Chapter 7, §40.1.2.12 – Rehabilitation Nursing.* (Accessed August 13, 2018)
13) **Venipuncture**

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

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

For venipuncture to be reasonable and necessary:

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

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

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

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

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

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

c. Venipuncture for fasting blood sugar (FBS)
   - An unstable insulin dependent or noninsulin dependent diabetic would require FBS more frequently than once per month if ordered by the physician.
   - Where there is a new diagnosis or where there has been a recent exacerbation, but the patient is not unstable, monitoring once per
month would be reasonable and necessary.
- A stable insulin or noninsulin dependent diabetic would require monitoring every 2-3 months.

d. Venipuncture for prothrombin
- Where the documentation shows that the dosage is being adjusted, monitoring would be reasonable and necessary as ordered by the physician.
- Where the results are stable within the therapeutic ranges, monthly monitoring would be reasonable and necessary.
- Where the results remain within nontherapeutic ranges, there must be specific documentation of the other factors that indicate why continued monitoring is reasonable and necessary.

See the Medicare Benefit Policy Manual, Chapter 7, §40.1.2.13 - Venipuncture. (Accessed August 13, 2018)

14) Student Nurse Visits
Visits made by a student nurse may be covered as skilled nursing care when the HHA participates in training programs that utilize student nurses enrolled in a school of nursing to perform skilled nursing services in a home setting. To be covered, the services must be reasonable and necessary skilled nursing care and must be performed under the general supervision of a registered or licensed nurse. The supervising nurse need not accompany the student nurse on each visit. All documentation requirements must be fulfilled by student nurses. See the Medicare Benefit Policy Manual, Chapter 7, §40.1.2.14 - Student Nurse Visits. (Accessed August 13, 2018)

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

Because the law precludes agencies that primarily provide care and treatment of mental diseases from participating as HHAs, psychiatric nursing must be furnished by an agency that does not primarily provide care and treatment of mental diseases.

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


c. Intermittent Skilled Nursing Care
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).

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.

*See the Medicare Benefit Policy Manual, Chapter 7, §40.1.3 - Intermittent Skilled Nursing Care, (Accessed August 13, 2018)*

3. **Skilled Therapy Services**

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

a. **General Principles Governing Reasonable and Necessary Physical Therapy, Speech-Language Pathology Services, and Occupational Therapy**

- The service of a physical therapist, speech-language pathologist, or occupational therapist is a skilled therapy service if the inherent complexity of the service is such that it can be performed safely and/or effectively only by or under the general supervision of a skilled therapist.
- To be covered the skilled services must also be reasonable and necessary to the treatment of the patient's illness or injury or to the restoration or maintenance of function affected by the patient's illness or injury.
- It is necessary to determine whether individual therapy services are skilled and whether, in view of the patient's overall condition, skilled management of the services provided is needed.
- The development, implementation, management, and evaluation of a patient care plan based on the physician's orders constitute skilled therapy services when, because of the patient's clinical condition, those activities require the specialized skills, knowledge, and judgment of a qualified therapist to ensure the effectiveness of the treatment goals and ensure medical safety.
- Where the specialized skills, knowledge, and judgment of a therapist are needed to manage and periodically re-evaluate the appropriateness of a maintenance program, such services would be covered, even if the skills of a therapist were not needed to carry out the activities performed as part of the maintenance program.
- While a patient's particular medical condition is a valid factor in deciding if skilled therapy services are needed, a patient's diagnosis or prognosis should never be the sole factor in deciding that a service is or is not skilled.
- The key issue is whether the skills of a therapist are needed to treat the illness or
injury, or whether the services can be carried out by unskilled personnel.

- A service that is ordinarily considered unskilled could be considered a skilled therapy service in cases where there is clear documentation that, because of special medical complications, skilled rehabilitation personnel are required to perform the service.

b. **Conditions for Coverage**

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

- The skills of a qualified therapist (not an assistant) are needed to restore patient function.
- The patient’s clinical condition requires the specialized skills, knowledge, and judgment of a qualified therapist to establish or design a maintenance program, related to the patient’s illness or injury, in order to ensure the safety of the patient and the effectiveness of the program, to the extent provided by regulation.
- The skills of a qualified therapist (not an assistant) are needed to restore patient function maintenance therapy.

Coverage of therapy services to perform a maintenance program is not determined solely on the presence or absence of a beneficiary’s potential for improvement from the therapy, but rather on the beneficiary’s need for skilled care. Assuming all other eligibility and coverage requirements are met, skilled therapy services are covered when an individualized assessment of the patient’s clinical condition demonstrates that the specialized judgment, knowledge, and skills of a qualified therapist (“skilled care”) are necessary for the performance of a safe and effective maintenance program.

Such a maintenance program to maintain the patient’s current condition or to prevent or slow further deterioration is covered so long as the beneficiary requires skilled care for the safe and effective performance of the program. When, however, the individualized assessment does not demonstrate such a necessity for skilled care, including when the performance of a maintenance program does not require the skills of a therapist because it could safely and effectively be accomplished by the patient or with the assistance of non-therapists, including unskilled caregivers, such maintenance services will not be covered.

Further, skilled care is necessary for the performance of a safe and effective maintenance program only when (a) the particular patient’s special medical complications require the skills of a qualified therapist to perform a therapy service that would otherwise be considered non-skilled; or (b) the needed therapy procedures are of such complexity that the skills of a qualified therapist are required to perform the procedure.

*For guidelines and principles governing reasonable and necessary physical therapy, speech-language pathology services and occupational therapy and specific examples, see the Medicare Benefit Policy Manual, Chapter 7, §40.2.1- General Principles Governing Reasonable and Necessary Physical Therapy, Speech-Language Pathology Services, and Occupational Therapy. (Accessed August 13, 2018)*

4. **Maintenance Therapy**

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

For specific coverage guidelines regarding maintenance therapy and examples, see the *Medicare Benefit Policy Manual, Chapter 7, §40.2.2 - Application of the Principles to Physical Therapy*. (Accessed August 13, 2018)

5. **Home Health Aides Services**
   a. For home health aide services to be covered:
      - The patient must meet the qualifying criteria as specified in Guideline #1 above;
      - The services provided by the home health aide must be part-time or intermittent (see Section II Definitions);
      - The services must meet the definition of home health aide services; and
      - The services must be reasonable and necessary to the treatment of the patient's illness or injury.

      **Note:** A home health aide must be certified consistent with the competency evaluation requirements.

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

      The physician's order should indicate the frequency of the home health aide services required by the patient.

   b. Home health aid services may include but are not limited to:
      - Personal care
      - Simple dressing changes that do not require the skills of a licensed nurse
      - Assistance with medications which are ordinarily self-administered and do not require the skills of a licensed nurse to be provided safely and effectively
      - Assistance with activities which are directly supportive of skilled therapy services but do not require the skills of a therapist to be safely and effectively performed such as routine maintenance exercises and repetitive practice of functional communication skills to support speech-language pathology services
      - Provision of services incidental to personal care services not care of prosthetic and orthotic devices

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

      For specific examples of home health aide services, see the *Medicare Benefit Policy Manual, Chapter 7, §50.2 - Home Health Aide Services*. (Accessed August 13, 2018)

6. **Medical Social Services**
   a. Medical social services provided by a qualified medical social worker or a social work assistant under the supervision of a qualified medical social worker may be covered as
home health services where the beneficiary meets the qualifying criteria outlined in Guideline #1 above; and

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

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

b. Services of these professionals which may be covered include, but are not limited to:

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

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

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

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

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

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

Refer to the Medicare Benefit Policy Manual, Chapter 7, §50.3 - Medical Social Services. (Accessed August 13, 2018)

7. Medical Supplies (Except for Drugs and Biologicals Other Than Covered Osteoporosis Drugs), the Use of Durable Medical Equipment and Furnishing Negative Pressure Wound Therapy Using a Disposable Device

a. Medical Supplies

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

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

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

See the Medicare Benefit Policy Manual, Chapter 7, §50.4.1 - Medical Supplies. (Accessed August 13, 2018)

b. Durable Medical Equipment
Durable medical equipment which meets the requirements of the Medicare Benefit Policy Manuals, Chapter 6, "Hospital Services Covered Under Part B," §80, and Chapter 15, “Covered Medical and Other Health Services” §110, is covered under the home health benefit. See the Medicare Benefit Policy Manual, Chapter 7, §50.4.2 - Durable Medical Equipment. (Accessed August 13, 2018)

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

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

- The individual is eligible for Medicare Part B coverage of home health services (the nursing visit to perform the injection may be the individual's qualifying service);
- The individual sustained a bone fracture that a physician certifies was related to post-menopausal osteoporosis; and
- The individual's physician certifies that she is unable to learn the skills needed to self-administer the drug or is otherwise physically or mentally incapable of administering the drug, and that her family or caregivers are unable or unwilling to administer the drug.

Refer to the Medicare Benefit Policy Manual, Chapter 7, §50.4.3 - Covered Osteoporosis Drugs. (Accessed August 13, 2018)

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

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

Refer to the Medicare Benefit Policy Manual, Chapter 7, §50.4.4 - Negative Pressure Wound Therapy Using a Disposable Device. (Accessed August 13, 2018)

8. **Heparin injections**

Home health nurse to teach the member or the caring person to give subcutaneous injections of low dose heparin if it is prescribed by a physician for a homebound member who:

- Is pregnant and requires anticoagulant therapy, or
- Requires treatment for deep venous thrombosis or pulmonary emboli or for another condition requiring anticoagulation and documentation justifies that the member cannot tolerate warfarin.

**Note:** If the member or caring person is unable to administer the injection, nursing visits to give the injections on a daily basis, 7 days a week, for a period of up to 6 months (in the case of pregnancy, visits may be made for a period beyond 6 months if reasonable and necessary) would be reimbursed by Medicare. Coverage for these services after 6 months of treatment would be provided only if the prescribing physician can justify and document the need for such an extended course of treatment. Documentation of need for heparin injections beyond 6 months would not be required for pregnant members who meet the homebound criteria. See the NCD for Home Health Nurse Visits to Patients Requiring Heparin Injection (290.2). (Accessed August 13, 2018)

9. **Intravenous Immune Globulin (IVIG)**

Beginning for dates of service on or after January 1, 2004, The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 provides coverage of intravenous immune globulin (IVIG) for the treatment of primary immune deficiency diseases in the home (ICD-9 diagnosis codes 279.04, 279.05, 279.06, 279.12, and 279.2 or ICD-10-CM codes D80.0, D80.5, D81.0, D81.1, D81.2, D81.6, D81.7, D81.89, D81.9, D82.0, D83.0, D83.2, D83.8, or D83.9 if only an unspecified diagnosis is necessary). The Act defines “intravenous immune globulin” as an approved pooled plasma derivative for the treatment of primary immune deficiency disease. It is covered under this benefit when the patient has a diagnosed primary immune deficiency disease, it is administered in the home of a patient with a diagnosed primary immune deficiency disease, and the physician determines that administration of the derivative in the patient’s home is medically appropriate. The benefit does not include coverage for items or services related to the administration of the derivative. For coverage of IVIG under this benefit, it is not necessary for the derivative to be administered through a piece of durable medical equipment.

Intravenous Immune Globulin (IVIG) for the treatment of Primary Immune Deficiency Diseases in the home is covered when determined to be medically appropriate and ordered by a physician to be given in the member’s home.
• See the Medicare Benefit Policy Manual, Chapter 15, §50.6 - Coverage of Intravenous Immune Globulin for Treatment of Primary Immune Deficiency Diseases in the Home (Accessed August 13, 2018)

• Local Coverage Determinations (LCDs) exist and compliance with these policies is required where applicable. These LCDs are available at http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx. (Accessed August 13, 2018)

10. Religious Nonmedical Health Care Institution Services
Religious nonmedical health care institution services furnished in the home are covered.

Note: The term ‘home health agency’ also includes a religious nonmedical health care institution, but only with respect to items and services ordinarily furnished by such an institution to individuals in their homes, and that are comparable to items and services furnished to individuals by a home health agency that is not a religious nonmedical health care institution.

See the Medicare Benefit Policy Manual, Chapter 1, §130.4 - Coverage of Religious Nonmedical and Services Furnished in the Home. (Accessed August 13, 2018)

11. Home Prothrombin Time/INR monitoring
Home Prothrombin Time/INR monitoring for anticoagulation management is covered to monitor the INR ratio when criteria are met. See the NCD for Home Prothrombin Time INR Monitoring for Anticoagulation Management (190.11). (Accessed August 13, 2018)

12. Home health visits to a member who is a blind diabetic
To qualify for home health benefits, a blind diabetic member must be confined to his home, under the care of a physician, and in need of either skilled nursing services on an intermittent basis or physical therapy or speech-language pathology services.

Notes:
• If a nurse makes a visit to provide skilled services, and also pre-fills syringes, the purpose of the visit, which was to provide skilled services, does not change. However, if the sole purpose of the nurse's visit is to pre-fill insulin syringes for a blind diabetic, it is not a skilled nursing visit although it may be reimbursed as such as indicated below.
• Filling a syringe can be safely and effectively performed by the average nonmedical person without the direct supervision of a licensed nurse. Consequently, it would not constitute a skilled nursing service even if it is performed by a nurse.
• If State law, however, precludes a home health aide from pre-filling insulin syringes, payment may be made for this service as part of the cost of skilled nursing services when performed by a nurse for a blind diabetic who is otherwise unable to pre-fill his or her syringes. There are no adverse consequences with respect to reimbursement to the home health agency for providing the service in this manner.
• If State law does not preclude a home health aide from pre-filling insulin syringes, but the home health agency chooses to send a nurse to perform only this task, the visit is reimbursed as if made by a home health aide.

See the NCD for Home Health Visits to a Blind Diabetic (290.1). (Accessed August 13, 2018)

13. The following services in the home are not covered:
   a. Home health services furnished when the member is not needing any other skilled service (e.g. physical therapy, speech language pathology services or continued occupational therapy); see Guideline 2 Skilled Nursing Care above.
   b. Part time or intermittent skilled nursing or home health aid services (when combined)
greater than 8 hours a day or more than 28 hours per week except when authorized on a case by case basis to be more than 8 hours a day and 35 hours or fewer hours per week.

See the Medicare Benefit Policy Manual, Chapter 7, §40.1.3 - Intermittent Skilled Nursing Care. (Accessed August 13, 2018)

c. Skilled nursing care solely for the purpose of drawing a member’s blood for testing

See the Medicare Benefit Policy Manual, Chapter 7, §40.1.2.13 - Venipuncture. (Accessed August 13, 2018)

Also see the Medicare Benefit Policy Manual, Chapter 7, §30.4. (Accessed August 13, 2018)

d. Drugs and biologicals are excluded from payment under the Medicare home health benefit. For more specific home health benefit information and skilled nursing services, refer to the Medicare Benefit Policy Manual, Chapter 7, §80.1. (Accessed August 13, 2018)

e. Transportation of a patient, whether to receive covered care or for other purposes, is excluded from home health coverage. Costs of transportation of equipment, materials, supplies, or staff may be allowable as administrative costs, but no separate payment is made; see the Medicare Benefit Policy Manual, Chapter 7, §80.2. (Accessed August 13, 2018)

f. Housekeeping services, i.e., services for which the sole purpose is to enable the patient to continue residing in their home (e.g., cooking, shopping, Meals on Wheels, cleaning, laundry) are excluded from home health coverage; see the Medicare Benefit Policy Manual, Chapter 7, §80.4 - Housekeeping Services. (Accessed August 13, 2018)

g. Private duty nursing care (refer to Definitions Section II); see the Medicare Benefit Policy Manual Chapter 1, §20 - Nursing and Other Services. (Accessed August 13, 2018)

h. Oral prescription drugs provided by a home health provider unless the member has a supplemental pharmacy benefit and the oral medications are obtained through a contracted UnitedHealthcare Medicare pharmacy provider. See the Medicare Benefit Policy Manual, Chapter 7, §40.1.2.4- Administration of Medications. (Accessed August 13, 2018)

Note: Refer to Guideline 2.b.4.c Oral Medications above for the home health coverage for the administration of oral medications.

i. Home health services for a blood draw unless the member has a need for another qualified skilled service and meets all home health eligibility criteria.

Note: For coverage of home blood draws (venipunctures) by an independent laboratory technician, refer to the Coverage Summary for Laboratory Tests and Services.


k. Services covered under the End Stage Renal Disease (ESRD) Program; see the Medicare Benefit Policy Manual, Chapter 7, §80.5. (Accessed August 13, 2018)

l. Prosthetic items are excluded from home health coverage. However, catheters, catheter
supplies, ostomy bags, and supplies related to ostomy care are not considered prosthetic devices if furnished under a home health plan of care and are not subject to this exclusion from coverage but are bundled while a patient is under a HH plan of care; see the Medicare Benefit Policy Manual, Chapter 7, §80.6. (Accessed August 13, 2018)

m. Medical social services furnished solely to family members of the patient's family and that are not incidental to covered medical social services being furnished to the patient are not covered; See the Medicare Benefit Policy Manual, Chapter 7, §80.6. (Accessed August 13, 2018)

n. Respiratory care services; see the Medicare Benefit Policy Manual, Chapter 7, §80.8. (Accessed August 13, 2018)

o. Dietary and nutrition personnel; see the Medicare Benefit Policy Manual, Chapter 7, §80.9. (Accessed August 13, 2018)

For more specific home health benefit information and skilled nursing services, refer to the Medicare Benefit Policy Manual, Chapter 7. (Accessed August 13, 2018)

Local Coverage Determinations (LCDs) for Home Health Services exist and compliance with these policies is required where applicable. These LCDs are available at http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx. (Accessed August 13, 2018)

II. DEFINITIONS

Custodial Care: Non-medically necessary personal health care for the purposes of assisting the patient in meeting the requirements of daily living. Does not require the continuing attention of trained medical or paramedical personnel. Medicare Benefit Policy Manual, Chapter 16, §110-Custodial Care. (Accessed August 13, 2018)

Intermittent Visit: For purposes of benefit eligibility, under §§1814(a)(2)(C) and 1835(a)(2)(A) of the Act, "intermittent" means skilled nursing care that is either provided or needed on fewer than 7 days each week or less than 8 hours of each day for periods of 21 days or less (with extensions in exceptional circumstances when the need for additional care is finite and predictable). Medicare Benefit Policy Manual, Chapter 7, § 40.1.3-Intermittent Skilled Nursing Care. (Accessed August 13, 2018)

Part Time or Intermittent Services: Skilled nursing and home health aide services furnished any number of days per week as long as they are furnished (combined) less than 8 hours each day and 28 or fewer hours each week (or subject to review on a case by case basis as to the need of care, less than 8 hours each day and 35 hours or fewer per week). Medicare Benefit Policy Manual, Chapter 7, §50.7 - Part-Time or Intermittent Home Health Aide and Skilled. (Accessed August 13, 2018)

Private Duty Nursing Services: The services provided by a private-duty nurse or other private-duty attendant.. Private-duty nurses or private-duty attendants are registered nurses, licensed practical nurses, or any other trained attendant whose services ordinarily are rendered to, and restricted to, a particular patient by arrangement between the patient and the private-duty nurse or attendant. Such persons are engaged or paid by an individual patient or by someone acting on their behalf, including a hospital that initially incurs the costs and looks to the patient for reimbursement for such noncovered services. Medicare Benefit Policy Manual Chapter 1, §20 - Nursing and Other Services. (Accessed August 13, 2018)
III. REFERENCES

See above

IV. REVISION HISTORY

04/01/2019 Updated policy introduction; added language to clarify:
- There are instances where [the Coverage Summary] may direct readers to a UnitedHealthcare Commercial Medical Policy, Medical Benefit Drug Policy, and/or Coverage Determination Guideline (CDG)
- In the absence of a Medicare National Coverage Determination (NCD), Local Coverage Determination (LCD), or other Medicare coverage guidance, CMS allows a Medicare Advantage Organization (MAO) to create its own coverage determinations, using objective evidence-based rationale relying on authoritative evidence (Medicare IOM Pub. No. 100-16, Ch. 4, §90.5)

08/21/2018 Annual review with the following updates:

Guideline 1.e (Face-to-face Home Health Certification Requirement)
- Deleted the following:

  As a condition for payment, the Affordable Care Act mandates that prior to certifying a patient’s eligibility for the home health benefit, the certifying physician must document that he or she, or an allowed non-physician practitioner (NPP) has had a face-to-face encounter with the patient. Documentation regarding these encounters must be present on certifications for patients with starts of care on and after January 1, 2011.

- Added the following language from the reference Medicare Benefit Policy Manual:

  As part of the certification of patient eligibility for the Medicare home health benefit, a face-to-face encounter with the patient must be performed by the certifying physician himself or herself, a physician that cared for the patient in the acute or post-acute care facility (with privileges who cared for the patient in an acute or post-acute care facility from which the patient was directly admitted to home health) or an allowed non-physician practitioner (NPP).

  Timeframe Requirements
  - The encounter must occur no more than 90 days prior to the home health start of care date or within 30 days after the start of care.
  - In situations when a physician orders home health care for the patient based on a new condition that was not evident during a visit within the 90 days prior to start of care, the certifying physician or an allowed NPP must see the patient again within 30 days after admission. Specifically, if a patient saw the certifying physician or NPP within the 90 days prior to start of care, another encounter would be needed if the patient’s condition had changed to the extent that standards of practice would indicate that the physician or a non-physician practitioner should examine the patient in order to establish an effective treatment plan.

Guideline 2.b.4.b (Insulin Injections) – removed the example

Guideline 2.b.4.d (Eye Drops and Topical Ointments) – removed examples

Guideline 2.b.7 (Catheters) – removed example
Guideline 2.b.8 (Wound Care) – removed examples
Guideline 2.b.13 (Venipuncture) – removed example
Guideline 2.b.15 (Psychiatric Evaluation, Therapy, and Teaching) – removed examples
Guideline 7.b (Durable Medical Equipment) – deleted the following Medicare-specific coinsurance language: “with the beneficiary responsible for payment of a 20 percent coinsurance”
Guideline 7.c (Covered Osteoporosis Drugs) – deleted the following Medicare-specific coinsurance information:
This drug is considered part of the home health benefit under Part B. Therefore, Part B deductible and coinsurance apply regardless of whether home health visits for the administration of the drug are covered under Part A or Part B.
Guideline 7.d (Negative Pressure Wound Therapy Using a Disposable Device) – deleted example
Guideline 13.h (Oral Prescription Drugs) – added a reference link to the Medicare Benefit Policy Manual, Chapter 7, §40.1.2.4 - Administration of Medications.

08/15/2017 Annual review with the following updates:
Guideline 2.b.8 (wound care) – updated the following language regarding Negative Pressure Wound Therapy based on the updated Medicare Benefit Policy Manual, Chapter 7§40.1.2.8 Wound Care
Guideline 7 [Medical Supplies (Except for Drugs and Biologicals Other Than Covered Osteoporosis Drugs), the Use of Durable Medical Equipment and Furnishing Negative Pressure Wound Therapy Using a Disposable Device] – added “and Furnishing Negative Pressure Wound Therapy Using a Disposable Device” to title based on the Medicare Benefit Policy Manual, Chapter 7§40.1.2.8 Wound Care to the title of the guideline.
Guideline 7.d (Negative Pressure Wound Therapy Using a Disposable Device) – guideline new to coverage summary based on updated Medicare Benefit Policy Manual, Chapter 7§40.1.2.8 Wound Care.

08/16/2016 Annual review; no updates.

09/15/2015 Annual review with the following updates:
Guideline 1.a.3 - added the following language based on the updated Medicare Benefit Policy Manual, Chapter 7 Home Health Services, §30.3 Under the Care of a Physician: A patient is expected to be under the care of the physician who signs the plan of care. It is expected that in most instances, the physician who certifies the patient’s eligibility for home health services, in accordance with §30.5 below, will be the same physician who establishes and signs the plan of care.
Guideline 1.1 (Impact of Other Available Caregivers and Other Available Coverage on Medicare Coverage of Home Health Services) - added the following language
based on the updated Medicare Benefit Policy Manual, Chapter 7 Home Health Services, § 20.2: Similarly, a patient is entitled to reasonable and necessary Medicare home health services even if the patient would qualify for institutional care (e.g., hospital care or skilled nursing facility care) and Medicare payment should be made for reasonable and necessary home health services where the patient is also receiving supplemental services that do not meet Medicare’s definition of skilled nursing care or home health aide services.

Guideline 13.f - deleted the following (no specific Medicare reference):
Routine/custodial/convalescent care, long term physical therapy and rehabilitation

03/24/2015
Guideline 1.b [Homebound (Confined to the Home)]
• Added criteria for individual to be considered “confined to the home” based on the Medicare Benefit Policy Manual, Chapter 7, § 30.1.1 - Patient Confined to the Home

Guideline 1.c (Place of Residence)
• Added benefit guidance pertaining to place of residence based on the Medicare Benefit Policy Manual, Chapter 7, § 30.1.2 - Patient’s Place of Residence

Definitions
• Removed the definitions of:
  o Homebound (now addressed in Guideline 1.b)
  o Place of Residence (now addressed in Guideline 1.c)

09/16/2014
Annual review; no updates.

05/20/2014
Guideline #1.e (Frequency of Review of Plan of Care) - Added applicable coverage guidelines.
Guideline #1.g (Impact of Other Available Caregivers and Other Available Coverage on Medicare Coverage of Home Health) - Added applicable coverage guidelines.
Guideline #2.a (Skilled Nursing Care) - Updated to include the following:
  o 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.
  o A patient's overall medical condition, without regard to whether the illness or injury is acute, chronic, terminal, or expected to extend over a long period of time, should be considered in deciding whether skilled services are needed. A patient's diagnosis should never be the sole factor in deciding that a service the patient needs is either skilled or not skilled. Skilled care may, depending on the unique condition of the patient, continue to be necessary for patients whose condition is stable.

Guideline #3.a (General Principles Governing Reasonable and Necessary Physical Therapy, Speech-Language Pathology Services, and Occupational Therapy) - Added applicable coverage guidelines (new to policy)

Guideline #3.b (Conditions for Coverage) - Updated to include additional language pertaining to maintenance program.
Guideline #4 (Maintenance Therapy) - Added applicable coverage guidelines (new to policy).

Guideline #5 (Home Health Aide Services) - Updated to more detailed guidelines.

Guideline #6 (Medical Social Services) - Updated to include the following language:

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

02/18/2014 Additional updates to the Coverage Summary made to align with the Medicare Benefit Policy Manual updates in accordance with the Jimmo v. Sebelius Settlement Agreement; CMS Transmittal 179, January 14, 2014, Change Request 8458.


10/24/2013 Annual review; no updates.

04/29/2013 Added a note pertaining to the January 24, 2013 court approval of settlement agreement in the case of Jimmo v. Sebelius.

12/17/2012 Guidelines # 1 (Home Health Services Criteria) updated to include the Medicare language pertaining to reasonable and necessary home health services. Also updated the definition of “Intermittent Visit”.

10/31/2012 Annual review; updated to include Guidelines #2.1 - Psychiatric Evaluation, Therapy, and Teaching.

10/13/2011 Annual review; no updates.

03/04/2011 Updated the LCD reference section (Guidelines # 1.)

Updated link to the Code of Federal Regulations (CFR) (Guidelines # 1.c.)

02/21/2011 Updated Guidelines #1 to include the note pertaining to the new CMS Face-to-face Home Health Certification Requirement (effective January 1, 2011) based on MLN Matters Article #SE1038.

09/07/2010 Policy updated to include more examples of covered benefits, e.g., teaching and training activities, wound care, etc.; criteria for coverage were also updated in based on Medicare language.