

(e) *Telecommunications technology.* Telecommunications technology, as indicated on the plan of care, can include: remote patient monitoring, defined as the collection of physiologic data (for example, ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient or caregiver or both to the home health agency; teletypewriter (TTY); and 2-way audio-video telecommunications technology that allows for real-time interaction between the patient and clinician. The costs of any equipment, set-up, and service related to the technology are allowable only as administrative costs. Visits to a beneficiary's home for the sole purpose of supplying, connecting, or training the patient on the technology, without the provision of a skilled service, are not separately billable.

[59 FR 65496, Dec. 20, 1994, as amended at 82 FR 4578, Jan. 13, 2017; 83 FR 56627, Nov. 13, 2018; 85 FR 27620, May 8, 2020; 85 FR 70354, Nov. 4, 2020]

§ 409.47 Place of service requirements.

To be covered, home health services must be furnished in either the beneficiary's home or an outpatient setting as defined in this section.

(a) *Beneficiary's home.* A beneficiary's home is any place in which a beneficiary resides that is not a hospital, SNF, or nursing facility as defined in sections 1861(e)(1), 1819(a)(1), of 1919(a)(1) of the Act, respectively.

(b) *Outpatient setting.* For purposes of coverage of home health services, an outpatient setting may include a hospital, SNF or a rehabilitation center with which the HHA has an arrangement in accordance with the requirements of § 484.105(e) of this chapter and that is used by the HHA to provide services that either—

(1) Require equipment that cannot be made available at the beneficiary's home; or

(2) Are furnished while the beneficiary is at the facility to receive services requiring equipment described in paragraph (b)(1) of this section.

[59 FR 65496, Dec. 20, 1994, as amended at 82 FR 4578, Jan. 13, 2017]

§ 409.48 Visits.

(a) *Number of allowable visits under Part A.* To the extent that all coverage requirements specified in this subpart are met, payment may be made on behalf of eligible beneficiaries under Part A for an unlimited number of covered home health visits. All Medicare home health services are covered under hospital insurance unless there is no Part A entitlement.

(b) *Number of visits under Part B.* To the extent that all coverage requirements specified in this subpart are met, payment may be made on behalf of eligible beneficiaries under Part B for an unlimited number of covered home health visits. Medicare home health services are covered under Part B only when the beneficiary is not entitled to coverage under Part A.

(c) *Definition of visit.* A visit is an episode of personal contact with the beneficiary by staff of the HHA or others under arrangements with the HHA, for the purpose of providing a covered service.

(1) Generally, one visit may be covered each time an HHA employee or someone providing home health services under arrangements enters the beneficiary's home and provides a covered service to a beneficiary who meets the criteria of § 409.42 (confined to the home, under the care of a physician or allowed practitioner, in need of skilled services, and under a plan of care).

(2) If the HHA furnishes services in an outpatient facility under arrangements with the facility, one visit may be covered for each type of service provided.

(3) If two individuals are needed to provide a service, two visits may be covered. If two individuals are present, but only one is needed to provide the care, only one visit may be covered.

(4) A visit is initiated with the delivery of covered home health services and ends at the conclusion of delivery of covered home health services. In those circumstances in which all reasonable and necessary home health services cannot be provided in the course of a single visit, HHA staff or others providing services under arrangements with the HHA may remain at the beneficiary's residence between