therapist in independent practice. However, Medicare pays only the appropriate portion (after deduction of applicable deductible and coinsurance amounts) of the first $500 of services furnished by such a practitioner in a year. This limitation on payment may not be a basis for finding that the needed care can only be provided in a SNF.

(b) *Examples of circumstances that meet practical matter criteria*—(1) *Beneficiary's condition.* Inpatient care would be required ''as a practical matter'' if transporting the beneficiary to and from the nearest facility that furnishes the required daily skilled services would be an excessive physical hardship.

(2) *Economy and efficiency.* Even if the beneficiary's condition does not preclude transportation, inpatient care might be more efficient and less costly if, for instance, the only alternative is daily transportation by ambulance.

[48 FR 12541, Mar. 25, 1983, as amended at 50 FR 33033, Aug. 16, 1985]

§ 409.36 Effect of discharge from posthospital SNF care.

If a beneficiary is discharged from a facility after receiving posthospital SNF care, he or she is not entitled to additional services of this kind in the same benefit period unless—

(a) He or she is readmitted to the same or another facility within 30 calendar days following the day of discharge (or, before December 5, 1980, within 14 calendar days after discharge); or

(b) He or she is again hospitalized for at least 3 consecutive calendar days.

Subpart E—Home Health Services Under Hospital Insurance

§ 409.40 Basis, purpose, and scope.

This subpart implements sections 1814(a)(2)(C), 1835(a)(2)(A), and 1861(m) of the Act with respect to the requirements that must be met for Medicare payment to be made for home health services furnished to eligible beneficiaries.

[59 FR 65493, Dec. 20, 1994]

§ 409.41 Requirement for payment.

In order for home health services to qualify for payment under the Medicare program the following requirements must be met:

(a) The services must be furnished to an eligible beneficiary by, or under arrangements with, an HHA that—

(1) Meets the conditions of participation for HHAs at part 484 of this chapter; and

(2) Has in effect a Medicare provider agreement as described in part 489, subparts A, B, C, D, and E of this chapter.

(b) The physician certification and recertification requirements for home health services described in § 424.22.

(c) All requirements contained in §§ 409.42 through 409.47.

[59 FR 65494, Dec. 20, 1994]

§ 409.42 Beneficiary qualifications for coverage of services.

To qualify for Medicare coverage of home health services, a beneficiary must meet each of the following requirements:

(a) *Confined to the home.* The beneficiary must be confined to the home or in an institution that is not a hospital, SNF or nursing facility as defined in section 1861(e)(1), 1819(a)(1) or 1919(a)(1) of the Act, respectively.

(b) *Under the care of a physician.* The beneficiary must be under the care of a physician who establishes the plan of care. A doctor of podiatric medicine may establish a plan of care only if that is consistent with the functions he or she is authorized to perform under State law.

(c) *In need of skilled services.* The beneficiary must need at least one of the following skilled services as certified by a physician in accordance with the physician certification and recertification requirements for home health services under § 424.22 of this chapter.

(1) Intermittent skilled nursing services that meet the criteria for skilled services and the need for skilled services found in § 409.32. (Also see § 409.33(a) and (b) for a description of examples of skilled nursing and rehabilitation services.) These criteria are subject to the following limitations in the home health setting:

(i) In the home health setting, management and evaluation of a patient care plan is considered a reasonable and necessary skilled service when underlying conditions or complications

are such that only a registered nurse can ensure that essential non-skilled care is achieving its purpose. To be considered a skilled service, 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 overall condition. Where nursing visits are not needed to observe and assess the effects of the non-skilled services being provided to treat the illness or injury, skilled nursing care would not be considered reasonable and necessary, and the management and evaluation of the care plan would not be considered a skilled service. In some cases, the condition of the patient may cause a service that would originally be considered unskilled to be considered a skilled nursing service. This would occur when the patient's underlying condition or complication requires that only a registered nurse can ensure that essential non-skilled care is achieving its purpose. The registered nurse is ensuring that service is safely and effectively performed. However, a service is not considered a skilled nursing service merely because it is performed by or under the supervision of a licensed nurse. Where a service can be safely and effectively performed (or self administered) by non-licensed staff without the direct supervision of a nurse, the service cannot be regarded as a skilled service even if a nurse actually provides the service.

(ii) In the home health setting, skilled education services are no longer needed if it becomes apparent, after a reasonable period of time, that the patient, family, or caregiver could not or would not be trained. Further teaching and training would cease to be reasonable and necessary in this case, and would cease to be considered a skilled service. 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.

(2) Physical therapy services that meet the requirements of § 409.44(c).

(3) Speech-language pathology services that meet the requirements of § 409.44(c).

(4) Continuing occupational therapy services that meet the requirements of § 409.44(c) if the beneficiary's eligibility for home health services has been established by virtue of a prior need for intermittent skilled nursing care, speech-language pathology services, or physical therapy in the current or prior certification period.

(d) *Under a plan of care.* The beneficiary must be under a plan of care that meets the requirements for plans of care specified in § 409.43.

(e) *By whom the services must be furnished.* The home health services must be furnished by, or under arrangements made by, a participating HHA.

[59 FR 65494, Dec. 20, 1994; 60 FR 39122, Aug. 1, 1995, as amended at 74 FR 58133, Nov. 10, 2009]

§ 409.43 Plan of care requirements.

(a) *Contents.* The plan of care must contain those items listed in § 484.18(a) of this chapter that specify the standards relating to a plan of care that an HHA must meet in order to participate in the Medicare program.

(b) *Physician's orders.* The physician's orders for services in the plan of care must specify the medical treatments to be furnished as well as the type of home health discipline that will furnish the ordered services and at what frequency the services will be furnished. Orders for services to be provided ''as needed'' or ''PRN'' must be accompanied by a description of the beneficiary's medical signs and symptoms that would occasion the visit and a specific limit on the number of those visits to be made under the order before an additional physician order would have to be obtained. Orders for care may indicate a specific range in frequency of visits to ensure that the most appropriate level of services is furnished. If a range of visits is ordered, the upper limit of the range is considered the specific frequency.

(c) *Physician signature*—(1) *Request for Anticipated payment signature requirements.* If the physician signed plan of care is not available at the time the