

(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

visits (for example, to provide non-covered services). However, if all covered services could be provided in the course of one visit, only one visit may be covered.

[59 FR 65497, Dec. 20, 1994, as amended at 85 FR 27620, May 8, 2020]

#### § 409.49 Excluded services.

(a) *Drugs and biologicals.* Drugs and biologicals are excluded from payment under the Medicare home health benefit.

(1) A drug is any chemical compound that may be used on or administered to humans or animals as an aid in the diagnosis, treatment or prevention of disease or other condition or for the relief of pain or suffering or to control or improve any physiological pathologic condition.

(2) A biological is any medicinal preparation made from living organisms and their products including, but not limited to, serums, vaccines, antigens, and antitoxins.

(b) *Transportation.* The transportation of beneficiaries, whether to receive covered care or for other purposes, is excluded from home health coverage. Costs of transportation of equipment, materials, supplies, or staff may be allowable as administrative costs, but no separate payment is made for them.

(c) *Services that would not be covered as inpatient services.* Services that would not be covered if furnished as inpatient hospital services are excluded from home health coverage.

(d) *Housekeeping services.* Services whose sole purpose is to enable the beneficiary to continue residing in his or her home (for example, cooking, shopping, Meals on Wheels, cleaning, laundry) are excluded from home health coverage.

(e) *Services covered under the End Stage Renal Disease (ESRD) program.* Services that are covered under the ESRD program and are contained in the composite rate reimbursement methodology, including any service furnished to a Medicare ESRD beneficiary that is directly related to that individual's dialysis, are excluded from coverage under the Medicare home health benefit.

(f) *Prosthetic devices.* Items that meet the requirements of § 410.36(a)(2) of this chapter for prosthetic devices covered under Part B are excluded from home health coverage. Catheters, catheter supplies, ostomy bags, and supplies relating to ostomy care are not considered prosthetic devices if furnished under a home health plan of care and are not subject to this exclusion from coverage.

(g) *Medical social services provided to family members.* Except as provided in § 409.45(c)(2), medical social services provided solely to members of the beneficiary's family and that are not incidental to covered medical social services being provided to the beneficiary are not covered.

(h) *Services covered under the home infusion therapy benefit.* Services that are covered under the home infusion therapy benefit as outlined at § 486.525 of this chapter, including any home infusion therapy services furnished to a Medicare beneficiary that is under a home health plan of care, are excluded from coverage under the Medicare home health benefit. Excluded home infusion therapy services pertain to the items and services for the provision of home infusion drugs, as defined at § 486.505 of this chapter. Services for the provision of drugs and biologicals not covered under this definition may continue to be provided under the Medicare home health benefit.

[59 FR 65497, Dec. 20, 1994; 60 FR 39123, Aug. 1, 1995; 85 FR 70354, Nov. 4, 2020]

#### § 409.50 Coinsurance for durable medical equipment (DME) and applicable disposable devices furnished as a home health service.

The coinsurance liability of the beneficiary or other person for the following home health services is:

(a) DME—20 percent of the customary (insofar as reasonable) charge.

(b) An applicable disposable device (as defined in section 1834(s)(2) of the Act)—20 percent of the payment amount for the disposable Negative Pressure Wound Therapy (NPWT) device (as that term is defined in § 484.202 of this chapter).

[81 FR 76796, Nov. 3, 2016, as amended at 88 FR 77874, Nov. 13, 2023]