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The Beacon Guide *–to–* Medicare Service Delivery

2014 Edition

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–*to*–
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HCPro

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Foreword

Homecare providers have been become accustomed to the never ending changes over the past decade, but 2014 may take the prize of most changes in one year. This year, our industry faces additional cuts in payment, a transition to a newly updated OASIS, ICD-10-CM coding, and the ever changing clarifications from CMS regarding conditions for coverage (such as face-to-face and homebound). During this time of change, we will need resources to provide training, support, and oversight. Instead of additional resources, home health agencies will be reimbursed less, and will face stiff civil monetary penalties beginning July 1, 2014, for noncompliance with the *Conditions of Participation*.

Compliance with all the regulations is critical to your agency's future success. To meet these challenges, your agency must implement a three-point strategy for the delivery of Medicare services.

- **Knowledge and Empowerment:** First, staff must know the requirements for service delivery. Educate all staff members about the regulations and recent changes, so they have a working knowledge of the requirements.
- **Culture of Compliance:** Second, staff must deliver services according to the regulations. The agency must implement a system of checks and balances to ensure appropriate service delivery.
- **Proof in Documentation:** Third, all staff members must document appropriately. Effective documentation shows that the patient met the requirements, the services were appropriate, and the patient responded or demonstrated progress.

The Beacon Guide to Medicare Service Delivery serves as a training tool and resource to assist you in implementing this three-point strategy. Because scrutiny is increasing, agencies must be in a perpetual state of survey readiness and compliance, and it is our hope that this Guide will assist you in meeting that goal. Completely revised and updated, you'll find five chapters of valuable information.

1. **The Basics of Medicare Service Delivery** presents the fundamentals of Medicare coverage criteria and the *Conditions of Participation*. This includes a section dedicated to survey preparation.
2. **The Prospective Payment System** gives an overview of critical concepts, including the Home Health Resource Group (HHRG), consolidated billing requirements, and clinical issues with an impact on billing.
3. **All About the OASIS** discusses the fundamentals of the OASIS and assessments.
4. **Compliance and Care Delivery** highlights issues related to visits, physician orders, and start of care, recertification, and discharge.
5. **Documentation Essentials** looks at documentation fundamentals, the clinical record, diagnoses, and the plan of care. This includes a section related to the 485 and elements of content.

Finally, you'll find appendixes featuring the HHRG, sample plans of care, a description of treatment codes, other pertinent information, and a glossary of terms used in home health care, along with references and an index.

The Basics of Medicare Service Delivery

The Process of Skilled Service Delivery
Medicare Coverage Criteria
Medicare Noncoverage and Beneficiary Notices
The *Conditions of Participation*

Introduction

This chapter, "The Basics of Medicare Service Delivery," presents the fundamentals you need in order to deliver appropriate services to your patients and produce documentation that justifies the services provided and promotes appropriate payment.

The Process of Skilled Service Delivery: Homecare providers must follow an organized process in service delivery. This chapter focuses on the basics of care delivery and documentation.

Medicare Coverage Criteria: This chapter highlights key elements in the delivery of Medicare services in the Prospective Payment System (PPS) and discusses the requirements for each of the Medicare-covered disciplines (skilled nursing, therapies, medical social services, and home health aide). The requirements for coverage are found in the *Medicare Benefit Policy Manual,* which is *CMS Publication 100-2*, Chapter 7, and, for payment, in *CMS Publication 100-4*, Chapter 10. It is imperative that all home health clinicians and leadership are familiar with these guidelines, as they are the judge of whether the patient meets the Medicare criteria or not. Think of this like that benefit booklet that you receive when you sign up for an insurance plan.

It is necessary, but difficult, to stay up to date with all of the changes to the rules and guidelines from Medicare. Beacon Health has paid extra attention to those changes, and included all of the changes for 2014 in *The Beacon Guide to Medicare Service Delivery*. The final rule to update the PPS payment rate, effective January 1, 2014, incorporated payment updates, decreases to our case-mix system, and a continued "green light" to ICD-10, which will be implemented on October 1, 2014. Also to be implemented on October 1this year is the updated OASIS-C1, which contains changes related to ICD-10, as well as multiple refinements to improve clarity and ease of use for clinicians. Lastly, we will cover a recent change in the regulations on the notification of non-coverage for patients. On December 9, 2013, the HHABN was retired, and the Advanced Beneficiary Notice (ABN) and the Home Health Change in Care Notice (HHCCN) were introduced. We will provide guidance regarding these mandated forms and hints on successfully training staff to use them.

The Conditions of Participation: These regulations apply to all patients in a Medicare-certified homecare agency. Agencies are basically saying "I agree to abide by these conditions in order to participate in the Medicare program." Learn about important concepts and certification issues that have an impact on care delivery and documentation. This chapter focuses on the top-cited regulations, although they are all important. We have also included a section dedicated to survey preparation and provided tools to ensure your agency is ready when that surveyor shows up at your front door.

The Process of Skilled Service Delivery

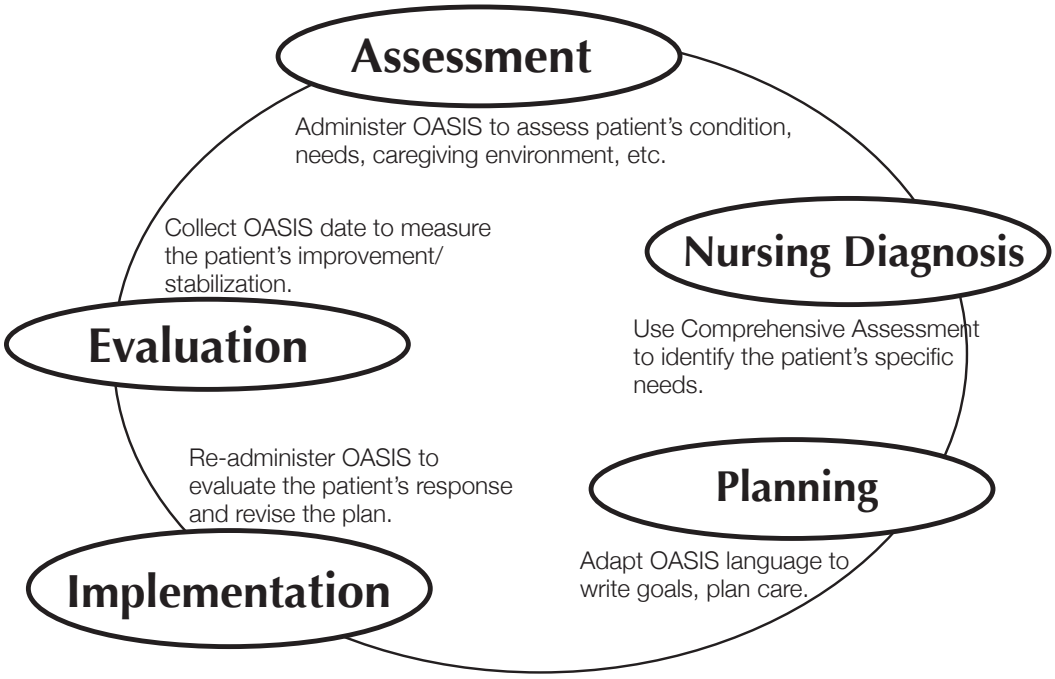
You are about to take a trip. You know there will be detours along the way, and traveling conditions may change without notice. Your time and resources are limited. But you have to make it to your destination on time and using the right route. What will you do? You develop a plan and you use a map.

Caring for the homecare patient in the PPS is similar to taking a trip. Care delivery often involves spur-of-the-moment revision and working with other caregivers and family members. Service delivery must be flexible, coordinated, efficient, and effective. Medicare certification rules require that the care provided meets the patient's individual needs. As homecare providers move further into the PPS and its past and almost-certain future revisions, Medicare will look more closely at patients' achievement of outcomes, provider compliance, and homecare revenue and expenses.

To accomplish all these objectives, care delivery must follow a systematic process. Because there are no travel agencies to help the homecare patient, it's up to you to develop and follow a process for the delivery of skilled services. With an organized process, you can react to changes and modify care without losing sight of the end results.

The process of care delivery is an organized, systematic method of providing individualized care that focuses on identifying and treating the patient's unique responses to actual or potential alterations in health. The steps in the process are interrelated, interdependent, and recurrent. Each step assists the staff member in fulfilling the requirements for service, providing appropriate care, and recognizing the crucial elements of documentation.

Figure 1: *The Process of Care Delivery*



Assessment

The American Nurses Association Standards of Clinical Practice define assessment as "a systematic, dynamic process by which the nurse, through interaction with the patient, significant others, and healthcare providers, collects and analyzes data about the patient." Assessment, the first step in the process of care delivery, establishes a database to help you monitor and evaluate the patient's condition. From a *coverage* perspective, the data substantiate that the patient meets the requirements for service initially and on an ongoing basis. Assessment is also the most frequently utilized qualifying skilled service by nursing in home health.

The comprehensive assessment must include the OASIS data for Medicare and Medicaid patients. The OASIS assessments at the start of care and recertification also provide a basis for the increase or decrease to the 60-day standard payment. This is performed by the Medicare Prospective Payment System by establishing a Home Health Resource Group (HHRG), the case-mix adjuster that determines payment for each payment episode.

Lastly, the assessment is key in a home health agency's quality data. The Outcome Based Quality Improvement (OBQI), as well as the Process Based Quality Improvement (PBQI) (and their publically reported subsets), are all driven by the OASIS data—measuring changes from the start of care (SOC) or resumption of care (ROC) to transfer or discharge.

Staff collect data through assessment at three important times during the care delivery process:

1. The initial comprehensive assessment provides data about the patient's needs, condition, caregiving environment, etc., to help you plan appropriate care. This information also establishes a baseline for future evaluation of the effectiveness of care (outcomes). This first visit most likely contains two mandated components. First, the "initial assessment" (484.55a) is simply an assessment of the patient's immediate care needs and whether to assess if the patient meets the Medicare guidelines for coverage. This is the standard that must be met within 48 hours of referral, or 48 hours from the patient's return home from an inpatient setting, or on the specific day (if applicable) that the physician ordered home health to begin. Most of the time, the clinician will move seamlessly into the comprehensive assessment (484.55b)after completing this high level initial assessment. The comprehensive assessment must be completed within five days after the start of care, per federal regulation, and must be conducted by one clinician.
2. Ongoing assessment while providing care evaluates the patient's condition and response to care and can lead to revisions in the plan.
3. Assessment of the patient's condition at the time of discharge provides insight into the patient's progress and response to care, as well as the effectiveness of care.

The *Conditions of Participation* require the agency to incorporate agency- and discipline-specific elements with Outcome and Assessment Information Set (OASIS) data elements to form a comprehensive assessment. Staff must complete a comprehensive assessment at specified times, including start of

care, transfer to an inpatient facility, resumption of care, follow-up (major decline or improvement in health status and recertification), and discharge.

Key points to assess include the patient's level of knowledge, resources, functional limitations, physical status, principal diagnosis, history of illness, pertinent medical history, body systems, weight, vital signs, allergies, personal and social history, and home condition and environment. Evaluate family and caregiver abilities and limitations.

Collect both objective and subjective data. Look at how well the patient is meeting basic requirements (respiration, safety, rest, etc.), as well as illness-imposed requirements (medications, diet, dressings). Determine that patients in the PPS meet Medicare coverage criteria. Evaluate and interpret data to identify a direction for care delivery.

> *The patient is on a therapeutic diet. Does he know what foods to eat? Is he able to obtain the food? Can he measure and prepare the food? Is he motivated to adhere to the diet?*

Record assessment data according to agency policy. Communicate significant findings to other members of the team.

Needs Identification

Use assessment data to identify applicable nursing diagnoses, needs, and problems. The nursing diagnosis is a clinical judgment about the individual, family, or community's behavior or physical response to actual or potential health problems or life processes. By clustering the patient's signs and symptoms and related etiology or contributing factors into a meaningful area of concern, the nursing diagnosis identifies problems that are amenable to resolution by means of nursing actions.

There are three components to a nursing diagnosis. The name of the nursing diagnosis refers to the human response. Related factors are situational, physiological, psychosocial, spiritual, or maturational considerations that can cause or contribute to the health problem. Document these as "R/T" (related to). The defining characteristics are observable cues or inferences that cluster as manifestations of a nursing diagnosis. These signs and symptoms are evidence that the nursing diagnosis applies to the patient. Document these "as evidenced by." If these signs and symptoms are recorded in the assessment notes, it is not necessary to include them in the documentation of the nursing diagnosis.

> *The patient had a hip arthroplasty. One nursing diagnosis would be impaired physical mobility R/T pain, as evidenced by decreased ability to ambulate and transfer.*

Use nursing diagnoses as the basis of care planning. The nursing diagnosis itself drives the patient's goal or expected outcome. The goal shows resolution or elimination of the problem. The related factors direct the selection of interventions. Interventions should prevent, reduce, control, or eliminate the factors that contribute to or cause the problem. The more specific the etiology and contributing factors, the more specialized the interventions can be.

> The nursing diagnosis identifies the problem: *Impaired skin integrity on buttocks.*
>
> Related factors direct interventions: *Paraplegia with long periods of sitting in wheelchair.*
>
> The expected outcome shows resolution of problem: *Demonstrate measures to prevent/minimize skin breakdown.*

Interventions control or eliminate related factors: *Assess skin condition. Change position in chair every hour. Massage bony prominences three to four times a day. Teach tecÚiques to improve nutrition and hydration.*

Although the use of nursing care plans is not mandated, they are a tried and true method of needs identification and the process of planning nursing care.

For therapy and medical social services, identify the patient's need for services, following the basic concepts employed in the use of nursing diagnoses. State the need or problem in terms of functional limitations, identifying the impact of the problem on the patient's life. Include related medical or physical factors to establish the medical necessity of the interventions. Identify an expected outcome to show resolution or improvement. And define interventions.

Need: *Patient cannot stand.*

Related factors: *Decreased range of motion (ROM) in knee joints, related to osteoarthritis.*

Expected outcome: *Patient can rise from chair without assistance.*

Interventions: *Active ROM exercises to knee. Develop and implement home program. Teach wife how to perform exercises.*

After you completely identify the patient's need or problem, focus documentation on the specific problem, as well as the patient's response.

Planning

Planning, also called the mapping step, is the process by which staff determine how they will provide care in an organized, individualized, and outcome-oriented manner. Include the patient in the planning process, keeping in mind his or her specific limitations and situation, to develop a plan that encourages the patient's participation. An outcome-oriented care plan shows that you believe you can meet the patient's needs in the home environment.

The process of care planning involves four substeps: identifying priorities of care, establishing expected outcomes, determining interventions, and writing the care plan.

Priorities of care

When the patient has multiple problems, establish priorities of care to identify areas of first intervention. Look closely at what you can accomplish within the homecare framework, given the patient's resources, abilities, motivation, and support. Assign highest priority to the most urgent problems—those that threaten the patient's safety or ability to remain in the home. Consider comorbidities that will affect the plan of care.

Goals

A goal, or expected outcome, details the results you expect after the patient receives the care. It is a prediction of a change in the patient's status as a result of care delivery and it drives the selection of interventions. Choose interventions designed to help the patient achieve the goal. Expected outcomes also serve to measure the success or appropriateness of the plan.

"The patient cannot ambulate. The expected outcome is for the patient to walk independently with a walker. The therapist will teach the patient ambulation tecÚiques and use of the walker. At the time of discharge, the therapist will evaluate the patient's progress toward achieving the goal."

Write goals that are realistic, attainable, specific, and quantifiable. The goal should explain how the patient will progress or respond, not how the nurse will intervene.

The planning process focuses on two types of expected outcomes. Long-term expected outcomes are broad statements representing the patient's maximal gain, which will take more time to accomplish. For many homecare patients, a long-term goal most closely resembles a discharge plan, which is written in Locator 22, Goals, Rehabilitation Potential, and Discharge Plans, on the plan of care.

"Patient can demonstrate wound care tecÚique."

A short-term expected outcome is the heart of the care delivery process. Derived from the long-term expected outcome or patient need, it reflects the ability of the patient to improve or stabilize in the immediate future. Short-term goals are usually incorporated into a discipline-specific care plan. Include a target date for achievement or review of the goal.

"Demonstrate aseptic tecÚique in wound care by August 7."

If you break the goals into components or smaller parts, you will be able to demonstrate and document smaller increments of progress. For example, the following statement reflects an expected outcome that is very general and difficult to measure:

"Will comply with diet."

By breaking this goal into its components, you can measure progress more readily.

"Demonstrate use of food exchange lists in planning meals."

Follow these steps to write effective goal statements.

- Make the patient the subject of the statement. This shows that the patient has some accountability or responsibility in care planning and also reflects the patient's participation in the process.
- Begin with an action verb. An action verb describes something you can see or hear. Examples include ambulate, explain, and perform.
- Include specific content. Describe the response or behavior you expect the patient to achieve in terms of when, how well, where, and/or how much, as appropriate. Focus on knowledge, skill, presence or absence of symptoms, or physiological findings. Make the language measurable. See Chapter 5.
- Include a time frame or target date. This holds you accountable for action or review by a particular date. Fit the timetable to the tasks, level of intended achievement, the patient's abilities, and your schedule.

With Medicare service delivery, outcomes play a huge role and may very well someday be relative

to payment. CMS has formulated outcome measures, many of which are publicly reported. When delivering care, agencies should consider these outcome measures, depicted in Chapter 2.

Interventions

Work with the patient and significant others to design approaches and interventions specific to the patient's problem, need, or nursing diagnosis, and acceptable to the patient. Approaches must be realistic and reasonable, given the situation. Specify who will do what and when, and show cooperation among the caregivers. Include the patient in the selection of interventions and individualize them to fit the unique situation. Correlate interventions with the medical plan of care, incorporating agency policy, procedure, and standards of care. Use a blend of assessment, teaching, and hands-on procedures. Incorporate Medicare skilled services, reflecting phraseology like that used in the now-retired CMS treatment codes. **Refer to Appendix C.**

> *"R.N. to do pressure ulcer care daily and teach procedure to wife."*
>
> *"Ultrasound by P.T. three times a week."*
>
> *"Complete bed, bath, personal care by aide twice a week."*

Because of the evidence-based practices/interventions noted in OASIS-C, Outcome-Based Quality Improvement (OBQI), and Process-Based Quality Improvement (PBQI) measurements, there are additional interventions that your home health agency may choose to implement for your patients, both patient care, and to obtain "credit" for these practices in the publically reported measures. These practices promote the delivery of consistent, high-quality care designed to improve patient outcomes. The development of best practices is specific to an agency. The practices must fit within the agency's policies and procedures and meet the needs of its patients, physicians, and staff. In a later chapter, we will discuss best practices and process measures in detail.

Care plan

A discipline-specific care plan directs the specific interventions and facilitates communication with other team members. It serves as the written map to guide care delivery and documentation and facilitate coordination of services. Discipline-specific care plans are not mandatory, so many agencies do not use them. However, as agencies move into outcome management, OBQI, PBQI, and P4P, the value of a written care plan (or its derivatives, such as clinical paths) will become more obvious. A care plan validates that staff addressed all patient needs, revised the plan to reflect changes in the patient's situation, and carried out all tasks, and that the patient participated in the process. **See Chapter 5.**

Alternatives to care plans include care maps, teaching plans, protocols, and disease management tools, to name a few. The value in these care planning tools comes from standardization. The tool lays out a path for care delivery for a patient in a given situation with particular needs. Following this path minimizes the possibility of errors and omissions and promotes consistent care. When using standardized care plans, etc., agencies must not ignore the very important component of individualizing those plans based on each patient's unique needs.

Implementation

Once you have identified the patient's needs and developed a plan, implementation puts the plan into action. It is the organization and actual delivery of care that are crucial to achieving outcomes. During care delivery, assess the patient and determine priorities of care. Coordinate services; communicate care with other members of the team, the physician, the patient, and family or caregivers; and follow established policy and procedure. Supervise staff according to established protocol.

Evaluation

The American Nurses Association defines evaluation as the process of determining both the patient's progress toward the attainment of goals and the effectiveness of the nursing care. Throughout care delivery, staff collect and record data on the patient's condition and response and modify the plan as needed. In this final step, compare the patient's health condition and level of functioning to the identified expected outcomes.

Evaluate two critical components. Look first at changes in the patient and how those changes affect ongoing care: Collect data to assess the patient's response, performance, or progress, comparing them to the expected outcome criteria. Identify any changes in condition or needs. How has the patient progressed toward achieving the goals? What improvements or changes in behavior do you notice?

Record responses precisely, concisely, and objectively.

> *"Compliant with medication regimen. Edema resolved."*

Document even the smallest changes or increments of progress, and compare them to the baseline.

> *The original goal was for the patient to ambulate independently. At the time of evaluation, the patient can transfer but not ambulate independently.*

In documenting the evaluation of patient progress, instead of emphasizing the perceived failure, note the positive gains in comparative language.

> *"On admission, patient could not ambulate or stand. Can now transfer independently."*

Then look at the appropriateness of the plan. Evaluation determines whether the needs or nursing diagnoses were correct, whether the outcomes were reasonable and realistic, whether the interventions were appropriate, and the impact of the total plan on the patient. If, upon evaluation, the patient's needs have changed or interventions are ineffective or require updating, the plan of care should be revised accordingly.

Medicare Coverage Criteria

The *Medicare Benefit Policy Manual*, CMS Publication 100-2, Chapter 7, Home Health Services, translates the regulations into guidelines for the delivery of home health services covered by Medicare. The implementation of the PPS in 2000 and subsequent revisions did not change the coverage criteria. It modified only the payment structure. The 2011 PPS revisions implemented a required face-to-face physician encounter for initial certification of home health patients and set forth requirements for therapy service delivery and documentation. You must be familiar with and apply the criteria as they appear in this publication. When your agency receives a referral, the clinician who assesses the patient must determine if the patient is eligible for homecare.

The requirements for coverage of home health services fall into three broad categories.

1. **Patient requirements:**
   - » The patient must be homebound.
   - » The patient cannot reside in an institution that meets Medicare's definition of a hospital or nursing home.
   - » The patient must have conditions that require treatment by a nurse, physical therapist, or a speech language pathologist.
2. **Service requirements:**
   - » Services are provided under a physician's plan of care.
   - » Services must be reasonable and necessary.
   - » Services must meet the qualifying criteria for home health care and the coverage criteria for part-time or intermittent services.
3. **Discipline requirements:**
   - » Medicare covers six services—three are "qualifying services": skilled nursing, physical therapy, and speech-language pathology services, and three are "dependent services": occupational therapy, medical social services, and home health aide services. Once eligibility has been established, the occupational therapy can stand alone and can qualify the patient for ongoing Medicare services. Each service must meet the specified criteria outlined in the *Medicare Benefit Policy Manual*, as well as meeting any more specific guidance provided by your specific Medicare Administrative Contractor (MAC), who pays your claims. The MACs can provide additional guidance through a format called the local coverage determinations (LCDs). Currently, CGS and Palmetto have home health LCDs for physical therapy, and Palmetto has several additional topics.

This chapter highlights selected portions of the regulations, noting the relevant sections in the CMS publication for reference. Because the rules cannot cover every situation, this chapter also presents principles to guide care delivery and documentation decisions.

Patient Requirements

The patient must be homebound

First and foremost, the patient must be confined to his or her home. In November 2013 an updated definition of "homebound,"per CMS, was implemented. This Change Request (CR8444) stated: For purposes of the statute, an individual shall be considered "confined to the home" (homebound) if the following two criteria are met:

Criteria One:

The patient must either:

- Because of illness or injury, need the aid of supportive devices such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the assistance of another person in order to leave their place of residence OR
- Have a condition such that leaving his or her home is medically contraindicated.

If the patient meets one of the Criteria One conditions, then the patient must also meet two additional requirements defined in Criteria Two below.

Criteria Two:

- There must exist a normal inability to leave home; AND
- Leaving home must require a considerable and taxing effort.

Impact of Temporary Absence on Homebound Status

CMS Change Request 8444 also provides examples of temporary absences from the home that are acceptable for a homebound patient. A patient could still be considered homebound if absences from the home are:

- Infrequent
- For periods of relatively short duration, or
- Attributable to the need to receive health care treatment.

Absence for Health Care Treatment: Absences attributable to the need to receive health care treatment include, but are not limited to attendance at adult day centers for the purpose of receiving medical care; ongoing receipt of outpatient kidney dialysis; or for outpatient chemotherapy or radiation therapy.

Adult Day Care Center: Regular absences for the purpose of participating in therapeutic, psychosocial, or medical treatment in an adult day-care program that is licensed, certified, or accredited by the state shall not disqualify an individual from being considered to be confined to his home.

Infrequent/Short Duration: If an absence is of an infrequent or of relatively short duration, a patient will not lose their homebound designation – including attending a religious service.

Non-Medical Absence: 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 such as an occasional trip to the barber, a walk around the block or 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 other criteria are met.

Medical Treatment Outside the Home: Sometimes a service cannot be provided at the residence of a homebound patient because equipment is required that cannot be made available there. If the services required by an individual involve the use of such equipment, the HHA may make arrangements with a hospital, skilled nursing facility, or a rehabilitation center to provide these services on an outpatient basis. However, even in these situations, for the services to be covered as home health services the patient must be considered as confined to 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.

Furnishing Information to an Intermediary: If homebound status is questioned, the CMS intermediary will request that the HHA furnish information needed to document that criteria are met.

Examples of homebound patients that illustrate the factors used to determine whether a homebound condition exists would be:

- A patient paralyzed from a stroke who is confined to a wheelchair or requires the aid of crutches in order to walk;
- A patient who is blind or senile and requires the assistance of another person in leaving their place of residence;
- A patient who has lost the use of their upper extremities and, therefore, is unable to open doors, use handrails on stairways, etc., and requires the assistance of another individual to leave their place of residence;
- A patient in the late stages of ALS or neurodegenerative disabilities;
- A patient who has just returned from a hospital stay involving surgery who may be suffering from resultant weakness and pain and, therefore, their actions may be restricted by their 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.;
- A patient with arteriosclerotic heart disease of such severity that they must avoid all stress and physical activity; and
- A patient with a psychiatric illness that is manifested in part by a refusal to leave home or is of such a nature that it would not be considered safe for the patient to leave home unattended, even if they have no physical limitations.

This resulted in an update of the *Medicare Benefit Policy Manual*, Chapter 7, Section 30.1.1 to reflect the above directives. §30.1.1 goes on to discuss absences from the home and states:

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 the State shall not disqualify an individual from being considered to be confined to the home. Any other absence of an individual from the home shall not so disqualify an individual if the absence is of infrequent or relatively short duration. For purposes of the preceding sentence, any absence for the purpose of attending a religious service should be deemed to be an absence of infrequent or short duration.

These paragraphs include several key concepts that we can translate into three questions to guide care delivery and documentation.

Is the patient confined to home?

First, determine that the patient is indeed confined to home. If patients can leave home regularly, at will, for whatever reason they desire, even if it takes great effort, they will not be considered homebound.

> *The patient had severe rheumatoid arthritis and could not prepare her meals. With the assistance of three friends, she went out every day for lunch. She was not considered homebound because she demonstrated the ability to leave home regularly, regardless of the difficulty involved or assistance required.*

Absent or impaired speech, by itself, does not justify a homebound determination.

Is the confinement related to a medical or physical condition?

If the patient is confined to home, that confinement must be related to a medical or physical condition. A patient with no physical or medical limitations who decides to stay home in order to qualify for Medicare coverage may not be considered homebound. Functional limitations identify the impact of the patient's condition on his or her daily life and help support a homebound determination.

What about absences from home?

Once you've determined that your patient is indeed confined to home, evaluate any absences. Absences fall into two categories: those for social or nonmedical reasons and those for the purposes of receiving medical care or treatment.

For social reasons, the absences must be infrequent or of short duration. Infrequent is generally viewed as less than once a week. There is no official definition for short duration, although CMS has, over the years, proposed a time frame of two to three hours.

> *If the patient leaves home only once a month to go to the beauty shop, this would be an example of an infrequent absence.*
>
> *If the patient cannot be left alone and must accompany the caregiver to pick up children at school, this absence would be of short duration.*

Even though the criteria state that absences must be infrequent or of short duration, it appears that the interpretation is shifting toward infrequent ***and*** short duration.

The patient may leave home to receive medical treatment as often and for as long as necessary to receive the treatment. Examples of absences attributable to the need to receive medical care include ongoing receipt of outpatient kidney dialysis, chemotherapy, and radiation therapy.

There are some medical absences that require explanation. Outpatient therapy, consolidated into an agency's episode payment, constitutes services that cannot be provided in the home. Leaving home to receive these services does not jeopardize homebound status. The absences, however, should require the assistance of another person or an assistive device and/or involve taxing effort.

Cardiac rehabilitation involves services that cannot be provided in the home, and it is not subject to

consolidated billing. There must be appropriate electrocardiographic monitoring, defibrillator, and life-saving equipment and trained personnel performing the program under the supervision of a physician. Once a patient enters a program, it will be necessary to pay attention to what is happening. It's possible that he or she won't be homebound for much longer. *What is the patient doing in the program? How quickly does the patient get to the level of being able to walk great distances without assistance or taxing effort?*

More homebound considerations

Day-care centers: Prior to legislative changes in 2000, attendance at adult day-care programs, no matter the reason, could cost patients their Medicare homecare eligibility because they were not homebound. Now, attendance at a state-licensed, state-certified, or accredited day-care center to participate in medical, psychosocial, or therapeutic treatment will not negate a patient's homebound status. This new provision does not define therapeutic or psychosocial treatment. CMS believes that patients, just by virtue of attending a qualified center, receive some sort of therapeutic or psychosocial treatment.

This provision is not without its challenges. First, a homecare agency must verify and maintain evidence that the center is licensed or certified by the state and/or accredited by an accrediting program. CMS believes that supporting documentation could include the number and effective date of licensure or certification and/or the accreditation number, and the name of the authority responsible for licensure or certification and/or accreditation. Patients who attend a day-care program that does not meet these requirements, no matter the reason for attendance, will not be considered homebound. A homecare agency cannot provide homecare services to patients while they are at the day-care center.

Document the reason and type of treatment that the patient receives at the day-care center. Not only does this help support compliance with the homebound requirement, it demonstrates coordination of services. Steer clear of documenting reasons for attendance at a day-care program related to family or caregiver issues (e.g., the daughter works). Attendance must relate to the patient's participation in treatment. The clinical record should demonstrate that transporting the patient to the center requires the assistance of another person or assistive device and/or requires taxing effort.

The patient who drives: CMS has said that patients who drive should not automatically be disqualified from Medicare coverage. Look at all the facts. The question of medical necessity of homecare services comes into play. If the patient drives, can he or she drive to a clinic or outpatient department to receive healthcare services? In many cases, the answer is yes, so the patient wouldn't need homecare services. Homecare is not a convenience for those who can leave home. However, if the patient lives in a very rural area and the nearest healthcare facilities are 75 miles away, driving that far might not be an option.

When evaluating your patient's homebound status, you must first decide that the patient is essentially confined to home and then determine whether or not absences from the home meet the criteria.

> *The patient is quadriplegic and requires maximum assistance with personal care and to transfer into a motorized wheelchair. Once the patient is in the wheelchair, however, he can get around at will, attending school or work. This patient would not be considered homebound because he is not confined to home.*

The patient has amyotrophic lateral sclerosis (ALS) and is ventilator-dependent. He leaves home only for medical appointments. This patient is essentially confined to home and would be considered homebound.

The patient suffers from advanced chronic obstructive pulmonary disease (COPD) and is on continuous oxygen. However, with the assistance of her family, a wheelchair, and portable oxygen system, she leaves home every day to play bingo. She would not be considered homebound.

The patient with a psychiatric problem: CMS Publication 100-2, Chapter 7, addresses this. The patient with a "psychiatric problem, if the illness is manifested in part by a refusal to leave his or her home environment or is of such a nature that it would not be considered safe for him or her to leave home unattended, even if he or she has no physical limitations" is considered homebound. Know what the regulations say and focus documentation on the patient's safety.

The patient has Alzheimer's disease and becomes very agitated. The patient walks about the home most of the day. However, the patient cannot go down steps without assistance, interpret traffic signals, or cross the street safely. This patient is not safe leaving the home alone, even though there are no physical limitations.

Environment: The home environment may affect the patient's homebound determination. Factors such as three flights of steps, hilly terrain, and steep inclines can limit the performance of a patient and support a homebound determination. Describe the functional limitations (what the patient can or cannot do), along with the related physical or medical condition.

"Can walk only one flight of steps before becoming exhausted and dyspneic. Lives in third-floor walk-up apartment."

"Can ambulate 150 feet with walker, then experiences fatigue. Elevator is 250 feet from apartment. Cannot ambulate on stairs."

Environmental conditions might also restrict the patient to home. Discuss with the physician the interrelationship between the patient's condition and the environmental factors and document that discussion. Because such patients will usually be homebound for very short and specific periods of time, documentation is crucial to support your claim.

"Hemiplegic. Unsteady gait with quad cane, unsafe in ambulation in snow and ice."

"Respiratory condition severely aggravated by ozone during periods of high heat, humidity. Physician ordered patient to stay indoors in July."

Temporarily homebound: There are times when a patient may be considered temporarily homebound. This can occur after surgery or when a chronic condition has been exacerbated by an illness. When providing care, emphasize the influence of the exacerbating condition as the reason for the homebound determination, and not the chronic disease.

The patient with severe weakness following major surgery can be temporarily homebound. Strength will return as the patient recuperates. Focus on the patient's limitations when documenting homebound status.

"Experiencing pain and weakness after surgery. Ambulates only 5 feet with assist of one."

Another example is the COPD patient recovering from pneumonia. The patient lived with COPD before, but the illness has weakened him. Focus on the exacerbation of the condition and its impact.

> *"Experiencing increased shortness of breath (SOB) due to pneumonia. Activity decreased to transfers from bed to chair with assistance."*

The patient in an assisted living facility

More and more homecare providers find themselves confronted with the issue of providing care to patients who live in an assisted living facility (ALF) or other type of supportive housing arrangement, such as a board and care home or a retirement facility. There are three questions you must answer.

First, is the facility considered an institution or a residence? CMS Publication 100-2, Chapter 7, says a residence is wherever a patient makes his or her home, as long as it doesn't meet the definition of an institution**.** If the facility employs nurses to provide skilled nursing care, it may be considered an institution, and the patient would not be eligible for home health coverage.

Second, is the patient eligible for homecare services? The major hurdle will be determining whether or not the patient is homebound. There is no easy way to define homebound status for a patient living in an ALF. Recognize that intermediaries are tightening the criteria and interpretations for homebound status. They're looking more closely at the patient's overall mobility and activity status. If patients leave the facility for group trips and activities, they won't be considered homebound. If patients go to the dining area and then spend the day in activities, they may not be homebound. If patients require assistance to get to the dining area and return to their rooms after the meal, you could build a case for homebound status.

After evaluating homebound status, verify that the patient needs intermittent skilled nursing, physical therapy, speech-language pathology services, or continuing occupational therapy and would receive services under a plan of care signed by the physician. If the patient is eligible for homecare services, the agency can provide skilled services.

The last issue deals with providing home health aide services to patients in ALFs. A homecare agency cannot duplicate the services that a facility provides—or is supposed to provide. You must decide: Does the patient have access to appropriate care? Determine whether the facility is licensed by the state. If it is, check the regulations to identify the level of personal care and supportive services the facility must provide. If the facility is not licensed, check the patient's contract to determine what services the facility is obligated to provide. If the facility is obligated to provide services, the patient therefore has access to them, and it would not be reasonable and necessary for an agency to provide the care.

The government and intermediaries have provided very little substantive guidance. It is imperative that you study the regulations, evaluate each patient's situation, and build your case through documentation.

When assessing homebound status, clinicians should look at two components: taxing effort and absences (nonmedical) that are infrequent and of short duration. Then, both of those components, along with the specific reason(s) the patient is homebound must be documented appropriately.

Assessing taxing effort: This needs to be clear and in objective terms; just saying "poor endurance" or

"continues to be homebound" is not adequate. Be clear about why the patient's endurance is poor; why the patient continues to be homebound. The clinician should clearly document what he or she sees that makes the patient confined to the home. Taxing effort requires detail; for example, what is the patient's poor endurance related to and what is it evidenced by?

Assessing absences (nonmedical) of infrequent or short duration: If the patient requires taxing effort to leave the home yet is able to do so at will, he or she is not homebound. Nor is the patient who chooses not to leave home but is able to do so. Homebound is an ability, not a choice. So, due to ability and routine, the clinician must assess absences.

Focus on documentation of homebound status

Documentation of homebound status consists of four essential components:

1. **The functional limitation(s) that restricts the patient's mobility:** This is an objective but broad description of the patient's limitation, which correlates to functional limitations listed in Locator 18 on the plan of care.
2. **The medical or physical reason(s) for the limitation(s):** The patient must be homebound because of the effects of an illness or injury.
3. **Impact of the limitation(s) on the patient's activity:** This details the specifics of the patient's situation. Include the use of assistive devices or the help of another person and detail any "considerable or taxing effort."
4. **Absences from home** (number and reason)**:** This supports the fact that the patient is confined to home.

Document all four components in the initial assessment and the progress notes and/or summary reports. The frequency of this documentation is completely dependent upon each patient. For example, a patient who is suffering from a chronic, debilitating illness that is not expected to change may only need this documentation every episode. However, postoperative patients or those suffering from an acute illness that is expected to resolve may require this documentation every visit. Selected OASIS data elements identify the patient's functional limitations. Add narrative comments to round out the four components. Here are some examples:

> *The assessment reveals that the patient has severe SOB upon exertion due to COPD. The nurse adds, "Cannot ambulate more than four steps before resting. Leaves home for MD appointment twice a month."*
>
> *The assessment shows that the patient is unable to ambulate and is confined to a wheelchair due to a cerebrovascular accident (CVA). The therapist writes, "Does not have the strength to push wheelchair more than short distances. Visits daughter for dinner once a month."*

Follow these documentation guidelines to support the homebound determination:

» Complete OASIS data elements accurately, especially those that can support homebound status, such as ambulation, transferring, and dyspnea. If the items do not capture the true clinical picture, due to specific CMS guidance on how to answer the item, or due to the narrow time frames considered, be sure to write a narrative to explain and paint that clinical picture.

- » Correlate Locator 18 on the plan of care to reflect the patient's functional limitations and activities.
- » Report on the plan of care a diagnosis that explains the reasons for the limitation.
- » Record in every visit note a brief activity assessment that supports the homebound determination for those patients who require it.
- » Ask at every visit about the patient's absences and document pertinent findings. Follow up on any questionable patterns.
- » Document the assistance that the patient requires when leaving home and any related taxing effort.
- » Maintain consistency in your descriptions of the patient's activity.

When evaluating the patient's homebound status, the intermediary will review/determine that:

1. The patient is essentially confined to the home.
2. The four components of homebound status documentation are evident (functional limitations, medical or physical reasons, impact of limitations on patient's activity, absences from home) and documented regularly.
3. Functional limitations and activities permitted correlate with the homebound determination on the plan of care.
4. Patient's diagnosis and/or problems explain or support the patient's limitation(s).
5. An activity assessment is conducted every visit, including a discussion with patients regarding absences from home; appropriate action is taken.
6. Other documentation affirms homebound status.
7. Appropriate action is taken when patient is determined to no longer be homebound.

The patient cannot reside in an institution that meets Medicare's definition of a hospital or nursing home

A residence is whatever a patient calls home. This may be his or her own dwelling, an apartment, a relative's home, a home for the aged, or some other type of institution. However, the patient will not qualify for homecare coverage if he or she resides in an institution that meets Medicare's definition of a hospital or nursing home as defined in §§1816(e)(i) and 1819(a)(i) of the Social Security Act. An institution may not be considered a patient's residence if it:

1. Meets at least the basic requirement in the definition of a hospital: It is primarily engaged in providing to inpatients, by or under the supervision of physicians, diagnostic and therapeutic services or rehabilitation services.
2. Meets at least the basic requirement in the definition of a skilled nursing facility (SNF): It is primarily engaged in providing to inpatients skilled nursing care and related services for patients who require medical or nursing care or rehabilitation services. All nursing homes that participate in Medicare and/or Medicaid as SNFs, most facilities that participate in Medicaid as intermediate care facilities, and some nursing homes that do not participate in Medicare or Medicaid meet this test.

Even if the patient is sick enough that services would be covered in an institution, he or she is entitled to homecare benefits. If you have any doubts about the patient's place of residence, consult your intermediary.

Medicare regulations do not prohibit the patient from having more than one residence (e.g., a home in the city and a cottage on the lake). Nor does having more than one residence disqualify a patient on the basis of homebound status. It is important to investigate the patient's homebound status at each location. The patient must meet the requirements of homebound status at each location. How does the patient get there? What does he or she do once at the second residence?

> *One weekend every month during the summer, the patient goes with his family to a resort 100 miles from his apartment. He rides with his family and, once at the resort, his grandchildren wheel him to the pier outside the cabin, where he watches them fish. This patient could be considered homebound.*

Simply put, home health cannot be provided in a facility where there are skilled services available—it would be considered a duplication of service.

Skilled Nursing Services Questions and Answers

Is it an appropriate use of Medicare to do three weeks of assessment and venipuncture for a patient hospitalized with DVT?

Since 1997, venipuncture has not been a qualifying service for Medicare coverage. However, once the patient qualifies for coverage, a nurse can perform venipuncture. Because this patient was hospitalized for deep vein thrombosis (DVT), there is the possibility of a further acute episode, so observation and assessment could be reasonable and necessary. The nurse would monitor the patient's condition, oversee medication adjustments, and complete necessary teaching, as well as perform venipuncture. Observation and assessment is a covered service for three weeks or as long as there is the potential for a further acute episode or complication. If the patient's condition is stable at the end of the three-week period, then it would be appropriate for the agency to discharge the patient.

How are we supposed to use observation and assessment for patients on telemonitoring?

Telemonitoring or telehealth is one technology that can help a patient in the home. It cannot substitute for visits, and the patient must otherwise qualify for Medicare coverage. From a Medicare coverage perspective, don't treat telemonitoring equipment any differently than a blood pressure cuff. It is equipment an agency uses to collect data about the patient's condition. Then the principles of observation and assessment apply. It is the actions that follow, and not the telemonitoring equipment, that contribute to managing the patient's condition. Also realize: Just because the patient is on telemonitoring does not mean homecare can continue indefinitely. It is the patient's condition that determines that.

When does Medicare consider a wound as chronic/nonhealing and no longer pays for services?

You won't find any mention in the Medicare coverage criteria about chronic or nonhealing wounds because the status of the wound is not a factor in coverage. Medicare has two criteria for coverage of wound care: 1) The care must be skilled, reasonable, and necessary. 2) Nursing visits to provide the care must be less than daily or daily for a predictable and finite period of time. If this patient's wound requires skilled nursing, and services are less than daily, Medicare can cover the procedure.

If the patient has an ostomy, cannot change it, and there are no caregivers to learn, does the agency stay in indefinitely?

Changing an ostomy bag, even if the patient can't do it and there's no caregiver available, is not a skilled service. If the patient does not qualify for Medicare coverage for some other reason, an agency cannot provide this service under Medicare. The agency could care for this patient indefinitely if there were another payer to cover the service.

Will Medicare cover nursing services twice daily for a PICC line flush and dressing change?

Flushing a peripherally inserted central catheter (PICC) line does indeed require the skills of a nurse, so it is a skilled nursing service. However, there is a caveat to Medicare coverage. CMS determined that Medicare would not cover flushes if the line is not used for medication administration for three months or longer.

When do we ever admit patients and not teach them?

There are very few times that a clinician will admit a patient and not complete some teaching. However, that teaching may not qualify the patient for Medicare coverage. According to the coverage criteria, teaching must be reasonable and necessary to the treatment of the patient's illness or injury.

Is it true that instead of discharging patients when goals are met, we can recertify them under management and evaluation?

What this agency heard is in error and could lead to denials. Just as with any Medicare-covered skilled service, management and evaluation of a care plan has specific coverage criteria. It is reasonable and necessary when the skills of a nurse are necessary to ensure safe and effective implementation of a complex, unskilled care plan for a patient with multiple medical problems and an unstable caregiving situation. When a patient's goals are met, chances are his or her needs are being met, and there's no continuing need for skilled care. If that's true, it would not be reasonable and necessary to put the patient on management and evaluation.

OASIS-C Diagnosis Data Elements and Symptoms Control

M1020, primary diagnosis, and M1022, other diagnoses, ask the clinician to assess the degree of symptom control for each medical diagnosis (no V or E codes). The responses range from "asymptomatic, no treatment needed at this time," to "symptoms poorly controlled, history of rehospitalizations."

In determining symptom control, a clinician should review presenting signs and symptoms, type and number of medications, frequency of changes in treatment, and contact with healthcare providers. The clinician should determine whether the current plan of care controls symptoms.

The *OASIS-C Guidance Manual* added a new and significant instruction. A clinician should not use the symptom control rating as the driving force in prioritizing diagnoses. It is one factor to consider. A condition with a lower rating could be the principal diagnosis.

The diabetic patient receives daily visits to treat gangrene. His primary diagnosis is diabetes, with a symptom control rating of 2, followed by gangrene, with a symptom control rating of 3. A manifestation of an underlying condition is the primary reason for homecare services.

The patient receives physical and occupational therapy visits (five a week for four weeks) to treat an exacerbation of multiple sclerosis (rating of 2). The patient's daughter, a registered nurse, manages the patient's unstable diabetic condition (rating of 3). Multiple sclerosis is the principal diagnosis because it requires the most intensive service.

Service Requirements

Services are provided under a physician's plan of care

Home health services must be provided under a physician's plan of care, which is developed by the homecare clinician in conjunction with the physician, after the start of care assessment has been completed. In the past, CMS required the CMS-485 format for the plan of care. Although it's no longer the required format, it contains all of the required components, and its use is highly recommended.

The *Medicare Benefit Policy Manual*, CMS Publication 100-2, Chapter 7, **addresses services to be provided under a physician's plan of care as follows:**

§30.2.1: The plan of care must contain all pertinent diagnoses, including the patient's mental status, the types of services, supplies and equipment ordered, the frequency of visits to be made, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, all medications and treatments, safety measures to protect against injury, and any additional items the agency or physician choose to include.

§30.2.4: The plan of care must be signed and dated by a physician ... before the claim for each episode is submitted for the final percentage payment.

§30.2.6: The plan of care must be reviewed and signed by the physician who established the plan, in consultation with agency professional personnel, at least every 60 days.

§30.3: A patient is expected to be under the care of a physician who signs the plan of care and physician certification. A face-to-face encounter must be performed by the certifying physician or an NPP-non-physician practitioner (nurse practitioner, clinical nurse specialist, physician assistant or a State-authorized certified nurse midwife) who is working in collaboration with and under the supervision of the certifying physician, at initial certification.

The certifying physician must document the encounter regardless of whether the physician him-/herself or one of the permitted NPP's perform the face-to-face encounter. This encounter must relate directly to the primary reason the patient requires home health care and must occur no more than 90 days prior to the home health start of care date or within 30 days after the start of care.

Documentation of the encounter must include the date of the encounter, an explanation of why the clinical findings of such encounter support that the patient is homebound and in need of either intermittent skilled nursing services or therapy services. The documentation of the face-to-face encounter must be a separate and distinct section of, or an addendum to, the certification; it must be clearly titled, dated, and signed by the certifying physician. If a NPP performs the face-to-face encounter, he/she must document the clinical findings and communicate those findings to the certifying physician.

A hospitalist or NPP may also perform, document, and sign the encounter and certification and a community physician order and sign the plan of care. If the encounter is performed by a hospitalist or NPP, the hospital record should reflect to whom the hospitalist is transferring care of the patient following inpatient discharge. If a face-to-face patient encounter occurred within 90 days of the start of care but was not related to the primary reason the patient requires home health services, the certifying physician or NPP must have another face-to-face encounter with the patient within 30 days of the start of home health care.

The *Conditions of Participation* mandate the plan of care to include the same components as the *Medicare Benefit Policy Manual*. When you complete the plan of care, you demonstrate compliance with the certification, coverage, and payment requirements for the medical plan of care.

The *Conditions of Participation*, §484.18(a), state that the attending physician and agency staff must review the plan of care as often as the severity of the patient's condition requires, but at least once every 60 days. Many state licensure codes have their own timeliness requirements for the physician's signature.

Medicare can consider the plan of care to be terminated if the patient does not receive at least one covered skilled nursing or qualifying therapy visit within a 60-day period. If there are no visits in that period and services will continue, the plan must include a statement that documents that the interval without care is appropriate to the treatment of the patient's illness or injury.

> *The patient requires skilled nursing visits every 90 days for silicone catheter changes. Locator 21 of the plan of care includes, "Requires SN visit every 90 days for catheter change and appropriate management of care."*

The plan of care should paint a complete picture of the patient and explain and justify services provided—it supports the medical necessity of services. All additional orders obtained during the episode of care are considered addendums to it.

Services must be reasonable and necessary

CMS Publication 100-2, Chapter 7, emphasizes the physician's certification as the basis of reasonable and necessary services. Each service has its own criteria, but generally, the services must be consistent with the nature and severity of the patient's illness or injury and accepted standards of medical and nursing practice. Look at the patient's overall condition, not just the diagnosis, in correlation with the frequency and duration of services ordered. However, don't overlook the importance of the principal diagnosis in supporting the plan of care.

The aforementioned publication addresses reasonable and necessary services as follows:

§20.1.2: Medicare does not deny coverage solely on the basis of the reviewer's general inferences about patients with similar diagnoses or on data related to utilization generally, but bases it upon objective clinical evidence regarding the patient's individual need for care.

§40.1.1: To be considered reasonable and necessary for the diagnosis or treatment of the patient's illness or injury, the services must be consistent with the nature and severity of the illness or injury, the patient's condition and accepted standards of medical and nursing practice. A patient's overall medical condition is a valid factor in deciding whether skilled services are needed. A patient's diagnosis should never be the sole factor in deciding that a service the patient needs is either skilled or not skilled. The determination of whether the services are reasonable and necessary should be made with the consideration that a physician has determined that the services ordered are reasonable and necessary.

Services must meet the qualifying criteria for home health care and the coverage criteria for part-time or intermittent services

The Balanced Budget Act of 1997 revised the definition of intermittent nursing. It is skilled nursing care that is either provided:

- Or needed on fewer than seven days each week
- Less than eight 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

Probably one of the most confusing issues for homecare providers to understand is the part-time or intermittent care requirements. The nurse and the home health aide are the only services that are subject to the intermittent criteria. To better understand this issue and determine whether care is intermittent, use the following algorithm:

1. Does the patient receive physical therapy, speech therapy, or continued occupational therapy?

   Yes - Intermittent qualifying criteria is met. Part-time criteria must be met.

   No - Go to Question 2.

2. Does the patient receive a skilled nurse visit at least once every 60 days?

   Yes - Go to Question 3.

   No - Patient does not qualify for Medicare home health services.

3. Does the patient receive skilled nurse visits seven days per week?

Yes - Go to Question 4.

No - The intermittent qualifying criteria is met. Part-time criteria must be met.

4. Is there a documented statement of a predictable and finite endpoint to daily skilled nurse visits?

   Yes - Intermittent qualifying criteria is met.

   No - Patient does not qualify for Medicare home health services.

Note: there is one exception to the intermittent criteria, and that is daily nurse visits to administer insulin, if the documentation in the clinical record clearly shows that the patient is physically or mentally unable to self-inject AND there is no willing and/or able caregiver to do so.

Daily visits are visits that are provided seven days a week. (The previous definition defined daily as five, six, or seven days a week.) To avoid denials of payment, identify a realistic and achievable date when daily visits will end.

> *The patient has an open, draining pressure ulcer. The physician and nurse identify a need for daily visits for five months to treat the ulcer.*

If the agency and physician do not identify a finite period at the initiation of daily visits, so it appears that daily nursing visits will continue indefinitely, the services do not meet the intermittent definition of nursing and will not be covered by Medicare.

> *The patient requires daily skilled nursing visits for an indefinite period of time for administration of total parenteral nutrition (TPN). Because there is no finite period identified, these services are not covered by Medicare.*

Medicare will cover skilled nursing and home health aide services—furnished any number of days per week—as long as they meet the part-time criteria:

- Provided (combined) less than eight hours each day, and
- Provided 28 or fewer hours each week, or
- Subject to review on a case-by-case basis as to the need for care, less than eight hours each day and 35 or fewer hours each week

The coverage criteria describe scenarios that have come to be known as the 28/35 rule. All patients who qualify for Medicare coverage can receive up to 28 hours of nursing and aide services combined. The intermediary will evaluate services provided from 28 to 35 hours on a case-by-case basis to determine whether services are reasonable and necessary.

The subject of part-time or intermittent services affects many areas of care. One of the most important is home health aide services provided to patients who are eligible for both Medicare and Medicaid coverage. In this situation, Medicare is the primary payer. Because the Medicare PPS episode payment is designed to cover all Medicare-covered services the patient requires, an agency cannot bill a secondary payer until it has utilized the Medicare benefit appropriately.

> *The patient receives physical therapy services under the Medicare benefit. The agency bills the home health aide visits for personal care, transfers, and exercises to Medicaid.*

> *The patient is receiving skilled nursing services under Medicare for monthly catheter*

changes. The agency provides personal care services under the state's personal care attendant program.

In both of these scenarios, the agency's actions are inappropriate. Medicare covers personal care services for a patient who receives a qualifying skilled service. To avoid any difficulties with the Medicaid program in your state, utilize Medicare services appropriately for dual-eligible patients.

Remember these important points as you apply the coverage criteria to your patients.

- The agency must maintain a record of the number of hours in each nursing and home health aide visit. This can be done through the use of time slips or in-and-out times on visit notes.
- The patient can purchase additional aide services (over 35 hours), regardless of whether he or she meets Medicare criteria, without reducing the Medicare benefit.
- List all services, Medicare-covered or not, on the plan of care.
- The agency cannot split-bill for nursing services to circumvent the intermittent requirement.

The nurse determines there is no finite date for daily nursing visits. The agency bills Medicare for three visits a week and the Medicaid program for the additional days. Medicare will consider those days in determining whether the situation meets the intermittent criteria.

Impact of other caregivers on homecare services

CMS Publication 100-2, Chapter 7, speaks to the availability of caregivers in the home.

§20.2: Where the Medicare criteria for coverage of home health services are met, patients are entitled by law to coverage of reasonable and necessary home health services. Therefore, a patient is entitled to have the costs of reasonable and necessary services reimbursed by Medicare **without regard to whether there is someone available in the home to furnish them.** However, where a family member or other person is or will be providing services that adequately meet the patient's needs, it would not be reasonable and necessary for agency personnel to furnish such services. Ordinarily, **it can be presumed that there is no able and willing person to provide the services** being rendered by the agency unless the patient or family indicates otherwise and objects to the provision of services by the agency, or the agency has first hand knowledge to the contrary.

If there are family members or other potential caregivers living with the patient, does the record describe the situation? Identify the individuals and document their roles in the initial assessment.

"Lives with daughter, who does grocery shopping and housekeeping, but is unwilling to perform personal care activities for patient."

Skilled Nursing Services

The *Medicare Benefit Policy Manual*, CMS Publication 100-2, Chapter 7, describes the general guidelines in determining whether skilled nursing care is reasonable and necessary, and those principles involve complexity of the service, inherent skill of the service, the patient's illness, exacerbation or in-

jury, and that skills don't become unskilled just because they are taught. The manual addresses skilled nursing as follows:

§40.1.1: A skilled nursing service is a service that **must be provided by a registered nurse, or a licensed practical (vocational) nurse under the supervision of a registered nurse to be safe and effective.** In determining whether a service requires the skills of a nurse, consider both the **inherent complexity of the service, the condition of the patient, and accepted standards of medical and nursing practice.**

A service is not considered a skilled nursing service merely because it is performed by or under the direct supervision of a licensed nurse.

A service which, by its nature, requires the skills of a licensed nurse to be provided safely and effectively **continues to be a skilled service even if it is taught** to the patient, the patient's family or other caregivers.

The skilled nursing service must be **reasonable and necessary to the diagnosis and treatment of the patient's illness or injury** within the context of the patient's unique medical condition. To be considered reasonable and necessary for the diagnosis or treatment of the patient's illness or injury, the services must be consistent with the nature and severity of the illness or injury, his or her particular medical needs, and accepted standards of medical and nursing practice .... The determination of whether a patient needs skilled nursing care should be **based solely upon the patient's unique condition and individual needs, without regard to whether the illness or injury is acute, chronic, terminal, or expected to extend over a long period of time.** In addition, skilled care may, dependent upon the unique condition of the patient, **continue to be necessary for patients whose condition is stable.**

Medicare recognizes a registered nurse and a licensed practical/vocational nurse (LPN/LVN) as skilled nurses. The LPN/LVN must provide services within the scope of licensure and the state's nursing practice act. Many states, for example, do not permit the LPN/LVN to teach a patient. The LPN/LVN cannot complete the OASIS, perform management and evaluation of a care plan, or supervise home health aides.

CMS Publication 100-2, Chapter 7, §40.1, identifies four Medicare-covered skilled nursing services and includes guidelines for care delivery and documentation:

- Observation and assessment
- Skilled procedures
- Teaching and training activities, and
- Management and evaluation of a patient's care plan

Observation and Assessment

The most widely used service in homecare, specific guidance is offered in the *Medicare Benefit Policy Manual*:

§40.1.2.1: Observation and assessment of the patient's condition by a licensed nurse are reasonable

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