

Medicare Rules for Home Care

1. Module One - Qualifying Criteria

General Requirements for Home Health Care

Medicare provides healthcare for almost all people age 65 or over, and some people with long-term disabilities. Coverage includes home health visits, *if* specific qualifying criteria are met.

- I. Beneficiary is “**homebound**”.
- II. Beneficiary has a “**skilled need**”.
- III. Beneficiary requires only “**intermittent**” care.
- IV. Services are performed under a **physician’s order**.

All of these terms have specific, detailed definitions. Homecare clinicians must understand these definitions in order to determine whether to admit a client to homecare, and whether to continue homecare when circumstances change.

I. **Homebound**

An individual does not have to be bedridden to be considered homebound. However, leaving home must require a “considerable and taxing effort”. A client will generally be considered homebound if:

- leaving home is medically contraindicated;
- the client cannot go out without supportive devices such as crutches, canes, wheelchairs, and walkers;
- the client cannot go out without the use of special transportation;
- the client cannot go out without the assistance of another person;
- the client suffers a psychiatric illness such that they refuse to leave home or it would not be considered safe for them to leave home unattended.

Homecare clinicians should document the reason a client is homebound on a continuing basis, according to agency policy.

Going out for medical treatment, such as to doctor’s appointments, hemo-dialysis, or outpatient chemotherapy or radiation therapy is always permissible. Attending Adult Daycare or religious services is also permissible.

Attending outpatient therapy services is permissible if the client needs services involving equipment that cannot be made available in the home.

Other absences, such as occasional trips to the barber, walks around the block or drives, attendance at family reunions, funerals, or graduations are permissible only if they are *infrequent* or for periods of relatively *short* duration.

Documentation of homebound status must include:

- Description of the taxing effort
- Frequency, duration, and purpose of absences from home
- Clear, specific, measurable terms

II. Skilled Need

Medicare will cover Homecare visits only if the client has a *skilled need*. The beneficiary must need at least one of the following;

- A. Skilled nursing
- B. Physical Therapy
- C. Speech Therapy
- D. "continued" Occupational Therapy

A. Skilled Nursing

Nursing assessment, treatment, or teaching is *skilled* if it must be provided by a registered nurse, or a licensed practical nurse under the supervision of a registered nurse, to be safe and effective. If a service can be safely and effectively performed by a non-nurse without training or oversight by a nurse, it is not a skilled service.

What would be non-skilled may be considered skilled if a client has a condition that predisposes him to complications. Thus though a client would not normally require Homecare visits to assess a leg cast; skilled assessments may be indicated if the client has underlying circulatory compromise.

Home visits must be reasonable and necessary. For example, visits to teach a newly diagnosed diabetic how to self-inject insulin are reasonable and necessary; however, visits to teach self-injection to a client who has been self-injecting successfully for ten years are not.

Medicare does not require that clients or family members perform care, such as dressing changes or IV medication administration, even if the client or family member is able. However, if a client or family member or other appropriate person indicates they are able and willing to perform a service, it is not reasonable and necessary for Home Health Agency personnel to provide the services.

If a nurse trains a non-nurse to perform a service, Medicare will still cover Homecare visits to perform the service when the trained person is unavailable.

If a client has a skilled need, Medicare will cover Homecare visits for as long as that skilled need continues, even if it will continue indefinitely. Thus a client with an indwelling foley catheter requiring Q four week catheter replacement can remain on-service for Q 4 week nursing visits as long as the catheter remains.

However, the need for *skilled assessments* does not usually continue indefinitely; once a client's condition stabilizes (client is without adverse symptoms, or changes in condition, plan of care, or medications for at least three weeks), the client's skilled need ends.

Skilled nursing visits for "management and evaluation" of the patient's care are covered in rare circumstances where underlying conditions or complications or the complexity of unskilled care necessitate that a nurse ensure that essential non-skilled care is achieving its purpose.

Nursing documentation should specify:

- The reason skilled nursing is needed now
- Any recent new diagnosis, exacerbation, or hospitalization
- Changes in the treatment regimen
- Skilled assessments
- Actions taken
- Treatments performed
- Specific education provided (what was taught, to whom, learner comprehension, changes to the plan of care)

B. Skilled Physical Therapy, Speech Therapy, or Occupational Therapy

Medicare covers home Physical Therapy, Speech Therapy, or Occupational Therapy visits necessary to treat a patient's illness or injury or restore function affected by illness or injury. For physical, occupational, or speech therapy visits to constitute a "skilled need," the patient must have "restorative potential," i.e., there must be an expectation that the patient will improve materially in a generally predictable period of time.

If there is no restorative potential, Medicare may cover visits to develop and establish a plan of care to be carried out by a non-therapist, or to periodically reevaluate a plan of care, or to teach the patient or the patient's family or care-givers necessary techniques, exercises or precautions.

General exercises to promote overall fitness or provide diversion or general motivation, however, do not constitute skilled therapy. Visits to train other HHA staff (e.g., home health aides) are non-billable visits.

C. "Continued" Occupational Therapy

Occupational therapy alone cannot establish eligibility for homecare. However, once another required service has established eligibility, occupational therapy can continue after that service ends. This is true only of occupational therapy, and not of any other service.

Therapy documentation should specify:

- The reason(s) skilled therapy is needed now, based on the complexity of the service or the condition of the patient
- The prior and current level of function
- Objective, realistic goals
- Detailed progress toward the goals (if progress is limited or slow, consider changes to the plan of treatment)

III. Part Time/Intermittent Care

Medicare pays only for part-time or intermittent services. The intermittency rules are complex; in brief there are three circumstances where the risk of violating the intermittency requirement arises:

A. Single visits.

Medicare will not cover a single nursing visit; the patient must need at least two skilled nursing visits, *unless* more than one visit was planned but only one could be provided (for example, if the client died before a second visit could be made).

This rule does not apply to therapy services or Home Health Aide services; Medicare will pay for a single therapy visit or single Home Health Aide visit.

Also, this rule only applies if nursing is the qualifying service; a single nursing visit to a client receiving physical therapy, for example, is permissible.

B. Daily visits

Medicare will not cover daily skilled nursing visits unless there is a finite and predictable end-date. Physician's orders for daily nursing visits must state a reasonable and predictable end date.

However, in an exception, Medicare will cover indefinite daily visits to administer insulin to clients who are mentally or physically unable to self-inject.

This rule does not apply to therapy services or Home Health Aide services; Medicare will pay for daily therapy visits or Home Health Aide visits.

Also, this rule only applies if nursing is the qualifying service; daily nursing visits to a client receiving physical therapy, for example, is permissible.

C. Total Services

Medicare will not cover Homecare services if the total number of hours of nursing and home health aides exceeds eight per day, or 28 per week. (Though this limit can be extended to 35 hours in exceptional circumstances.)

Therapy visits are not included in the total.

This rule applies regardless of whether nursing or therapy is the qualifying service.

IV. Physician's orders

Home health services must be ordered by a physician, and carried out according to the physician's orders. An initial visit to evaluate the client's eligibility and develop a plan of care may be performed under a verbal, or telephone order. The written plan of care must subsequently be signed by the ordering physician, and constitutes a written physician's order for services.

For additional services beyond those included in the original plan of care, a verbal or written order must be obtained *before the services are performed*.

If any ordered services are not performed, e.g., if visits are cancelled, the physician must be notified.

Quiz

1. Medicare provides health insurance for most people over the age of 65 and some permanently disabled persons.
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2. Four basic eligibility requirements for Medicare Homecare are: homebound status, skilled need, intermittency, and physician's orders.
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3. In general, a person is homebound if going out requires a considerable and taxing effort.
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4. In general, Medicare pays for home visits by a nurse to perform services that cannot be safely and effectively performed by a non-nurse.
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5. Medicare only pays for home visits if they are reasonable and necessary.
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6. In general, Medicare pays for home visits by physical therapists if a client has "restorative potential".
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7. Medicare will not pay for a single nursing visit, unless a second visit was planned but could not be performed.
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8. A physician's order for, "daily nursing visits", without any further directions, is valid.
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9. Medicare will not pay for Homecare if the total combined hours of nursing and Home Health Aide visits exceed 28 per week.
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10. Medicare will not pay for home care unless it is performed under a physician's orders.
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11. To add services beyond those ordered in the initial Plan of Care, you must obtain a physician's order before performing the additional services.
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12. If you perform fewer visits than a physician ordered, you must notify the physician.

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