CMS Codes

The purpose of this document is to give Physicians, HHS and DME an understanding of the billing codes selected from **Medicare Benefit Policy Manual** for the purpose of billing.

40.1.2.3-Teaching and Training Activities

(Rev. 179 ,Issued: 01-14-14, Effective: 01-07-14, Implementation: 01-07-14)
A3-3118.1.B.3, HHA-205.1.B.3

Teaching and training activities that require skilled nursing personnel to teach a patient, the patient's family, or caregivers how to manage the treatment regimen would constitute skilled nursing services. Where the teaching or training is reasonable and necessary to the treatment of the illness or injury, skilled nursing visits for teaching would be covered. The test of whether a nursing service is skilled relates to the skill required to teach and not to the nature of what is being taught. Therefore, where skilled nursing services are necessary to teach an unskilled service, the teaching may be covered. Skilled nursing visits for teaching and training activities are reasonable and necessary where the teaching or training is appropriate to the patient's functional loss, illness, or injury.

1. Teaching wound care where the complexity of the wound, the overall condition of the patient or the ability of the caregiver makes teaching necessary.

2. Teaching how to perform the activities of daily living when the patient or caregiver **must use special techniques and adaptive devices** due to a loss of function;

3. Teaching ambulation with prescribed assistive devices (such as crutches, walker, cane, etc.) that are needed due to a recent functional loss;

Teaching the use and care of braces, splints and orthotics and associated skin care

Teaching the proper care and application of any special dressings or skin treatments, (for example, dressings or treatments needed by patients with severe or widespread fungal infections, active and severe psoriasis or eczema, or due to skin deterioration due to **radiation treatments** observation and monitoring of the patient's blood pressure and medication regimen is required until the blood pressure remains stable and in a safe range. The patient’s necessity for skilled observation must be documented at each home health visit, until the patient's clinical condition and/or treatment regimen has stabilized.

EXAMPLE 1: A patient has chronic non-healing skin ulcers, Diabetes Mellitus Type I, and spinal muscular atrophy. In the past, the patient’s wounds have deteriorated, requiring the patient to be hospitalized. Previously, a skilled nurse has trained the patient’s wife to perform wound care. The treating physician orders a new episode of skilled care, at a frequency of one visit every 2 weeks to perform observation and assessment of the patient’s skin ulcers to make certain that they are not worsening. This order is reasonable and necessary because, although the unskilled family caregiver has learned to care for the wounds, the skilled nurse can use observation and assessment to determine if the condition is worsening.

40.2-Skilled Therapy Services (Rev. 179, Issued: 01-14-14, Effective: 01-07-14, Implementation: 01-07-14)

A3-3118.2, HHA-205.2

To be covered as skilled therapy, the services must require the skills of a qualified therapist and must be reasonable and necessary for the treatment of the patient's illness or injury as discussed below. Coverage does not turn on the presence or absence of an individual's potential for improvement, but rather on the beneficiary's need for skilled care.

40.2.1-General Principles Governing Reasonable and Necessary Physical Therapy, Speech-Language Pathology Services, and Occupational Therapy (Rev. 179, Issued: 01-14-14, Effective: 01-07-14, Implementation: 01-07-14)

1. Assessment, Measurement and Documentation of Therapy Effectiveness. To ensure therapy services are effective, at defined points during a course of treatment, for each therapy discipline for which services are provided, a qualified therapist (instead of an assistant) must perform the ordered therapy service. During this visit, the therapist must assess the patient using a method which allows for objective measurement of function and successive comparison of measurements. The therapist must document the measurement results in the clinical record.

Specifically: For each therapy discipline for which services are provided, a qualified therapist (instead of an assistant) must assess the patient's function using a method which objectively measures activities of daily living such as, but not limited to, **eating, swallowing, bathing, dressing, toileting, walking, climbing stairs, using assistive devices**, and mental and cognitive factors. The measurement results must be documented in the clinical record.

40.2.4.3-Illustration of Covered Services (Rev. 179, Issued: 01-14-14, Effective: 01-07-14, Implementation: 01-07-14)

A3-3118.2.D.3, HHA-205.2.D.3

EXAMPLE 2: A physician has ordered occupational therapy for a patient who is recovering from a CVA. The patient has **decreased range of motion**, strength, and sensation in both the upper and lower extremities on the right side. In addition, the patient has perceptual and cognitive deficits resulting from the CVA. The patient's condition has resulted in decreased function in activities of daily living **(specifically bathing, dressing, grooming, hygiene, and toileting). The loss of function requires assistive devices to enable the patient to compensate for the loss of function and maximize safety and independence.**
The patient also needs equipment such as himi-slings to prevent shoulder subluxation and a hand splint to prevent joint contracture and deformity in the right hand. The services of an occupational therapist would be necessary to:

•Assess the patient's needs;
•Develop goals (to be approved by the physician);
•Manufacture or adapt the needed equipment to the patient's use;
•Teach compensatory techniques;
•Strengthen the patient as necessary to permit use of compensatory techniques; and
•Provide activities that are directed towards meeting the goals governing increased perceptual and cognitive function. Occupational therapy services would be covered at a duration and intensity appropriate to the severity of the impairment and the patient's response to treatment. Such visits would be considered covered therapy services when the skills of a therapist are required to perform the services. The patient's needs, course of therapy and response to therapy must be documented.

50.2-Home Health Aide Services (Rev. 1, 10-01-03)

A3-3119.2, HHA-206.2

For home health aide services to be covered:
•The patient must meet the qualifying criteria as specified in§30;
•The services provided by the home health aide must be part-time or intermittent as discussed in§50.7;
•The services must meet the definition of home health aide services of this section; and
•The services must be reasonable and necessary to the treatment of the patient's illness or injury.

NOTE:
A home health aide must be certified consistent the competency evaluation requirements. The reason for the visits by the home health aide must be to provide hands-on personal care of the patient or services needed to maintain the patient's health or to facilitate treatment of the patient's illness or injury. The physician's order should indicate the frequency of the home health aide services required by the patient. These services may include but are not limited to:

A. Personal Care Personal care means:

1. **Bathing, dressing, grooming**, caring for hair, nail, and oral hygiene which are needed to facilitate treatment or to prevent deterioration of the patient's health, changing the bed linens of an incontinent patient, shaving, deodorant application, **skin care with lotions** and/or powder, **foot care**, and ear care; and
2. Feeding, assistance with elimination (including enemas unless the skills of a licensed nurse are required due to the patient's condition, routine catheter care and routine colostomy care), assistance with ambulation, changing position in bed, assistance with transfers.

EXAMPLE 1: A physician has ordered home health aide visits to assist the patient in **personal care** because the patient is recovering from a stroke and continues to have significant right side weakness that causes the patient to be **unable to bathe**, dress or perform hair and oral care. The plan of care established by the HHA nurse sets forth the specific tasks with which the patient needs assistance. Home health aide visits at an appropriate frequency would be reasonable and necessary to assist in these tasks.

EXAMPLE 2: A physician ordered four home health aide visits per week for **personal care** for a multiple sclerosis patient who is unable to perform these functions because of increasing debilitation. The home health aide gave the patient a bath twice per week and washed hair on the other two visits each week. Only two visits are reasonable and necessary since the services could have been provided in the course of two visits.

50.4.1-Medical Supplies (Rev. 1, 10-01-03)

A3-3119.4.A, HHA-206.4.A

Medical supplies are items that, due to their therapeutic or diagnostic characteristics, are essential in enabling HHA personnel to conduct home visits or to carry out effectively the care the physician has ordered for the treatment or diagnosis of the patient's illness or injury. All supplies which would have been covered under the cost-based reimbursement system are bundled under home health PPS. Payment for the cost of supplies has been incorporated into the per visit and episode payment rates. Supplies fit into two categories. <u>They are classified as:</u>

•Routine-because they are used in small quantities for patients during the usual course of most home visits; or

•Nonroutine-because they are needed to treat a patient's specific illness or injury in accordance with the physician's plan of care and meet further conditions discussed in more detail below.

All HHAs are expected to separately identify in their records the cost of medical and surgical supplies that are not routinely furnished in conjunction with patient care visits and the use of which are directly identifiable to an individual patient.

50.4.2-Durable Medical Equipment (Rev. 1, 10-01-03)

A3-3119.4.B, HHA-206.4.B

Durable medical equipment which meets the requirements of the **Medicare Benefit Policy Manuals**, Chapter 6, "Hospital Services Covered Under Part B," §80, and Chapter 15, Covered Medical and Other Health Services" §110, is covered under the home health benefit with the beneficiary responsible for payment of a 20 percent coinsurance.

50.4.1.3-Nonroutine Supplies (Reportable)(Rev. 1, 10-01-03)

A3-3119.4.A.2, HHA-206.4.A.2

Nonroutine supplies are identified by the following conditions:
1. The HHA follows a consistent charging practice for Medicare and other patients receiving the item;
2. The item is directly identifiable to an individual patient;
3. The cost of the item can be identified and accumulated in a separate cost center; and
4. The item is furnished at the direction of the **patient's physician** and is specifically **identified in the plan of care.**

All nonroutine supplies must be **specifically ordered by the physician** or the physician's order for services must require the use of the specific supplies to be effectively furnished. The charge for nonroutine supplies is excluded from the per visit costs

Consider other items that are often used by persons who are not ill or injured to be medical supplies only where:
•The item is recognized as having the capacity **to serve a therapeutic** or diagnostic purpose in a specific situation; and
•The item is required as a part of the actual physician-prescribed treatment of a patient's existing illness or injury.

1. For example, items that generally serve a **routine hygienic purpose**, e.g., soaps and shampoos and items that generally serve as skin conditioners, e.g., baby lotion, baby oil, skin softeners, as serving a specific therapeutic purpose in the physician's prescribed treatment of the patient's existing skin (scalp) disease or **injury.**

Limited amounts of medical supplies may be left in the home between visits where repeated applications are required and rendered by the patient or other caregivers. These items must be part of the plan of care in which the home health staff is actively involved.

2. For example, the patient is independent in insulin injections but the nurse visits once a day to change wound dressings. The wound dressings/irrigation solution may be left in the home between visits. Supplies such as needles, syringes, and catheters that require administration by a nurse should not be left in the home between visits.

100-Physician Certification for Medical and Other Health Services Furnished by Home Health Agency (HHA)(Rev. 1, 10-01-03)

A3-3128, HHA-224

A physician must certify that the medical and other health services covered by medical insurance, which were provided by (or under arrangements made by) the HHA, were medically required. This certification needs to be made only once where the patient may require over a period of time the furnishing of the same item or service related to one diagnosis. There is no requirement that the certification be entered on any specific form or handled in any specific way as long as the approach adopted by the HHA permits the intermediary to determine that the certification requirement is, in fact, met. A written physician's order designating the services required would also be an acceptable certification.

B. Medical Supplies

The law requires all medical supplies (routine and nonroutine) bundled to the agency while the patient is under a home health plan of care. The agency that establishes the episode is the only entity that can bill and receive payment for medical supplies during an episode for a patient under a home health plan of care. Both routine and nonroutine medical supplies are included in the base rates for every Medicare home health patient regardless of whether or not the patient requires medical supplies during the episode. Due to the consolidated billing requirements, CMS provided additional amounts in the base rates for those nonroutine medical supplies that have a duplicate Part B code that could have been unbundled to Part B prior to PPS. See §§50.4 for detailed discussion of medical supplies. **Medical supplies used by the patient, provider, or other practitioners under arrangement on behalf of the agency (other than physicians) are subject to consolidated billing and bundled to the HHA episodic payment rate.** Once a patient is discharged from home health and not under a home health plan of care, the HHA is not responsible for medical supplies.

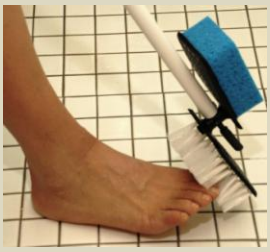
The DME, including supplies covered as DME, are paid separately from the PPS rates and are excluded from the consolidated billing requirements governing PPS. The determining factor is the medical classification of the supply, not the diagnosis of the patient. For example, infusion therapy will continue to be covered under the DME benefit separately paid from the PPS rate and excluded from the consolidated billing requirements governing PPS.

The DME supplies that are currently covered and paid in accordance with the DME fee schedule as category SU are billed under the DME benefit and not included in the bundled HHA episodic payment rate. The HHAs are not required to do consolidated billing of SU supplies.

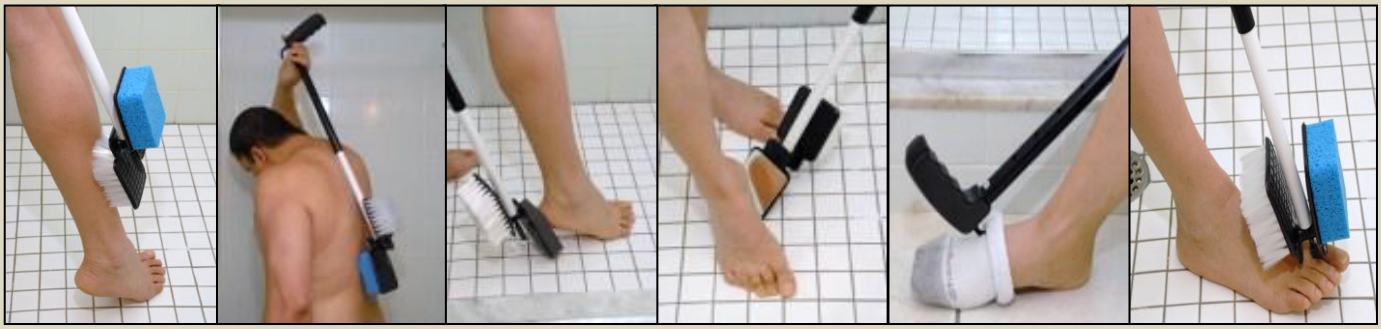
Need Clarity

The law specifically excludes durable medical equipment from the 60-day episode rate and consolidated billing requirements. DME continues to be paid on the fee schedule outside of the PPS rate.

Ergonomically designed soft handle



Mirror with a Lip that can be used to determine sensation underneath the feet (Monofilament)



https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c16.pdf
http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf

300.-Payment for DSMT (Rev. 72, Issued: 05-25-07; Effective: 07-01-07; Implementation: 07-02-07)

Payment for DSMT may only be made to any provider that bills Medicare for other individual Medicare services and may be made only for training sessions actually attended by the beneficiary and documented on attendance sheets.
See Pub. 100-04, chapter 18, section 120 for specific payment information for physicians and all provider types.

300.5.1 -Special Claims Processing Instructions for FIs

(Rev. 24, Issued: 10-29-04, Effective: 01-01-05, Implementation: 01-03-05)
•Coding and Payment Requirements
The provider bills for DSMT on Form CMS-1450 or its electronic equivalent. The cost of the service is billed under revenue code 942 in FL 42 “Revenue Code.” The provider will report HCPCS codes G0108 or G0109 in FL 44 “HCPCS/Rates.” The definition of the HCPCS code used should be entered in FL 43 “Description.”