# Coverage Summary

## Home Health Services and Home Health Visits

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<td>Approved by:</td>
<td>UnitedHealthcare Medicare Benefit Interpretation Committee</td>
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<td>Last Review Date:</td>
<td>08/20/2019</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, 2019)

   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 the Medicare Benefit Policy Manual, Chapter 7, §30.4. (Accessed August 13, 2019)

   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, 2019)

   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, 2019)

   Also see the Medicare Benefit Policy Manual, Chapter 7, § 30.5 - Physician Certification. (Accessed August 13, 2019)

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 no longer 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*
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, 2019)

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, 2019)


f. **Outpatient Services**
Outpatient services include any of the items or services which are provided under arrangements on an outpatient basis at a hospital, skilled nursing facility, rehabilitation center, or outpatient department affiliated with a medical school, and (1) which require equipment which cannot readily be made available at the patient's place of residence, or (2) which are furnished while the patient is at the facility to receive the services described in (1). The hospital, skilled nursing facility, or outpatient department affiliated with a medical school must all be qualified providers of services. However, there are special provisions for the use of the facilities of rehabilitation centers. The cost of transporting an individual to a facility cannot be reimbursed as home health services.


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, 2019)

**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, 2019)

**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 recertification 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, 2019)

**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 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, see the Medicare Benefit Policy Manual, Chapter 7, §40.1- Skilled Nursing Care. (Accessed August 13, 2019)

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. 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.

For guidelines and principles governing reasonable and necessary physical therapy, speech-language pathology services and occupational therapy and specific examples, see the...
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, 2019)

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 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, 2019)

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, 2019)

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, 2019)

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, 2019)

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, 2019)

d. Negative Pressure Wound Therapy Using a Disposable 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, 2019)

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, 2019)

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

   IVIG 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 Coverage Summary for Medications/Drugs (Outpatient/Part B) for coverage guideline.

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, 2019)
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)](https://www.readyhealthcare.com/NCD-190.11) (Accessed August 13, 2019)

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)](https://www.readyhealthcare.com/NCD-290.1) (Accessed August 13, 2019)

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](https://www.readyhealthcare.com/medicare-benefit-policy-manual-chapter-7-40.1.3) (Accessed August 13, 2019)

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


Also see the [Medicare Benefit Policy Manual, Chapter 7, §30.4](https://www.readyhealthcare.com/medicare-benefit-policy-manual-chapter-7-30.4) (Accessed August 13, 2019)

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](https://www.readyhealthcare.com/medicare-benefit-policy-manual-chapter-7-80.1) (Accessed August 13, 2019)

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, 2019)

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, 2019)

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, 2019)

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, 2019)

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, 2019)

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, 2019)

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, 2019)


o. Dietary and nutrition personnel; see the Medicare Benefit Policy Manual, Chapter 7, §80.9. (Accessed August 13, 2019)

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, 2019)

II. DEFINITIONS

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, 2019)

**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, 2019)

**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, 2019)

### III. REFERENCES

See above

### IV. REVISION HISTORY

**Guideline 1.f (Outpatient Services)**

- Removed/replaced language indicating:
  - 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
- Added language to indicate:
  - Outpatient services include any of the items or services which are provided under arrangements on an outpatient basis at a hospital, skilled nursing facility, rehabilitation center, or outpatient department affiliated with a medical school, and:
    - (1) which require equipment which cannot readily be made available at the patient’s place of residence, or
    - (2) which are furnished while the patient is at the facility to receive the services described in (1)
  - The hospital, skilled nursing facility, or outpatient department affiliated with a medical school must all be qualified providers of services
  - There are special provisions for the use of the facilities of rehabilitation centers
  - The cost of transporting an individual to a facility cannot be reimbursed as home health services

**Guideline 2 (Skilled Nursing Care)**

- Replaced detailed coverage guidelines with a reference link to the *Medicare Benefit Policy Manual, Chapter 7, §40.1 - Skilled Nursing Care* for applicable
Guideline 3 (Skilled Therapy Services)
- Replaced detailed coverage guidelines with a reference link to the Medicare Benefit Policy Manual, Chapter 7, §40.2 - Skilled Therapy Services for applicable details

Guideline 7.d (Negative Pressure Wound Therapy Using a Disposable Device)
- Removed language pertaining to Sections §1834 and §1861(m)(5) of the Social Security Act

Guideline 9 (Intravenous Immune Globulin (IVIG) in Home)
- Removed content/languange pertaining to the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 [refer to the UnitedHealthcare Advantage Coverage Summary titled Medications/Drugs (Outpatient/Part B) for coverage guidelines]
- Removed reference link to the Medicare Benefit Policy Manual, Chapter 15, §50.6 - Coverage of Intravenous Immune Globulin for Treatment of Primary Immune Deficiency Diseases in the Home

Guideline 13 (Services in the Home That Are Not Covered)
- Removed reference link to the Medicare Benefit Policy Manual, Chapter 7

Definitions
- Removed definition of “Custodial Care”