Home Health

Medicare Coverage Guidelines for Nursing & Therapy Services

Source

Home Health Agency Manual (HIM 11)

Cherokee Nation Home Health Services Inc.

One Plaza South PMB #374

Tahlequah OK 74464

Phone: 918-458-6102 /888-281-6910

Fax: 918-456-5192

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CONDITIONS THE PATIENT MUST MEET TO QUALIFY FOR COVERAGE OF HOME HEALTH SERVICES

To qualify for Medicare coverage of any home health services, the patient must meet each of the criteria described in this section. Patients who meet each of these criteria are eligible to have payment made on their behalf for the services discussed in §§205 and 206.

Section 1

Confined to the Home.--

A. Patient Confined to the home.--In order 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. (See §240.l.) An individual does not have to be bedridden to be considered as confined to the home. However, the condition of these patients should be such that there exists a normal inability to leave home and, consequently, leaving home would require a considerable and taxing effort. 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 attributable to the need to receive health care treatment include, but are not limited to, attendance at adult day centers to receive medical care, ongoing receipt of outpatient kidney dialysis, and the receipt of outpatient chemotherapy or radiation therapy. Any absence of an individual from the home attributable to the need to receive health care treatment, including regular absences for the purpose of participating in therapeutic, psychosocial, or medical treatment in an adult day-care program that is licensed or certified by a State, or accredited, to furnish adult day-care services in a State shall not disqualify an individual from being considered to be confined to his home. Any other absence of an individual from the home shall not so disqualify an individual if the absence is of an infrequent or of relatively short duration. For purposes of the preceding sentence, any absence for the purpose of attending a religious service shall be deemed to be an absence of infrequent or short duration. It is expected that in most instances, absences from the home that occur will be for the purpose of receiving health care treatment. However, occasional absences from the home for nonmedical purposes, e.g., an occasional trip to the barber, a walk around the block, a drive, attendance at a family reunion, funeral, graduation, or other infrequent or unique event would not necessitate a finding that the patient is not homebound if the absences are undertaken on an infrequent basis or are of relatively short duration and do not indicate that the patient has the capacity to obtain the health care provided outside rather than in the home. The examples provided above are not all-inclusive and are meant to be illustrative of the kinds of infrequent or unique events a patient may attend.

Generally speaking, a patient will be considered to be homebound if he/she has a condition due to an illness or injury that restricts his/her ability to leave his/her place of residence except with the aid of supportive devices such as crutches, canes, wheelchairs, and walkers, the use of special transportation, or the assistance of another person or if leaving home is medically contraindicated. Some examples of homebound patients that illustrate the factors used to determine whether a homebound condition exists would be: (1) a patient paralyzed from a stroke who is confined to a wheelchair or requires the aid of crutches in order to walk; (2) a patient who is blind or senile and requires the assistance of another person to leave his/her residence; (3) a patient who has lost the use of his/her upper extremities and, therefore, is unable to open doors, use handrails on stairways, etc., and requires the assistance of another individual to leave his/her residence; (4) a patient who has just returned from a hospital stay involving surgery suffering from resultant weakness and pain and, therefore, his/her actions may be restricted by his/her physician to certain specified and limited activities such as getting out of bed only for a specified period of time, walking stairs only once a day, etc.; (5) a patient with arteriosclerotic heart disease of such severity that he/she must avoid all stress and physical activity; (6) a patient with a psychiatric problem if the illness is manifested in part by a refusal to leave home or is of such a nature that it would not be considered safe to leave home unattended, even if he/she has no physical limitations; and (7) a patient in the late stages of ALS or a neurodegenerative disabilities.

In determining whether the patient has the general inability to leave the home and leaves the home only infrequently or for periods of short duration, it is necessary (as is the case in determining whether skilled nursing services are intermittent) to look at the patient's condition over a period of time rather than for short periods within the home health stay. For example, a patient may leave the home (under the conditions described above, e.g, with severe and taxing effort, with the assistance of others) more frequently during a short period when, for example, the presence of visiting relatives provides a unique opportunity for such absences, than is normally the case. So as long as the patient's overall condition and experience is such that he or she meets these qualifications, he or she should be considered confined to the home.

The aged person who does not often travel from home because of feebleness and insecurity brought on by advanced age would not be considered confined to the home for purposes of receiving home health services unless he/she meets one of the above conditions. A patient who requires skilled care must also be determined to be confined to the home in order for home health services to be covered.

Although a patient must be confined to the home to be eligible for covered home health services, some services cannot be provided at the patient's residence because equipment is required that cannot be made available there. If the services required by a patient involve the use of such equipment, the HHA may make arrangements or contract with a hospital, skilled nursing facility, or a rehabilitation center to provide these services on an outpatient basis. (See §§200.2 and 206.5.) However, even in these situations, for the services to be covered as home health services, the patient must be considered confined to his/her home; and to receive such outpatient services a homebound patient will generally require the use of supportive devices, special transportation, or the assistance of another person to travel to the appropriate facility.

If a question is raised as to whether a patient is confined to the home, the HHA will be asked to furnish the intermediary with the information necessary to establish that the patient is homebound as defined above.

Section 2

Patient's Place of Residence.--A patient's residence is wherever he/she makes his/her home. This may be his/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 home if the institution meets the requirements of §§1861(e)(1) or 1819 (a)(1) of the Act. Included in this group are hospitals and skilled nursing facilities, as well as most nursing facilities under Medicaid.

Thus, if a patient is in an institution or distinct part of an institution identified above, the patient is not entitled to have payment made for home health services under either Part A or Part B since these institutions may not be considered his/her residence. When a patient remains in a participating SNF following his/her discharge from active care, the facility may not be considered his/her residence for purposes of home health coverage.

A patient may have more than one home and the Medicare rules do not prohibit a patient from having one or more places of residence. A patient, under a Medicare home health plan of care, who resides in more than one place of residence during an episode of Medicare covered home health services will not disqualify the patient's homebound status for purposes of eligibility. For example, a person may reside in a principal home and also a second vacation home, mobile home or the home of a caretaker relative. The fact that the patient resides in more than one home and, as a result, must transit from one to the other, is not in itself, an indication that the patient is not homebound. The requirements of homebound must be met at each location (e.g., considerable taxing effort etc).

Section 3

Assisted Living Facilities, Group Homes & Personal Care Homes.-- An individual may be "confined to the home" for purposes of Medicare coverage of home health services if he or she resides in an institution that is not primarily engaged in providing to inpatients diagnostic and therapeutic services for medical diagnosis, treatment, care of disabled or sick persons, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons, or skilled nursing care or related services for patients who require medical or nursing care, or rehabilitation services for the rehabilitation of injured, sick, or disabled persons. 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.

From the Medicare perspective, individuals who reside in assisted living facilities may be eligible for coverage of Medicare home health services. A major consideration is the location of the individual within the assisted living facility in terms of the level and type of care that is provided.

Section 4

Observation and Assessment of Patient's Condition When Only the Specialized Skills of a Medical Professional Can Determine a Patient's Status.-Observation and assessment of the patient's condition by a licensed nurse are reasonable and necessary skilled services when the likelihood of change in a patient's condition 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 treatment regimen is essentially 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 as long as there remains a reasonable potential for such a complication or further acute episode.

Information from the patient's medical history may support the likelihood of a future complication or acute episode and, therefore, may justify the need for continued skilled observation and assessment beyond the 3-week period. Moreover, such indications as abnormal/fluctuating vital signs, weight changes, edema, symptoms of drug toxicity, abnormal/fluctuating laboratory values, and respiratory changes on auscultation may justify skilled observation and assessment. Where these indications are such that it is likely that skilled observation and assessment by a nurse will result in changes to the treatment of the patient, then the services would be covered. There are cases where patients who are stable continue to require skilled observation and assessment. (See example in §205.1B.13.d.) However, observation and assessment by a nurse is not reasonable and necessary to the treatment of the illness or injury where these indications are part of a longstanding pattern of the patient's condition, and there is no attempt to change the treatment to resolve them.

EXAMPLE 1: A patient with arteriosclerotic heart disease with congestive heart failure requires close observation by skilled nursing personnel for signs of decompensation or adverse effects resulting from prescribed medication. Skilled observation is needed to determine whether the drug regimen should be modified or whether other therapeutic measures should be considered until the patient's treatment regimen is essentially stabilized.

EXAMPLE 2: A patient has undergone peripheral vascular disease treatment including a revascularization procedure (bypass). The incision area is showing signs of potential infection (e.g., heat, redness, swelling, drainage) and the patient has elevated body temperature. Skilled observation and monitoring of the vascular supply of the legs and the incision site is required until the signs of potential infection have abated and there is no longer a reasonable potential of infection.

EXAMPLE 3: A patient was hospitalized following a heart attack and, following treatment but before mobilization, is discharged home. Because it is not known whether exertion will exacerbate the heart disease, skilled observation is reasonable and necessary as mobilization is initiated until the patient's treatment regimen is essentially stabilized.

EXAMPLE 4: A frail 85 year old man was hospitalized for pneumonia. The infection was resolved, but the patient, who had previously maintained adequate nutrition, will not eat or eats poorly. The patient is discharged to the HHA for monitoring of fluid and nutrient intake, and assessment of the need for tube feeding. Observation and monitoring by licensed nurses of the patient's oral intake, output and hydration status is required to determine what further treatment or other intervention is needed.

EXAMPLE 5: A patient with glaucoma and a cardiac condition has a cataract extraction. Because of the interaction between the eye drops for the glaucoma and cataracts and the beta blocker for the cardiac condition, the patient is at risk for serious cardiac arrhythmias.

Skilled observation and monitoring of the drug actions is reasonable and necessary until the patient's condition is stabilized.

EXAMPLE 6: A patient with hypertension suffered dizziness and weakness. The physician found that the blood pressure was too low and discontinued the hypertension medication. Skilled observation and monitoring of the patient's blood pressure and medication regimen is required until the blood pressure remains stable and in a safe range.

Section 5

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 nonskilled 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 licensed nurses to promote the patient's recovery and medical safety in view of the patient's overall condition.

EXAMPLE 1: An aged patient with a history of diabetes mellitus and angina pectoris is recovering from an open reduction of the neck of the femur. He requires among other services, careful skin care, appropriate oral medications, a diabetic diet, a therapeutic exercise program to preserve muscle tone and body condition, and observation to notice signs of deterioration in his condition or complications resulting from his restricted, but increasing mobility. Although any of the required services could be performed by a properly instructed person, that person would not have the capability to understand the relationship among the services and their effect on each other. Since the combination of the patient's condition, age and immobility creates a high potential for serious complications, such an understanding is essential to ensure the patient's recovery and safety. The management of this plan of care requires skilled nursing personnel until the patient's treatment regimen is essentially stabilized.

EXAMPLE 2: An aged patient with a history of mild dementia is recovering from pneumonia which has been treated at home. The patient has had an increase in disorientation, has residual chest congestion, decreased appetite and has remained in bed, immobile, throughout the episode with pneumonia. While the residual chest congestion and recovery from pneumonia alone would not represent a high risk factor, the patient's immobility and increase in confusion could create a high probability of a relapse. In this situation, skilled oversight of the nonskilled services would be reasonable and necessary pending the elimination of the chest congestion and resolution of the persistent disorientation to ensure the patient's medical safety.

Where visits by a nurse are not needed to observe and assess the effects of the nonskilled services being provided to treat the illness or injury, skilled nursing care would not be considered reasonable and necessary to treat the illness or injury.

EXAMPLE: A physician orders one skilled nursing visit every 2 weeks and three home health aide visits each week for bathing and hair washing for a patient whose cerebral vascular accident has resulted in residual weakness on the left side. The cardiovascular condition is stable, and the patient has reached the maximum restoration potential. There are no underlying conditions that would necessitate the skilled supervision of a licensed nurse in assisting with bathing or hair washing. The skilled nursing visits are not necessary to manage and supervise the home health aide services and would not be covered.

Section 6

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 his/her 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 that 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.

EXAMPLE 1: A physician has ordered skilled nursing care for teaching a diabetic who has recently become insulin dependent. The physician has ordered teaching of self-injection and management of insulin, signs and symptoms of insulin shock and actions to take in emergencies. The teaching services would be reasonable and necessary to the treatment of the illness or injury.

EXAMPLE 2: A physician has ordered skilled nursing care to teach a patient to follow a new medication regimen (in which there is a significant probability of adverse drug reactions due to the nature of the drug and the patient's condition), signs and symptoms of adverse reactions to new medications and necessary dietary restrictions. After it becomes apparent that the patient remains unable to take the medications properly, cannot demonstrate awareness of potential adverse reactions, and is not following the necessary dietary restrictions, skilled nursing care for further teaching would not be reasonable and necessary.

EXAMPLE 3: A physician has ordered skilled nursing visits to teach self-administration of insulin to a patient who has been self-injecting insulin for 10 years and there is no change in the patient's physical or mental status that would require reteaching. The skilled nursing visits would not be considered reasonable and necessary since the patient has a longstanding history of being able to perform the service.

EXAMPLE 4: A physician has ordered skilled nursing visits to teach self-administration of insulin to a patient who has been self-injecting insulin for 10 years because the patient has recently lost the use of the dominant hand and must be retrained to use the other hand. Skilled nursing visits to reteach self-administration of the insulin would be reasonable and necessary.

In determining the reasonable and necessary number of teaching and training visits, consideration must be given to whether the teaching and training provided constitute a reinforcement of teaching provided previously in an institutional setting or in the home or whether it represents the 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 a 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.

EXAMPLE 5: A patient recovering from pneumonia is being sent home requiring IV infusion of antibiotics 4 times per day. The patient's spouse has been shown how to administer the drug during the hospitalization and has been told the signs and symptoms of infection. The physician has also ordered home health services for a nurse to teach administration of the drug and the signs and symptoms requiring immediate medical attention. Teaching by the nurse in the home would be reasonable and necessary to continue that begun in the hospital, since the home environment and the nature of the supplies used in the home, differ from that in the hospital.

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.

EXAMPLE 6: A well established diabetic who loses the use of his or her dominant hand would need to be retrained in self-administration of insulin.

EXAMPLE 7: A spouse who has been taught to perform a dressing change for a post surgical patient may need to be re-taught wound care if the spouse demonstrates improper performance of wound care.

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 administer insulin injections, prepare and follow a diabetic diet, observe foot-care precautions, and 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 turning 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 proper care and application of any specialized 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 from radiation treatments);
- Teaching the preparation and maintenance of a therapeutic diet; and
- Teaching proper administration of oral medications, including signs of side-effects and avoidance of interaction with other medications and food.

Section 7

Administration of Medications.--Although drugs and biologicals are specifically excluded from coverage by the statute (§1861(m)(5) of the Social Security Act), the services of a licensed nurse that are required to administer medications safely and effectively may be covered if they are reasonable and necessary to the treatment of the illness or injury.

Intravenous, intramuscular, or subcutaneous injections and infusions, and hypodermoclysis or intravenous feedings require the skills of a nurse to be performed (or taught) safely and effectively. Where these services are reasonable and necessary to treat the illness or injury, they may be covered. For these services to be reasonable and necessary, the medication being administered must be accepted as safe and effective treatment of the patient's illness or injury, and there must be a medical reason that the medication cannot be taken orally. Moreover, the frequency and duration of the administration of the medication must be within accepted standards of medical practice or there must be a valid explanation regarding the extenuating circumstances to justify the need for the additional injections.

(1) 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,
- 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.

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.

(2) 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 able and willing to inject the patient, the injections would be considered a reasonable and necessary skilled nursing service.

EXAMPLE: A patient who requires an injection of insulin once per day for treatment of diabetes mellitus, also has multiple sclerosis with loss of muscle control in the arms and hands, occasional tremors, and vision loss that causes inability to fill syringes or self-inject insulin. If there is no able and willing caregiver to inject the insulin, skilled nursing care would be reasonable and necessary for the injection of the insulin.

The pre-filling of syringes with insulin (or other medication which is self-injected) does not require the skills of a licensed nurse, and therefore is not considered to be a skilled nursing service. If the patient needs someone only to pre-fill syringes (and therefore needs no skilled nursing care on an intermittent basis, or physical therapy or speech-language pathology services), the patient does not qualify for any Medicare coverage of home health care. Pre-filling of syringes for self-administration of insulin or other medications is considered to be assistance with medications that are ordinarily self-administered and is an appropriate home health aide service. (See §206.1.) However, where State law requires that a nurse pre-fill syringes, a skilled nursing visit

to pre-fill syringes is paid as a skilled nursing visit (if the patient otherwise needs skilled nursing care or physical therapy or speech-language pathology services), but is not considered to be a skilled nursing service.

b. Oral Medications.--The administration of oral medications by a nurse is not a 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 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.

c. Eye Drops and Topical Ointments.--The administration of eye drops and topical ointments does not require the skills of a licensed nurse. Therefore, even if the administration of eyedrops or ointments is necessary to the treatment of an illness or injury, the patient cannot self-administer the drops, and there is no one available to administer them, the visits cannot be covered as skilled nursing services. This section does not eliminate coverage for skilled nursing visits for observation and assessment of the patient's condition. (See §205.1.B.1.)

EXAMPLE 1: A physician has ordered skilled nursing visits to administer eye drops and ointments for a patient with glaucoma. The administration of eye drops and ointments does not require the skills of a nurse. Therefore, the skilled nursing visits cannot be covered as skilled nursing care, notwithstanding the importance of the administration of the drops as ordered.

EXAMPLE 2: A physician has ordered skilled nursing visits for a patient with a reddened area under the breast. The physician instructs the patient to wash, rinse, and dry the area daily and apply vitamin A and D ointment. Skilled nursing care is not needed to provide this treatment safely and effectively.

Section 8

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.

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.

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.

EXAMPLE: A patient who has a Foley catheter due to loss of bladder control because of multiple sclerosis has a history of frequent plugging of the catheter and urinary tract infections. The physician has ordered skilled nursing visits once per month to change the catheter, and has left a "PRN" order for up to 3 additional visits per month for skilled observation and evaluation and/or catheter changes if the patient or family reports signs and symptoms of a urinary tract infection or a plugged catheter. During the certification period, the patient's family contacts the HHA because the patient has an elevated temperature, abdominal pain, and scant urine output. The nurse visits the patient and determines that the catheter is plugged and there are symptoms of a urinary tract infection. The nurse changes the catheter and contacts the physician to advise him of her findings and to discuss treatment. The skilled nursing visit to change the catheter and to evaluate the patient would be reasonable and necessary to the treatment of the illness or injury.

Section 9

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), 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. 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, administration of prescription medications, etc.) of wounds with the following characteristics, the skills of a nurse are usually reasonable and necessary:

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

b. Wounds with a drain or T-tube;

c. Wounds that require irrigation or instillation of a sterile cleansing or medicated solution into several layers of tissue and skin and/or packing with sterile gauze;

d. Recently debrided ulcers;

e. Pressure sores (decubitus ulcers) with the following characteristics:

   o There is partial tissue loss with signs of infection such as foul odor or purulent drainage, or

   o 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.

f. 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);

g. Open wounds or widespread skin complications following radiation therapy or result from immune deficiencies or vascular insufficiencies;

h. Post-operative wounds where there are complications such as infection or allergic reactior where there is an underlying disease that has a reasonable potential to adversely affect healing (e.g., diabetes);

i. Third degree burns, and second degree burns where the size of the burn or presence of complications causes skilled nursing care to be needed;

j. Skin conditions that require application of nitrogen mustard or other chemotherapeutic medication that presents a significant risk to the patient; or

k. Other open or complex wounds that require treatment that can only be provided safely and effectively by a licensed nurse.

EXAMPLE 1: A patient has a second-degree burn with full thickness skin damage on his back. The wound is cleansed, followed by an application of Sulfamylon. While the wound requires skilled monitoring for signs and symptoms of infection or complications, the dressing change requires skilled nursing services.

EXAMPLE 2: A patient experiences a decubitus ulcer where the full thickness tissue loss extends through the dermis to involve subcutaneous tissue and the wound involves necrotic tissue. The physician's order is to apply a covering of a debriding ointment following vigorous irrigation. The wound is then packed loosely with wet to dry dressings or continuous moist dressing and covered with dry sterile gauze. Skilled nursing care is necessary for a proper treatment and understanding of cellular adherence and/or exudate or tissue healing or necrosis.

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 (see §205.1.B.1) or skilled teaching of wound care to the patient or family. (See §205.1.B.3.)

Section 10

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.

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 as skilled nursing services.

Medical Gasses.--Initial phases of a regimen involving the administration of medical gasses 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 gasses and to teach the patient and family when and how to properly manage the administration of the gasses.

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.

Section 11

Venipuncture.--Effective February 2, 1998, as mandated by the Balanced Budget Act (BBA) of 1997, venipuncture for the purposes of obtaining a blood sample can no longer be the sole reason for Medicare home health eligibility. However, if a beneficary 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. Venipuncture when the collection of the specimen is necessary to the diagnosis and treatment of the patient's illness or injury and when the venipuncture cannot be performed in the course of regularly scheduled absences from the home to acquire medical treatment is a skilled nursing service. The frequency of visits for venipuncture must be reasonable within accepted standards of medical practice for treatment of the illness or injury.

For venipuncture to be reasonable and necessary:

- 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 for monitoring the treatment to be reasonable and necessary.

- 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.

Examples of reasonable and necessary venipuncture for stabilized patients include, but are not limited to those described below. While these guidelines do not preclude a physician from ordering more frequent venipuncture for these laboratory tests, the HHA must present justifying documentation to support the reasonableness and necessity of more frequent testing.

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 3 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. Therefore, it is appropriate to monitor the level on a routine basis (every 3 months) when the results are stable and the patient is asymptomatic.

c. Venipuncture for fasting blood sugar (FBS):

   - An unstable insulin dependent or non-insulin dependent diabetic would require FBS more frequently than once per month if ordered by the physician.

   - Where there is a new diagnosis or 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 non-insulin 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 are stable within non-therapeutic ranges, there must be documentation of other factors that would indicate why continued monitoring is reasonable and necessary.

EXAMPLE: A patient with coronary artery disease was hospitalized with atrial fibrillation and was subsequently discharged to the HHA with orders for anticoagulation therapy. Monthly venipuncture as indicated are necessary to report prothrombin (protime) levels to the physician, notwithstanding that the patient's prothrombin time tests indicate essential stability.

Section 12

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.

Section 13

Psychiatric Evaluation, Therapy, and Teaching.--The evaluation, psychotherapy, and teaching activities 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. If a substantial number of an HHA's patients attend partial hospitalization programs or receive outpatient mental health services, the intermediary may verify whether the patients meet the eligibility requirements specified in §204 and whether the HHA is primarily engaged in 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.

EXAMPLE 1: A patient is homebound for medical conditions, but has a psychiatric condition for which he has been receiving medication. The patient's psychiatric condition has not required a change in medication or hospitalization for over 2 years. During a visit by the nurse, the patient's spouse indicates that the patient is awake and pacing most of the night and has begun ruminating about perceived failures in life. The nurse observes that the patient does not exhibit an appropriate level of hygiene and is dressed inappropriately for the season. The nurse comments to the patient about her observations and tries to solicit information about the patient's general medical condition and mental status. The nurse advises the physician about the patient's general medical condition and the new symptoms and changes in the patient's behavior. The physician orders the nurse to check blood levels of medication used to treat the patient's medical and psychiatric conditions. The physician then orders the psychiatric nursing service to evaluate the patient's mental health and communicate with the physician about whether additional intervention to deal with the patient's symptoms and behaviors is warranted.

EXAMPLE 2: A patient is homebound after discharge following hip replacement surgery and is receiving skilled therapy services for range of motion exercise and gait training. In the past, the patient had been diagnosed with clinical depression and was successfully stabilized on medication. There has been no change in her symptoms. The fact that the patient is taking an antidepressant does not indicate a need for psychiatric nursing services.

EXAMPLE 3: A patient was discharged after 2 weeks in a psychiatric hospital with a new diagnosis of major depression. The patient remains withdrawn, in bed most of the day, refusing to leave home. The patient has a depressed affect and continues to have thoughts of suicide, but is not considered to be suicidal. Psychiatric nursing is necessary for supportive interventions until antidepressant blood levels are reached and the suicidal thoughts are diminished further, to monitor suicide ideation, ensure medication compliance and patient safety, perform suicidal assessment, and teach crisis management and symptom management to family members.

Section 14

Intermittent Skilled Nursing Care.--The Balanced Budget Act of 1997 provided a definition of intermittent skilled nursing services for purposes of eligibility by providing the following language to §1861(m) of the Act: For purposes of §§1814(a)(2)(C) and 1835(a)(2)(A), "intermittent" means 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.

Since the need for "intermittent" skilled nursing care makes the patient eligible for other covered home health services, the intermediary should evaluate each claim involving skilled nursing services furnished less frequently than once every 60 days. In such cases, payment should be made only if documentation justifies a recurring need for reasonable, necessary, and medically predictable skilled nursing services.

There is a possibility that a physician may order a skilled visit less frequently than once very 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.

Where the need for "intermittent" skilled nursing visits is medically predictable but a situation arises after the first visit making additional visits unnecessary, e.g., the patient is institutionalized or dies, the one visit would be paid at the wage adjusted LUPA amount for that discipline type. However, a one-time order; e.g., to give gamma globulin following exposure to hepatitis, would not be considered a need for "intermittent" skilled nursing care since a recurrence of the problem that would require this service is not medically predictable.

Although most patients require services no more frequently than several times a week, Medicare will pay for part-time (as defined in §206.7) medically reasonable and necessary skilled nursing care 7 days a week for a short period of time (2-3 weeks). There may also be a few cases involving unusual circumstances where the patient's prognosis indicates a medical need for daily skilled services beyond 3 weeks. As soon as the patient's physician makes this judgment, which usually should be made before the end of the 3-week period, the HHA must forward medical documentation justifying the need for such additional services and include an estimate of how much longer daily skilled services will be required.

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, usually would not qualify for home health benefits.

Section 15

Skilled Therapy Services.--

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

1. The service of a physical, 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 of 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 although many or all of the specific services needed to treat the illness or injury do not require the skills of a therapist.

2. 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 condition, those activities require the involvement of a skilled therapist to meet the patient's needs, promote recovery and ensure medical safety. Where the skills of a therapist are needed to manage and periodically reevaluate the appropriateness of a maintenance program because of an identified danger to the patient, such services would be covered even if the skills of a therapist are not needed to carry out the activities performed as part of the maintenance program.

3. While a patient's particular medical condition is a valid factor in deciding if skilled therapy services are needed, the 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 nonskilled personnel.

4. A service that is ordinarily considered nonskilled could be considered a skilled therapy service in cases in which there is clear documentation that, because of special medical complications, skilled rehabilitation personnel are required to perform or supervise the service or to observe the patient. However, the importance of a particular service to a patient or the frequency with which it must be performed does not, by itself, make a nonskilled service into a skilled service.

5. The skilled therapy services must be reasonable and necessary to the 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 treatment of the illness or injury:

a. The services must be consistent with the nature and severity of the illness or injury, the patient's particular medical needs, including the requirement that the amount, frequency and duration of the services must be reasonable;

b. The services must be considered, under accepted standards of medical practice, to be specific, safe, and effective treatment for the patient's condition; and

c. The services must be provided with the expectation, based on the assessment made by the physician of the patient's rehabilitation potential, that:

a. The condition of the patient will improve materially in a reasonable and generally predictable period of time; or

b. The services are necessary to the establishment of a safe and effective

maintenance program.

Services involving activities for the general welfare of any patient, e.g., general exercises to promote overall fitness or flexibility and activities to provide diversion or general motivation, do not constitute skilled therapy. Those services can be performed by nonskilled individuals without the supervision of a therapist.

d. Services of skilled therapists for the purpose of teaching the patient, family or caregivers necessary techniques, exercises or precautions are covered to the extent that they are reasonable and necessary to treat illness or injury. However, visits made by skilled therapists to a patient's home solely to train other HHA staff (e.g., home health aides) are not billable as visits since the HHA is responsible for ensuring that its staff is properly trained to perform any service it furnishes. The cost of a skilled therapist's visit for the purpose of training HHA staff is an administrative cost to the agency.

EXAMPLE: A patient with a diagnosis of multiple sclerosis has recently been discharged from the hospital following an exacerbation of her condition that has left her wheelchair bound and, for the first time, without any expectation of achieving ambulation again. The physician has ordered physical therapy to select the proper wheelchair for her long term use, to teach safe use of the wheelchair and safe transfer techniques to the patient and family. Physical therapy would be reasonable and necessary to evaluate the patient's overall needs, to make the selection of the proper wheelchair and to teach the patient and family safe use of the wheelchair and proper transfer techniques.

e. The amount, frequency, and duration of the services must be reasonable.

B. Application of the Principles to Physical Therapy Services.--The following discussion of skilled physical therapy services applies the principles in §205.2A to specific physical therapy services about which questions are most frequently raised.

1. Assessment.--The skills of a physical therapist to assess a patient's rehabilitation needs and potential or to develop and/or implement a physical therapy program are covered when they are reasonable and necessary because of the patient's condition. Skilled rehabilitation services concurrent with the management of a patient's care plan include objective tests and measurements such as, but not limited to, range of motion, strength, balance coordination endurance or functional ability.

2. Therapeutic Exercises.--Therapeutic exercises which must be performed by or under the supervision of the qualified physical therapist to ensure the safety of the patient and effectiveness of the treatment, due either to the type of exercise employed or to the condition of the patient, constitute skilled physical therapy.