§ 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 or allowed practitioner, as defined at § 484.2 of this chapter.* The beneficiary must be under the care of a physician or allowed practitioner, as defined at § 484.2 of this chapter 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 or allowed practitioner, as defined at § 484.2 of this chapter in accordance with the 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) Occupational therapy services in the current and subsequent certification periods (subsequent adjacent episodes) that meet the requirements of § 409.44(c) initially qualify for home health coverage as a dependent service as defined in § 409.45(d) 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. Subsequent to an initial covered occupational therapy service, continuing occupational therapy services which meet the requirements of § 409.44(c) are considered to be qualifying services.

(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.

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§ 409.43 Plan of care requirements.

(a) *Contents.* An individualized plan of care must be established and periodically reviewed by the certifying physician or allowed practitioner.

(1) The HHA must be acting upon a plan of care that meets the requirements of this section for HHA services to be covered.

(2) For HHA services to be covered, the individualized plan of care must specify the services necessary to meet the patient-specific needs identified in the comprehensive assessment.

(3)(i) The plan of care must include all of the following:

(A) The identification of the responsible discipline(s) and the frequency and duration of all visits as well as those items listed in § 484.60(a) of this chapter that establish the need for such services.

(B) Any provision of remote patient monitoring or other services furnished via telecommunications technology (as defined in § 409.46(e)) or audio-only technology. Such services must be tied to the patient-specific needs as identified in the comprehensive assessment, cannot substitute for a home visit ordered as part of the plan of care, and cannot be considered a home visit for the purposes of patient eligibility or payment.

(ii) All care provided must be in accordance with the plan of care.

(b) *Physician's or allowed practitioner's orders.* The physician or allowed practitioner'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 or allowed practitioner 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 or allowed practitioner signature*—(1) *Request for Anticipated payment signature requirements.* If the physician or allowed practitioner signed plan of care is not available at the time the HHA requests an anticipated payment of the initial percentage prospective payment in accordance with § 484.205, the request for the anticipated payment must be based on—

(i) A physician or allowed practitioner's orders that—

(A) Is recorded in the plan of care;

(B) Includes a description of the patient's condition and the services to be provided by the home health agency;

(C) Includes an attestation (relating to the physician's or allowed practitioner's orders and the date received) signed and dated by the registered nurse or qualified therapist (as defined in 42 CFR 484.115) responsible for furnishing or supervising the ordered service in the plan of care; and

(D) Is copied into the plan of care and the plan of care is immediately submitted to the physician or allowed practitioner; or

(ii) A referral prescribing detailed orders for the services to be rendered that is signed and dated by a physician.

(2) *Final percentage payment signature requirements.* The plan of care must be signed and dated—