MEDICARE COVERAGE REQUIREMENTS: HH

Medicare Benefit Policy Manual, Chapter 7: Home Health Services

Rev. 12382 / 12425 (2023) | 108 pages | 21 requirements

KEY PRINCIPLE

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. Skilled care may be necessary to improve a patient's current condition, to maintain the patient's current condition, or to prevent or slow further deterioration of the patient's condition.

p. 43

Homebound Status

The patient must be confined to the home. Two criteria must both be met for homebound status. (Section 30.1.1)

REQUIRED — p. 24

Criterion One: The patient must either (a) 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 (b) have a condition such that leaving the home is medically contraindicated.

REQUIRED — p. 24

Criterion Two: There must exist a normal inability to leave the home AND leaving the home must require a considerable and taxing effort.

CONDITIONAL — p. 25

If the patient does in fact leave the home, the patient may nevertheless be considered homebound if the absences from the home are infrequent or for periods of relatively short duration, or are attributable to the need to receive health care treatment.

Absences for medical care (adult day centers, dialysis, chemotherapy, radiation) do not disqualify homebound status.

REFERENCE — p. 25

The condition of these patients should be such that there exists a normal inability to leave home and that leaving home requires a considerable and taxing effort.

Skilled Need

The patient must need at least one qualifying skilled service: skilled nursing, physical therapy, or speech-language pathology. (Section 30.4)

REQUIRED

The patient needs or needed skilled nursing services on an intermittent basis (other than solely venipuncture for the purposes of obtaining a blood sample), or physical therapy, or speech-language pathology services.

OT alone does not qualify the patient for home health. OT is covered only after eligibility is established by SN, PT, or SLP.

pp. 34-35

REQUIRED

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, and must be intermittent.

p. 43

REQUIRED

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.

p. 65

Intermittent Requirement

Skilled nursing must be needed on an intermittent basis. Therapy services are inherently intermittent. (Section 40.1.3)

REQUIRED

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.

p. 64

CONDITIONAL

Medicare will pay for part-time medically reasonable and necessary skilled nursing care 7 days a week for a short period of time (2 to 3 weeks). There may also be a few cases involving unusual circumstances where the patient's prognosis indicates the medical need for daily skilled services will extend beyond 3 weeks.

Daily services beyond 3 weeks require medical documentation justifying continued need and an estimate of duration.

pp. 64-65

REFERENCE

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

p. 65

Reasonable and Necessary

Services must be reasonable and necessary for the treatment of the patient's illness or injury. (Section 40.1.1)

REQUIRED
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.
p. 44

REQUIRED
Clinical notes should be written so that they adequately describe the reaction of a patient to his/her skilled care. Clinical notes should also provide a clear picture of the treatment, as well as next steps to be taken. Vague or subjective descriptions of the patient's care should not be used.
p. 45

Documentation must support why skilled care is needed, not just what was done.

Plan of Care

A plan of care must be established, periodically reviewed, and signed by a physician or allowed practitioner. (Section 30.2)

REQUIRED
A plan of care must be established and periodically reviewed by a physician or allowed practitioner.
p. 29

REQUIRED
The plan must describe a course of treatment which is consistent with the qualified therapist's assessment of the patient's function.
p. 30

REQUIRED
The orders on the plan of care must indicate the type of services to be provided to the patient, both with respect to the professional who will provide them and the nature of the individual services, as well as the frequency of the services.
p. 30

REQUIRED
The plan of care must be signed and dated by a physician or allowed practitioner before the claim for each 30-day period for services is submitted for the final percentage payment.
p. 31

Physician Certification

The physician or allowed practitioner must certify the patient's eligibility for home health services. (Section 30.5)

REQUIRED
The certification must include: (1) the home health services are or were needed because the patient is or was confined to the home; (2) the patient needs or needed skilled nursing services on an intermittent basis (other than solely venipuncture for the purposes of obtaining a blood sample), or physical therapy, or speech-language pathology services; (3) a plan of care has been established and is periodically reviewed by a physician or allowed practitioner; (4) the services are or were furnished while the patient is or was under the care of a physician or allowed practitioner; and (5) a face-to-face encounter occurred within the required time frame.
pp. 35-37

REQUIRED

The certification must be complete prior to when an HHA bills Medicare for reimbursement; however, physicians and allowed practitioners should complete the certification when the plan of care is established, or as soon as possible thereafter.

p. 37

Face-to-Face Encounter

A face-to-face encounter must occur within a specific time window and be related to the primary reason the patient requires home health services. (Section 30.5.1.1)

REQUIRED

A face-to-face encounter occurred no more than 90 days prior to or within 30 days after the start of the home health care, was related to the primary reason the patient requires home health services, and was performed by a physician or non-physician practitioner.

pp. 36, 37

REQUIRED

The physician responsible for certifying the patient's eligibility for home health must document that the face-to-face encounter, which is related to the primary reason the patient requires home health services, occurred within the required time frame. The documentation must include the date of the encounter.

pp. 39-40

CONDITIONAL

In situations when a physician or allowed practitioner 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 physician or an allowed NPP must see the patient again within 30 days after admission.

New condition exception: if the patient's condition changed since the prior visit, a new encounter is required within 30 days after admission.

p. 38

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