

therapist, speech-language pathologist, or occupational therapist is required.

(2) The maintenance program must be established by a qualified therapist (and not an assistant).

(C) The unique clinical condition of a patient may require the specialized skills of a qualified therapist or therapist assistant to perform a safe and effective maintenance program required in connection with the patient's specific illness or injury. Where the clinical condition of the patient is such that the complexity of the therapy services required—

(1) Involve the use of complex and sophisticated therapy procedures to be delivered by the therapist or the therapist assistant in order to maintain function or to prevent or slow further deterioration of function; or

(2) To maintain function or to prevent or slow further deterioration of function must be delivered by the therapist or the therapist assistant in order to ensure the patient's safety and to provide an effective maintenance program, then those reasonable and necessary services must be covered.

(iv) The amount, frequency, and duration of the services must be reasonable and necessary, as determined by a qualified therapist and/or physician or allowed practitioner, using accepted standards of clinical practice.

(A) Where factors exist that would influence the amount, frequency or duration of therapy services, such as factors that may result in providing more services than are typical for the patient's condition, those factors must be documented in the plan of care and/or functional assessment.

(B) Clinical records must include documentation using objective measures that the patient continues to progress towards goals. If progress cannot be measured, and continued progress towards goals cannot be expected, therapy services cease to be covered except when—

(1) Therapy progress regresses or plateaus, and the reasons for lack of progress are documented to include justification that continued therapy treatment will lead to resumption of progress toward goals; or

(2) Maintenance therapy as described in § 409.44(c)(2)(iii)(B) or (C) is needed.

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§ 409.45 Dependent services requirements.

(a) *General.* Services discussed in paragraphs (b) through (g) of this section may be covered only if the beneficiary needs skilled nursing care on an intermittent basis, as described in § 409.44(b); physical therapy or speech-language pathology services as described in § 409.44(c); or has a continuing need for occupational therapy services as described in § 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; and otherwise meets the qualifying criteria (confined to the home, under the care of a physician or allowed practitioner, in need of skilled services, and under a plan of care) specified in § 409.42. Home health coverage is not available for services furnished to a beneficiary who is no longer in need of one of the qualifying skilled services specified in this paragraph. Therefore, dependent services furnished after the final qualifying skilled service are not covered, except when the dependent service was not followed by a qualifying skilled service as a result of the unexpected inpatient admission or death of the beneficiary, or due to some other unanticipated event.

(b) *Home health aide services.* To be covered, home health aide services must meet each of the following requirements:

(1) The reason for the visits by the home health aide must be to provide hands-on personal care to the beneficiary or services that are needed to maintain the beneficiary's health or to facilitate treatment of the beneficiary's illness or injury. The physician or allowed practitioner's orders must indicate the frequency of the home health aide services required by

the beneficiary. These services may include but are not limited to:

(i) Personal care services such as bathing, dressing, grooming, caring for hair, nail and oral hygiene that are needed to facilitate treatment or to prevent deterioration of the beneficiary's health, changing the bed linens of an incontinent beneficiary, shaving, deodorant application, skin care with lotions and/or powder, foot care, ear care, feeding, assistance with elimination (including enemas unless the skills of a licensed nurse are required due to the beneficiary's condition, routine catheter care, and routine colostomy care), assistance with ambulation, changing position in bed, and assistance with transfers.

(ii) Simple dressing changes that do not require the skills of a licensed nurse.

(iii) Assistance with medications that are ordinarily self-administered and that do not require the skills of a licensed nurse to be provided safely and effectively.

(iv) Assistance with activities that are directly supportive of skilled therapy services but do not require the skills of a therapist to be safely and effectively performed, such as routine maintenance exercises and repetitive practice of functional communication skills to support speech-language pathology services.

(v) Routine care of prosthetic and orthotic devices.

(2) The services to be provided by the home health aide must be—

(i) Ordered by a physician or allowed practitioner in the plan of care; and

(ii) Provided by the home health aide on a part-time or intermittent basis.

(3) The services provided by the home health aide must be reasonable and necessary. To be considered reasonable and necessary, the services must—

(i) Meet the requirement for home health aide services in paragraph (b)(1) of this section;

(ii) Be of a type the beneficiary cannot perform for himself or herself; and

(iii) Be of a type that there is no able or willing caregiver to provide, or, if there is a potential caregiver, the beneficiary is unwilling to use the services of that individual.

(4) The home health aide also may perform services incidental to a visit that was for the provision of care as described in paragraphs (b)(3)(i) through (iii) of this section. For example, these incidental services may include changing bed linens, personal laundry, or preparing a light meal.

(c) *Medical social services.* Medical social services may be covered if the following requirements are met:

(1) The services are ordered by a physician or allowed practitioner and included in the plan of care.

(2)(i) The services are necessary to resolve social or emotional problems that are expected to be an impediment to the effective treatment of the beneficiary's medical condition or to his or her rate of recovery.

(ii) If these services are furnished to a beneficiary's family member or caregiver, they are furnished on a short-term basis and it can be demonstrated that the service is necessary to resolve a clear and direct impediment to the effective treatment of the beneficiary's medical condition or to his or her rate of recovery.

(3) The frequency and nature of the medical social services are reasonable and necessary to the treatment of the beneficiary's condition.

(4) The medical social services are furnished by a qualified social worker or qualified social work assistant under the supervision of a social worker as defined in § 484.115 of this chapter.

(5) The services needed to resolve the problems that are impeding the beneficiary's recovery require the skills of a social worker or a social work assistant under the supervision of a social worker to be performed safely and effectively.

(d) *Occupational therapy.* Occupational therapy services that are not qualifying services under § 409.44(c) are nevertheless covered as dependent services if the requirements of § 409.44(c)(2)(i) through (iv), as to reasonableness and necessity, are met.

(e) *Durable medical equipment.* Durable medical equipment in accordance with § 410.38 of this chapter, which describes the scope and conditions of payment for durable medical equipment under Part B, may be covered under the home health benefit as either a Part A or

Part B service. Durable medical equipment furnished by an HHA as a home health service is always covered by Part A if the beneficiary is entitled to Part A.

(f) *Medical supplies.* Medical supplies (including catheters, catheter supplies, ostomy bags, and supplies relating to ostomy care but excluding drugs and biologicals) may be covered as a home health benefit. For medical supplies to be covered as a Medicare home health benefit, the medical supplies must be needed to treat the beneficiary's illness or injury that occasioned the home health care.

(g) *Intern and resident services.* The medical services of interns and residents in training under an approved hospital teaching program are covered if the services are ordered by the physician or allowed practitioner who is responsible for the plan of care and the HHA is affiliated with or under the common control of the hospital furnishing the medical services.

Approved means—

(1) Approved by the Accreditation Council for Graduate Medical Education;

(2) In the case of an osteopathic hospital, approved by the Committee on Hospitals of the Bureau of Professional Education of the American Osteopathic Association;

(3) In the case of an intern or resident-in-training in the field of dentistry, approved by the Council on Dental Education of the American Dental Association; or

(4) In the case of an intern or resident-in-training in the field of podiatry, approved by the Council on Podiatric Medical Education of the American Podiatric Medical Association.

[59 FR 65495, Dec. 20, 1994; 60 FR 39122, 39123, Aug. 1, 1995, as amended at 82 FR 4578, Jan. 13, 2017; 85 FR 27620, May 8, 2020]

§ 409.46 Allowable administrative costs.

Services that are allowable as administrative costs but are not separately billable include, but are not limited to, the following:

(a) *Registered nurse initial evaluation visits.* Initial evaluation visits by a registered nurse for the purpose of assess-

ing a beneficiary's health needs, determining if the agency can meet those health needs, and formulating a plan of care for the beneficiary are allowable administrative costs. If a physician or allowed practitioner specifically orders that a particular skilled service be furnished during the evaluation in which the agency accepts the beneficiary for treatment and all other coverage criteria are met, the visit is billable as a skilled nursing visit. Otherwise it is considered to be an administrative cost.

(b) *Visits by registered nurses or qualified professionals for the supervision of home health aides.* Visits by registered nurses or qualified professionals for the purpose of supervising home health aides as required at § 484.80(h) of this chapter are allowable administrative costs. Only if the registered nurse or qualified professional visits the beneficiary for the purpose of furnishing care that meets the coverage criteria at § 409.44, and the supervisory visit occurs simultaneously with the provision of covered care, is the visit billable as a skilled nursing or therapist's visit.

(c) *Respiratory care services.* If a respiratory therapist is used to furnish overall training or consultative advice to an HHA's staff and incidentally provides respiratory therapy services to beneficiaries in their homes, the costs of the respiratory therapist's services are allowable as administrative costs. Visits by a respiratory therapist to a beneficiary's home are not separately billable. However, respiratory therapy services that are furnished as part of a plan of care by a skilled nurse or physical therapist and that constitute skilled care may be separately billed as skilled visits.

(d) *Dietary and nutrition personnel.* If dietitians or nutritionists are used to provide overall training or consultative advice to HHA staff and incidentally provide dietetic or nutritional services to beneficiaries in their homes, the costs of these professional services are allowable as administrative costs. Visits by a dietitian or nutritionist to a beneficiary's home are not separately billable.