



**PROVIDER
INSIGHTS**

Busting The Myths On What Medicare Pays For!

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How do YOU know what Medicare pays for?

Orientation

Leadership

Meetings

Preceptorships

Do you ever hear contradictory guidance?

Ever told "As long as you assess and teach..."

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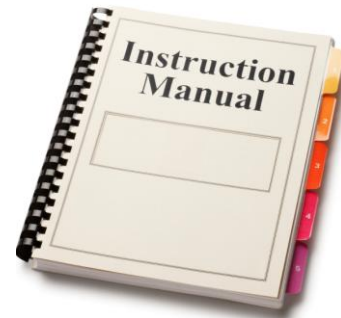
The Mythbuster: Chapter 7!



Chapter 7 of the Medicare Benefit Policy manual is the Conditions for Payment

- Describes the Medicare Home Health benefit
- Defines what Medicare pays for, under what circumstances
- Rules are only for Medicare patients (or other payers that adopt the Medicare coverage rules)
- Used upon payment audits

- Different than the Conditions of Participation
 - Survey/Quality standards
 - Applicable to all patients/all payers



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How to find the rules

<https://www.cms.gov/medicare/enrollment-renewal/providers-suppliers/home-health-agency-center>



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Home > Medicare > Payment > All Fee-For-Service-Providers > Home Health Agency (HHA) Center

All Fee-For-Service-Providers

- Home Health Agency (HHA) Center
- Shared Savings Program
- Hospital-Acquired Conditions (HAC)
- Physician bonuses in Health Professional Shortage Areas

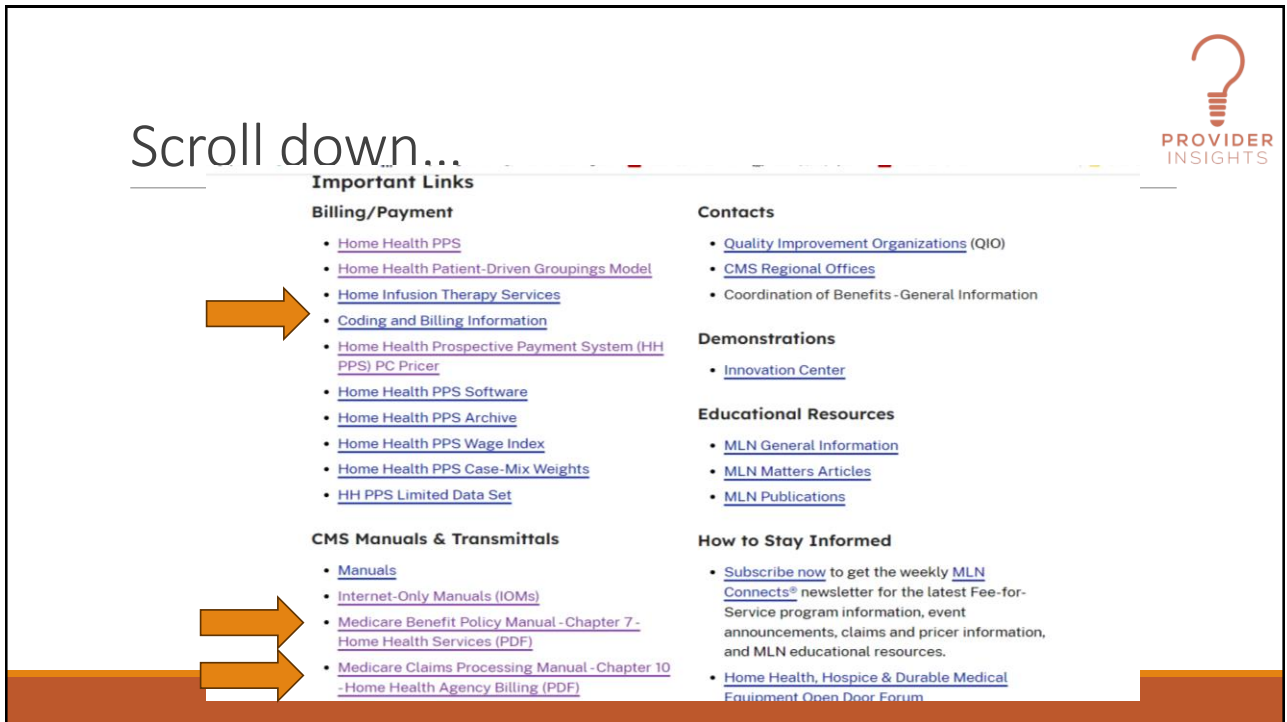
Home Health Agency (HHA) Center

CY 2025 Home Health Prospective Payment System Final Rule

A correction notice to the CY 2025 Home Health Prospective Payment System Final Rule [has been issued](#). An additional update to the correction notice is forthcoming with the following change: Removing the 14th row (entry for Neoplasms 20 (Non-Hodgkin's Lymphoma)). Please note: The grouper itself has already been updated with the correct subgroups so claims are being grouped correctly. The [CY 2025 final rule](#), which displayed at the Federal Register on November 1, 2024 included the wrong low comorbidity subgroup list; however, both the [CY 2025 Final Low Comorbidity and High Comorbidity Adjustment Interactions \(ZIP\)](#) file in the Downloads section and the [Home Health PPS Grouper Software \(HHGS\) | CMS](#) contain the correct low comorbidity subgroups. The rule contains policies which will be effective January 1, 2025.

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Scroll down...



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Important Links

Billing/Payment

- [Home Health PPS](#)
- [Home Health Patient-Driven Groupings Model](#)
- [Home Infusion Therapy Services](#)
- [Coding and Billing Information](#)
- [Home Health Prospective Payment System \(HH PPS\) PC Pricer](#)
- [Home Health PPS Software](#)
- [Home Health PPS Archive](#)
- [Home Health PPS Wage Index](#)
- [Home Health PPS Case-Mix Weights](#)
- [HH PPS Limited Data Set](#)

CMS Manuals & Transmittals

- [Manuals](#)
- [Internet-Only Manuals \(IOMs\)](#)
- [Medicare Benefit Policy Manual - Chapter 7 - Home Health Services \(PDF\)](#)
- [Medicare Claims Processing Manual - Chapter 10 - Home Health Agency Billing \(PDF\)](#)

Contacts

- [Quality Improvement Organizations \(QIO\)](#)
- [CMS Regional Offices](#)
- [Coordination of Benefits - General Information](#)

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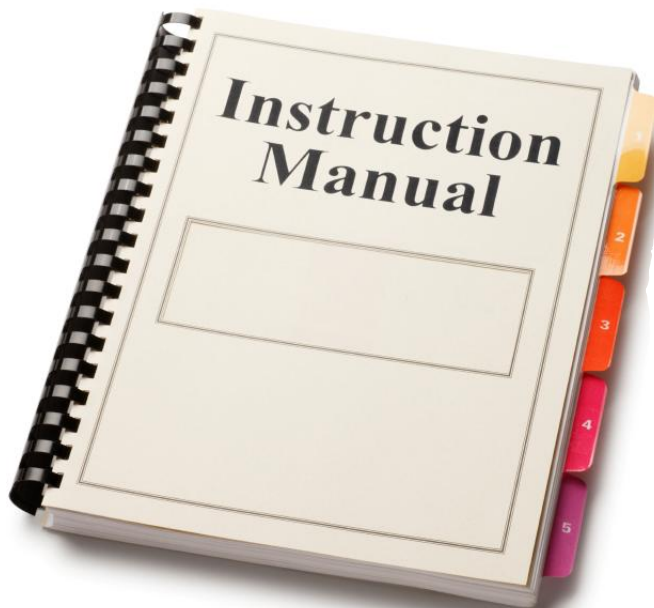
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Admission requirements

“An agency only needs an order to admit to the Medicare home health benefit” or “You must admit a patient if you have orders”

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Let's see what Chapter 7 says...





Sections 20-30 speak to the fact that ALL services must be “medically necessary” for all covered services, as well as the following technical components

- Under the care of a physician
- Need PT, SLP or intermittent nursing
- Homebound
- Certification/POC
- Acceptable face to face for reason home health was needed

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Under the Care of a Medical Provider


What does that mean? The referral source?

- Must be a community physician, NP, or PA that is ordering HH, or will agree to follow after you have a referral from another source, like the hospital

Putting it together: On referral/intake, are you asking who the attending physician is that will be signing the POC and providing for ongoing orders?

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Homebound

Statement "1" must first be met:	• The patient must either need physical assistance or a device leaving the home or leaving is medically contraindicated
Followed by Statement "2"	• There must also be a normal inability to leave the home
"3"	Leaving the home must require a considerable and taxing effort
And "4"	Absences for nonmedical reasons must be infrequent and short duration

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Taxing Effort
1 & 3



Absences Infrequent and Short Duration
2 & 4



Homebound

Homebound Decisions and Documentation

- Documentation must support throughout
 - Amount needed varies by type of patient
- Beware of vague descriptions
- Utilize objective, measurable language

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Myth busted!

There is far more than "just an order" to Medicare HH benefit coverage!



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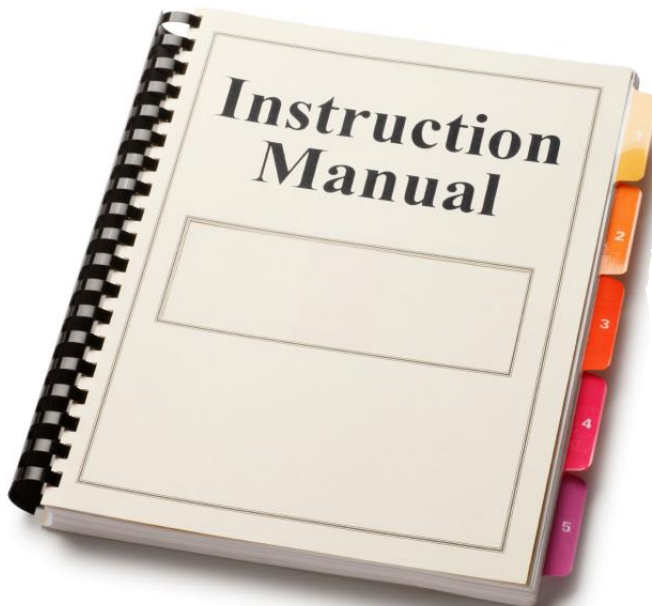
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Intermittent Nursing- One time visit

“Medicare will never cover a single nursing visit”

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Let's see what Chapter 7 says...




Section 40: “Covered Services”

- Provides details for when Medicare will cover skilled nursing and therapies
- Useful for decisions on referrals and admissions
- “Coverage”= What Medicare will pay for, under what conditions

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Intermittent Nursing

Must be intermittent as a qualifying service

- If intent and orders for more than once (if SN only), and something disrupts further visits, the one-time SN would still be covered
- If PT or SLP is the qualifying service, then the SN does not need to be intermittent
 - SN may be ordered one time to provide an injection, venipuncture, etc

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Myth busted!

There are many circumstances that a one-time SN visit may be covered!

Myth

Reality

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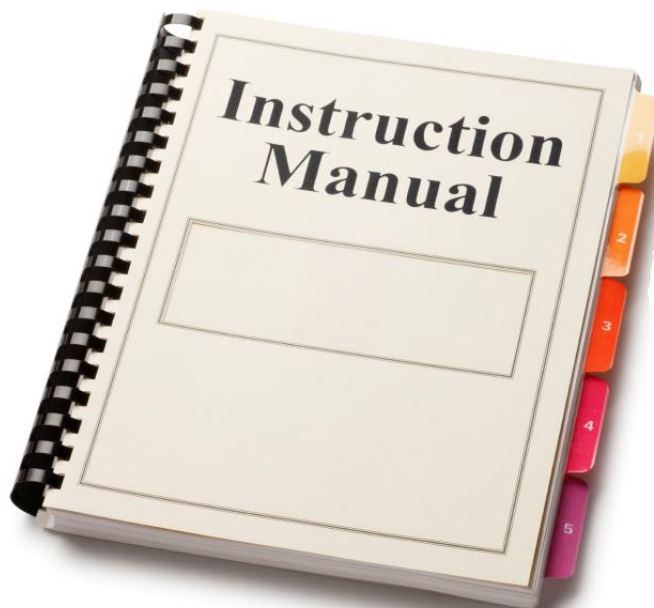


Intermittent Nursing- Daily visits

“MEDICARE WILL NEVER COVER DAILY VISITS BY A NURSE”

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Let's see what Chapter 7 says...



Sections 20 & 40: "Covered Services"

- Provides details for when Medicare will cover skilled nursing and therapies
- Useful for decisions on referrals and admissions
- "Coverage"= What Medicare will pay for, under what conditions

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Daily Nursing

- Daily SN visits are allowed for up to 21 days, or with a finite, realistic endpoint to the need for daily services from HHA
 - Wound examples
- Exception: insulin injections do not need end point

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Myth busted!

There are times that daily nurse visits are a covered service under Medicare

Myth

Reality

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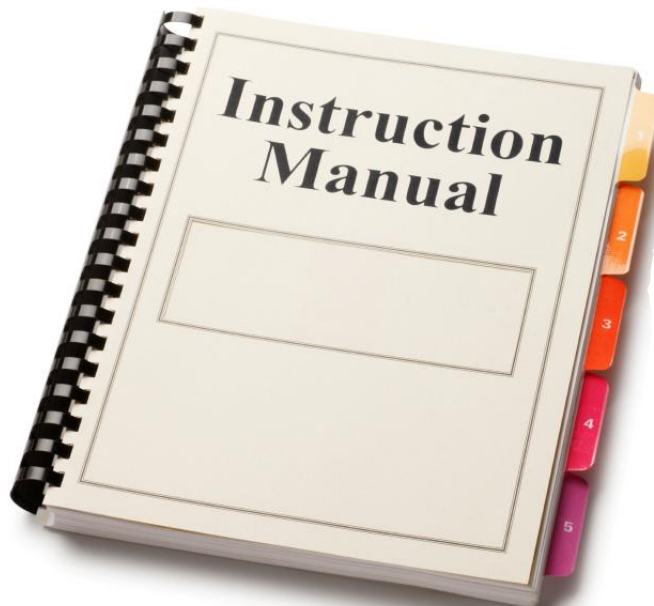


Observation/assessment as a covered service

“Medicare will always pay for three weeks of nursing, if you document assessment”

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Let's see what Chapter 7 says...





Section 40.1.2.1: “SN Observation”

Medicare pays for a SN x 3 weeks, when there is a **reasonable potential for change** in a patient's condition that requires SN to identify and evaluate the patient's need for possible modification of treatment or initiation of additional medical procedures

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Supporting the need...

Typically related to a recent change in:

- Diagnosis
- Symptoms
- Treatment/medications

Medicare examples:

- Abnormal/fluctuating vital signs
- Weight changes
- Edema
- Symptoms of drug toxicity
- Abnormal/fluctuating lab values
- Respiratory changes on auscultation

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Supporting the need...

Medicare will NOT pay:

- When 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
- If patient/physician does not want to alter plan

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Straight from Chapter 7- Examples...

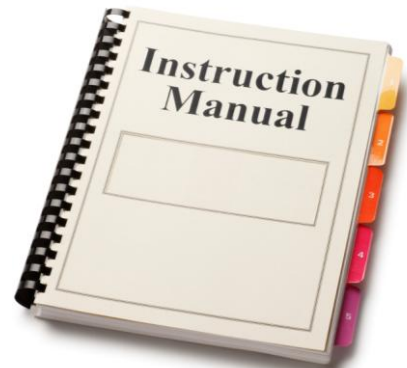


CHF patient with exacerbation and new medications

Post-op patient with s/s of infection

Patient with history of HTN, becomes hypotensive and physician discontinues medications

NOTE: MC does not pay for a "SN Eval" or SOC Comprehensive assessment/OASIS only



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Myth busted!

Medicare won't just pay for observation for three weeks- UNLESS your documentation shows the recent changes warranting this service!

Myth

Reality

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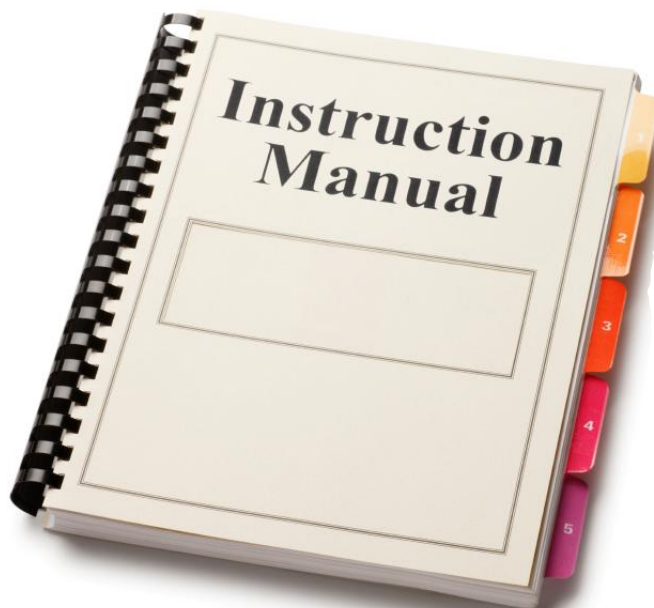


Teaching as a covered service

“Medicare will always pay for nursing visits, as long as you document teaching on each visit!”

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Let's see what Chapter 7 says...




Section 40.1.2.3: “SN Teaching”

Medicare pays when it takes the skills of the nurse to teach a patient/CG/family re: management of treatment for illness, functional change or injury


Takes skill to teach– is not limited to teaching skilled interventions- could also teach unskilled treatments (repositioning, medication set up)

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Supporting the need...



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If unsuccessful teaching after “reasonable time” teaching is no longer a payable service


- Document why teaching was unsuccessful
- Paid until that point

Medicare examples:

- How to self-inject insulin or other self-administered injectables
- New medications- effects, side effects, adverse reaction with diet
- A change in ability to manage health– patient has been self-injecting, but now has a fractured hand
- Wound care
- Re-teaching if any of above found not being done correct, unless it is clear that it is not reasonable for learner

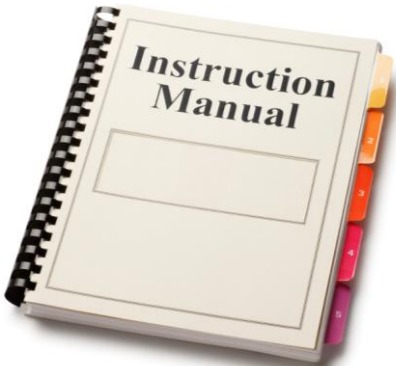
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Straight from Chapter 7- Examples...



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1. Teaching the **self-administration of injectable medications, or a complex range of medications**
2. 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
3. Teaching **self-administration of medical gases**
4. Teaching **wound care** where the complexity of the wound, the overall condition of the patient or the ability of the caregiver makes teaching necessary
5. Teaching **care for a recent ostomy** or where **reinforcement of ostomy care** is needed
6. Teaching **self-catheterization**
7. Teaching **self-administration of gastrostomy or enteral feedings**
8. Teaching care for and maintenance of **peripheral and central venous lines**



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Teaching examples (continued from Ch. 7)



9. Teaching **bowel or bladder training** when bowel or bladder dysfunction exists
10. 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
11. Teaching **transfer techniques**, e.g., from bed to chair, that are needed for safe transfer
12. Teaching **proper body alignment and positioning**, and timing techniques of a bed-bound patient
13. Teaching **ambulation with prescribed assistive devices** (such as crutches, walker, cane, etc.) that are needed due to a recent functional loss
14. Teaching **prosthesis care and gait training**
15. Teaching the **use and care of braces, splints and orthotics** and associated skin care
16. Teaching the **preparation and maintenance of a therapeutic diet**
17. Teaching proper **administration of oral medication**, including signs of side effects and avoidance of interaction with other medications and food
18. Teaching the **proper care and application of any special dressings or skin treatments**

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Myth busted!

Medicare won't just pay for generic teaching- but it needs to be specific to a patient need and be reasonable for the patient goals- not just "best practice" teaching



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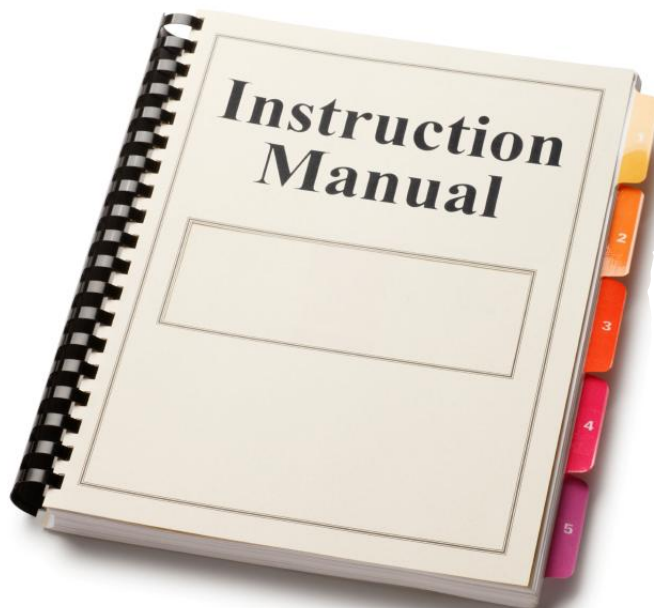


SN providing injections

“Medicare will always pay for nursing visits to administer an injection”

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Let's see what Chapter 7 says...



Section 40.1.2.4: "Administration of Medications"

Medicare pays for a SN to administer medications when it takes the skills of a nurse, and are not typically self-administered

IV

IM

May cover Subcutaneous if adequate documentation why the patient is unable and there is no willing/able caregiver to provide

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Supporting the need...

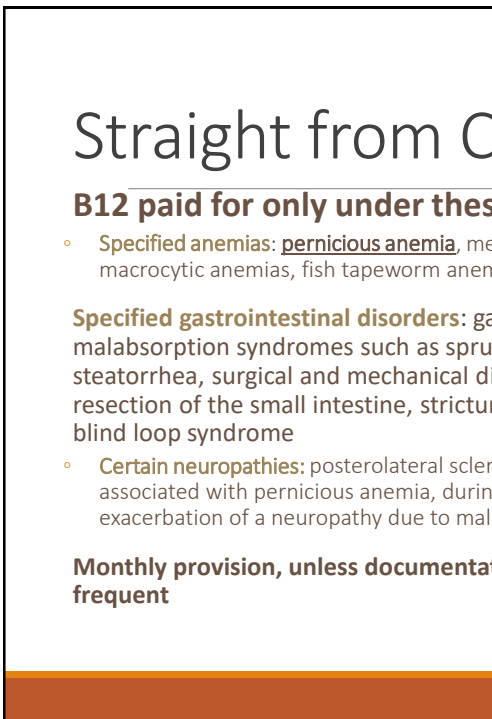
Medicare may pay for administration of injections/IV


- *Ask and document:*
- Does patient have a diagnosis or condition that is consistent with this med?
- Does this medication come in a less invasive form? If so, document why the oral medication is not being used (specific to patient)
- Is injection at a medically necessary frequency?

MC does not typically pay for self-administered

- No administration of oral, topical or eye drops (may pay for teaching, but not administration)
- Subcutaneous injections - e.g. Insulin
- **If patient unable to do own subcutaneous injection- document why not , and that there is no willing/able caregiver to provide**

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Straight from Chapter 7- Examples...

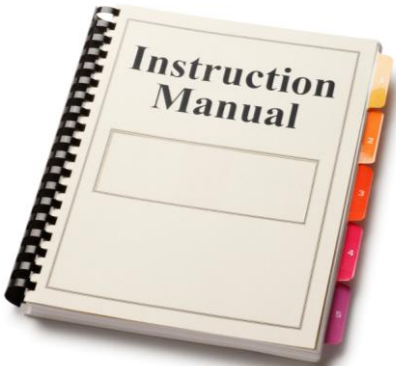
B12 paid for only under these conditions:

- **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

- **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.

Monthly provision, unless documentation supports more frequent



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Myth busted!

Medicare won't just pay for administration of all injections, but must be typically IM/IV and must also be related to an appropriate diagnosis/need by the patient



Myth

Reality

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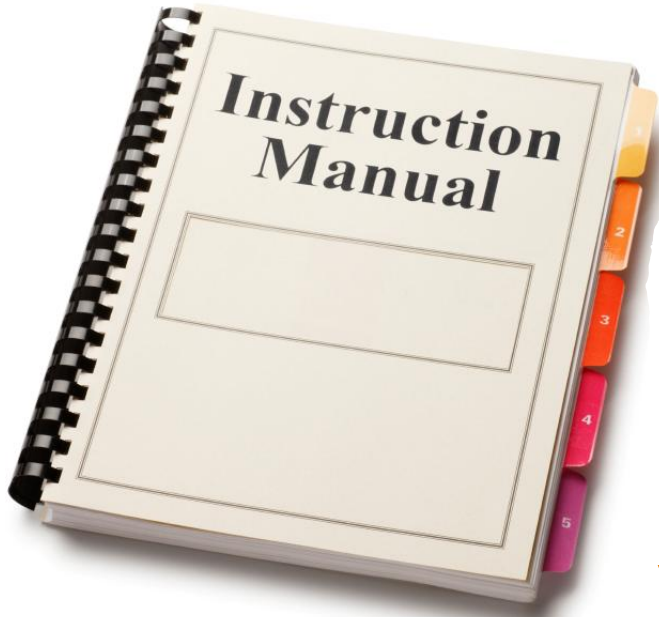


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Nursing providing wound care

“Medicare will always pay for wound care if the patient has a wound”

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Let's see what Chapter 7 says...



Section 40.1.2.8: "Wound care"


To be paid- wound care must have:

- **Complete documentation** of wound characteristics, and
- Wound care orders


Wound must be complicated, or
The wound care itself is complicated

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Supporting the need...



Documentation must support complexity of the hands-on skill needed and/or

Complexity of the wound itself and/or

Complexity of the risk (simple wound on a diabetic patient's ankle with PVD)

- In these cases, focus on the assessment/risk first, then the simple wound care, which is "incidental"

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Straight from Chapter 7- Examples...

Open wounds which are draining purulent or colored exudate or have a foul odor present or for which the patient is receiving antibiotic therapy

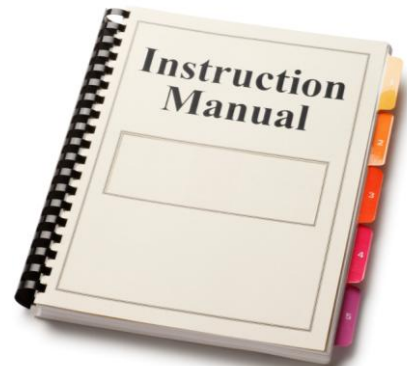
Wounds with a drain or T-tube that require shortening or movement of such drains

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.



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Straight from Chapter 7- Examples...

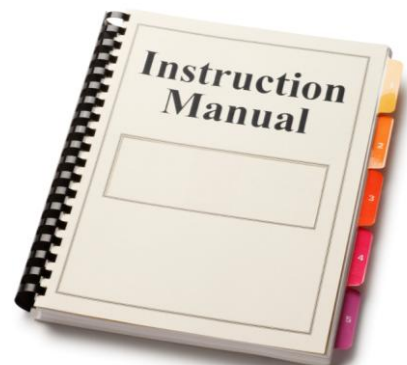
Wounds with exposed internal vessels or a mass that may have a proclivity for hemorrhage when a dressing is changed (e.g., post radical neck surgery, cancer of the vulva)

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 that has a reasonable potential to adversely affect healing (e.g., diabetes)

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



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Myth busted!

Medicare won't just pay for any wound care! We must show complexity/skill needed



Myth

Reality

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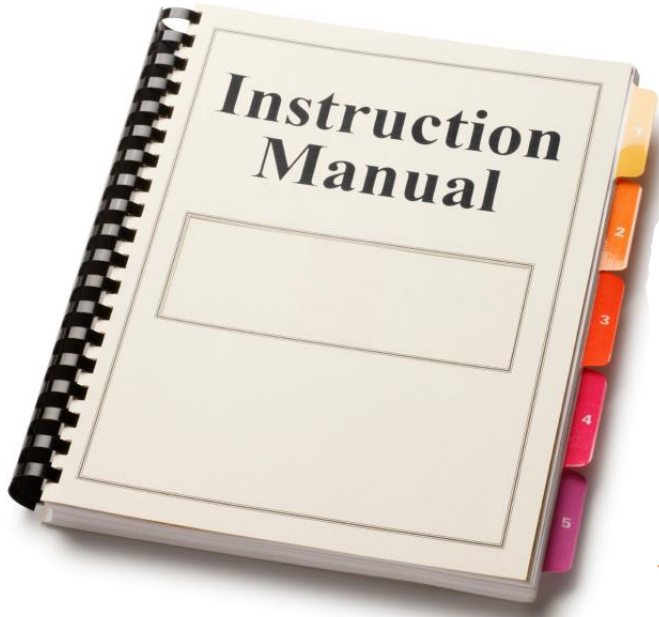


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Nursing and venipuncture

“Medicare will not pay for a nurse to perform venipuncture”

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Let's see what Chapter 7 says...




Section 40.1.2.13: "Venipuncture"


Venipuncture is defined as a "Skilled service" by Chapter 7

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Supporting the need...



- Can not be the "Qualifying" skill for the HH benefit
- Can stand alone a reason/skill for the SN visit
- Example: Patient on service for PT, could provide SN ordered for venipuncture
- Example: Patient on service for SN to provide assessment and teaching, could also then perform venipuncture
- Document reason for testing and results

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Myth busted!

Medicare will pay for venipuncture, as long as it is not the qualifying need for home health!



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And, what are your top Myths??



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TOOL OF THE MONTH

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Recertification/30-day Review



- 1.) Does the patient still have needs for nursing or therapy related to unmet goals? If yes, continue to #2- if no, discharge from care, unless payer will pay for non-skilled care only.
- 2.) Is this a payer who requires authorization? If yes, proceed to seek orders and authorization. If "no"- proceed to #3.
- 3.) Is this a traditional Medicare patient? If yes, the agency must determine coverage by considering homebound status, and the following:

Nursing:

- A. Is there still a "hands-on" skill below that the patient needs? If yes= Covered service for recertification, If no= Go to "B"
 - Ongoing skilled wound care such as wound vac, packing, full thickness wound
 - Vitamin B12 or other IM injections with appropriate diagnoses to support
 - IV medication administration
 - Foley/suprapubic catheter changes
- B. For ongoing assessment or teaching:
 - Has there been a **medication or treatment order change** in **last three weeks**?
 - Has there been a new or exacerbated condition in last three weeks (requiring medication or treatment changes)
 - If yes to one of above, covered services for recertification. If no- consider DC from nursing/ca

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Therapies:

- Are there still skilled modalities, such as ultrasound, that the patient needs?
- Are the other manual modalities (therapeutic exercises, gait training, ADL training, balance work) **advancing/changing with the professional assessment and adjustments of plan of care? (not repetitive each visit)**
 - Note: Due to Jimmo vs Sebalius case, we do not need to see improvement to qualify for home health- but it is NOT considered to take skills of therapist to simply perform repetitive modalities that could be taught to non- therapist
- Has there been a change in setting? Caregiver? Function?
- Is it reasonable to meet goals?

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Questions?



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