Program Memorandum Intermediaries

Department of Health and Human Services (DHHS)
HEALTH CARE FINANCING ADMINISTRATION (HCFA)

Transmittal A-01-21 **Date: FEBRUARY 6, 2001**

CHANGE REQUEST 1503

SUBJECT: Clarification of the Homebound Definition Under the Medicare Home Health Benefit

Background

Section 507 of the Beneficiary Improvement and Protection Act (BIPA) amends the Social Security Act (the Act) (§§1814(a) and 1835(a); (42 U.S.C. 1395f(a) and 1395n(a)), which establish the homebound requirement under the Medicare home health benefit. The statutory language of the homebound definition is amended as follows:

(A) In the last sentence, by striking, 'and that absences of the individual from home are infrequent or of relatively short duration, or are attributable to the need to receive medical treatment" and

(B) By adding at the end the following new sentences: "Any absence of an individual from the home attributable to the need to receive health care treatment, including regular absences for the purpose of participating in therapeutic, psychosocial, or medical treatment in an adult day-care program that is licensed or certified by a State, or accredited, to furnish adult day-care services in the State shall not disqualify an individual from being considered to be confined to his home. Any other absence of an individual from the home shall not so disqualify an individual if the absence is of infrequent or of relatively short duration. For purposes of the preceding sentence, any absence for the purpose of attending a religious service shall be deemed to be an absence of infrequent or short duration."

The amendments made to the Act (§1814(a); and 1835(a); (42 U.S.C. 1395n(a)), apply to home health services furnished on or after December 21, 2000 (the enactment date of BIPA).

Discussion

This Program Memorandum (PM) provides clarification of the homebound statutory eligibility requirement applicable to the Medicare home health benefit now that it has been amended by BIPA.

Sections 1814 and 1835 of the Act and §1395 of the U.S.C. establish the homebound/confined to the home definition under the Medicare home health benefit. Section 507 of BIPA clarifies the statutory definition of homebound/confined to the home for purposes of eligibility under the Medicare home health benefit. To qualify for the Medicare home health benefit, §§1814(a)(2)(C) and 1835(a)(2)(A) of the Act require a Medicare beneficiary to be confined to the home, under the care of a physician, receiving services under a plan of care established and periodically reviewed by a physician, be in need of skilled nursing care on an intermittent basis (other than solely venipuncture), or physical therapy or speech-language pathology or have a continuing need for occupational therapy.

Sections 1814 and 1835 of the Act sets forth the conditions and limitations on payment for home health services. Physician certification that the beneficiary is confined to his home is an eligibility requirement for all home health services.

The new provision expands the list of circumstances in which absences from the home would be consistent with a determination that the patient is "confined to the home" or "homebound" for Medicare purposes, it does not change the existing homebound guidelines beyond the two specific provisions below. The new provisions include:

- Any absence of an individual from the home attributable to the need to receive health care treatment, including regular absences for the purpose of participating in therapeutic, psychosocial, or medical treatment in an adult day-care program that is licensed or certified by a State, or accredited, to furnish adult day care services in the State shall not negate the beneficiary's homebound status for purposes of eligibility.

- Any absence for religious service is deemed to be an absence of infrequent or short duration and thus does not negate the homebound status of the beneficiary.

This new statutory provision does not imply that Medicare coverage has been expanded to include adult day care services.

Implementation

The new statutory provisions replace the eligibility requirements which have been used in the course of medical review. Accordingly, replace the previous definition of "confined to the home" in your medical review guidelines with the new provisions contained in this PM. This material will subsequently be incorporated into HCFA manuals and program regulations.

Home health agencies (HHAs) enrolling patients eligible for these new provisions are responsible for demonstrating the adult day care center is licensed or certified/accredited as part of determining whether the patient is homebound for purposes of Medicare eligibility. Examples of information that could demonstrate licensure or certification/accreditation include: the license/certificate of accreditation number of the adult day care center and the effective date of the license/certificate of accreditation and the name of the authority responsible for the license/certificate or accreditation of the adult day care center.

Inform HHAs of this statutory clarification of current Medicare policy. The contents of this PM should be published in the next regularly scheduled edition of your bulletin or newsletter and should also be posted on your web-site for HHAs.

These instructions should be implemented within your current operating budget.

The *effective date* for this PM is December 21, 2000.

The *implementation date* is February 6, 2001.

The discard date for this PM is February 6, 2002.

If you have any questions, contact: Kathy Walch (410) 786-7970.