

(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]

§ 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.

[59 FR 65497, Dec. 20, 1994; 60 FR 39123, Aug. 1, 1995]

§ 409.50 Coinsurance for durable medical equipment (DME) furnished as a home health service.

The coinsurance liability of the beneficiary or other person for DME furnished as a home health service is 20 percent of the customary (insofar as reasonable) charge for the services.

[51 FR 41339, Nov. 14, 1986. Redesignated at 59 FR 65496, Dec. 20, 1994]

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

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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;

(iv) A beneficiary's care did not meet the skilled level of care requirements if a Medicaid SNF claim was denied on the grounds that the services were not at the skilled level of care (even if paid under applicable Medicaid administratively necessary days provisions which result in payment for care not meeting the skilled level of care requirements);

(2) For purposes of determining whether a beneficiary was an inpatient

of a SNF under paragraph (b)(2) of this section a beneficiary's care in a SNF is presumed—

(i) To have met the skilled level of care requirements during any period for which the beneficiary was assigned to one of the Resource Utilization Groups designated as representing the required level of care, as provided in § 409.30.

(ii) To have met the skilled level of care requirements if a Medicaid or Medicare claim was denied on grounds other than that the services were not at the skilled level of care;

(iii) Not to have met the skilled level of care requirements if a Medicare SNF claim was denied on the grounds that the services were not at the skilled level of care and payment was not made under § 411.400; or

(iv) Not to have met the skilled level of care requirements if no Medicare or Medicaid claim was submitted by the SNF.

(3) If information upon which to base a presumption is not readily available, the intermediary may, at its discretion review the beneficiary's medical records to determine whether he or she was an inpatient of a SNF as set forth under paragraph (b)(2) of this section.

(4) When the intermediary makes a benefit period determination based upon paragraph (c)(1) of this section, the beneficiary may seek to reverse the benefit period determination by timely appealing the prior Medicare SNF claim determination under part 405, subpart G of this chapter, or the prior Medicaid SNF claim under part 431, subpart E of this chapter.

(5) When the intermediary makes a benefit period determination under paragraph (c)(2) of this section, the beneficiary will be notified of the basis for the determination, and of his or her right to present evidence to rebut the determination that the skilled level of care requirements specified in § 409.31 (b)(1) and (b)(3) were or were not met on reconsideration and appeal under 42 CFR, part 405, subpart G of this chapter.

(d) *Limitation on benefit period determinations*. When the intermediary considers the same prior SNF stay of a

particular beneficiary in making benefit period determinations for more than one inpatient Medicare claim—

(1) Medicare will recognize only the initial level of care characterization for that prior SNF stay (or if appealed under 42 CFR part 405, subpart G of this chapter, the level of care determined under appeal); or

(2) If part of a prior SNF stay has one level of care characterization and another part has another level of care characterization, Medicare will recognize only the initial level of care characterization for a particular part of a prior SNF stay (or if appealed under 42 CFR part 405, subpart G of this chapter, the level of care determined under appeal).

(e) *Relation of benefit period to benefit limitations.* The limitations specified in §§ 409.61 and 409.64, and the deductible and coinsurance requirements set forth in subpart G of this part apply for each benefit period. The limitations of § 409.63 apply only to the initial benefit period.

[52 FR 22645, June 15, 1987; 52 FR 28824, Aug. 4, 1987, as amended at 58 FR 30667, May 26, 1993; 63 FR 26307, May 12, 1998; 70 FR 45055, Aug. 4, 2005]

§ 409.61 General limitations on amount of benefits.

(a) *Inpatient hospital or inpatient CAH services*—(1) *Regular benefit days.* Up to 90 days are available in each benefit period, subject to the limitations on days for psychiatric hospital services set forth in §§ 409.62 and 409.63.

(i) For the first 60 days (referred to in this subpart as *full benefit days*), Medicare pays the hospital or CAH for all covered services furnished the beneficiary, except for a deductible which is the beneficiary's responsibility. (Section 409.82 specifies the requirements for the inpatient hospital deductible.)

(ii) For the next 30 days (referred to in this subpart as *coinsurance days*), Medicare pays for all covered services except for a daily coinsurance amount, which is the beneficiary's responsibility. (Section 409.83 specifies the inpatient hospital coinsurance amounts.)

(2) *Lifetime reserve days.* Each beneficiary has a non-renewable lifetime reserve of 60 days of inpatient hospital or inpatient CAH services that he may

draw upon whenever he is hospitalized for more than 90 days in a benefit period. Upon exhaustion of the regular benefit days, the reserve days will be used unless the beneficiary elects not to use them, as provided in § 409.65. For lifetime reserve days, Medicare pays for all covered services except for a daily coinsurance amount that is the beneficiary's responsibility. (See § 409.83.)

(3) *Order of payment for inpatient hospital or inpatient CAH services.* Medicare pays for inpatient hospital services in the following order.

(i) The 60 full benefit days;
(ii) The 30 coinsurance days;
(iii) The remaining lifetime reserve days.

(b) *Posthospital SNF care furnished by a SNF, or by a hospital or a CAH with a swing-bed approval.* Up to 100 days are available in each benefit period after discharge from a hospital or CAH. For the first 20 days, Medicare pays for all covered services. For the 21st through 100th day, Medicare pays for all covered services except for a daily coinsurance amount that is the beneficiary's responsibility.

(c) *Renewal of inpatient benefits.* The beneficiary's full entitlement to the 90 inpatient hospital or inpatient CAH regular benefit days, and the 100 SNF benefit days, is renewed each time he or she begins a benefit period. However, once lifetime reserve days are used, they can never be renewed.

(d) *Home health services.* Medicare Part A pays for all covered home health services¹ with no deductible, and subject to the following limitations on payment for durable medical equipment (DME):

(1) For DME furnished by an HHA that is a nominal charge provider, Medicare Part A pays 80 percent of fair compensation.

(2) For DME furnished by an HHA that is not a nominal charge provider, Medicare Part A pays the lesser of the following:

(i) 80 percent of the reasonable cost of the service.

¹Before July 1, 1981, Medicare Part A paid for not more than 100 home health visits during one year following the beneficiary's most recent discharge from a hospital or a SNF.