

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 furnishing Negative Pressure Wound Therapy (NPWT) using a disposable device (as that term is defined in § 484.202 of this chapter).

[81 FR 76796, Nov. 3, 2016]

**Subpart F—Scope of Hospital Insurance Benefits**

**§ 409.60 Benefit periods.**

(a) *When benefit periods begin.* The initial benefit period begins on the day the beneficiary receives inpatient hospital, inpatient CAH, or SNF services for the first time after becoming entitled to hospital insurance. Thereafter, a new benefit period begins whenever the beneficiary receives inpatient hospital, inpatient CAH, or SNF services after he or she has ended a benefit period as described in paragraph (b) of this section.

(b) *When benefit periods end—*(1) A benefit period ends when a beneficiary has, for at least 60 consecutive days not been an inpatient in any of the following:

(i) A hospital that meets the requirements of section 1861(e)(1) of the Act.

(ii) A CAH that meets the requirements of section 1820 of the Act.

(iii) A SNF that meets the requirements of sections 1819(a)(1) or 1861(y) of the Act.

(2) For purposes of ending a benefit period, a beneficiary was an inpatient of a SNF if his or her care in the SNF met the skilled level of care requirements specified in § 409.31(b) (1) and (3).

(c) *Presumptions.* (1) For purposes of determining whether a beneficiary was an inpatient of a SNF under paragraph (b)(2) of this section—

(i) A beneficiary's care met the skilled level of care requirements if inpatient SNF claims were paid for those services under Medicare or Medicaid, unless:

(A) Such payments were made under § 411.400 or Medicaid administratively necessary days provisions which result in payment for care not meeting the skilled level of care requirements, or

(B) A Medicare denial and a Medicaid payment are made for the same period, in which case the presumption in paragraph (c)(2)(ii) of this section applies;

(ii) A beneficiary's care met the skilled level of care requirements if a SNF claim was paid under section 1879(e) of the Social Security Act;

(iii) A beneficiary's care did not meet the skilled level of care requirements if a SNF claim was paid for the services under § 411.400;