

70 BRACES - TRUSSES - ARTIFICIAL LIMBS AND EYES

70-1 CORSET USED AS HERNIA SUPPORT

A hernia support (whether in the form of a corset or truss) which meets the definition of a brace is covered under Part B under §1861(s)(9) of the Act.

See Intermediary Manual, §3110.5; Medicare Carriers Manual, §2133; and Hospital Manual, §228.5.

70-2 SYKES HERNIA CONTROL

Based on professional advice, it has been determined that the sykes hernia control (a spring-type, U-shaped, strapless truss) is not functionally more beneficial than a conventional truss. Make program reimbursement for this device only when an ordinary truss would be covered. (Like all trusses, it is only of benefit when dealing with a reducible hernia). Thus, when a charge for this item is substantially in excess of that which would be reasonable for a conventional truss used for the same condition, base reimbursement on the reasonable charges for the conventional truss.

See Intermediary Manual, §3110.5; Medicare Carriers Manual, §2133; and Hospital Manual, §228.5.

70-3 PROSTHETIC SHOE

A prosthetic shoe (a device used when all or a substantial portion of the front part of the foot is missing) can be covered as a terminal device; i.e., a structural supplement replacing a totally or substantially absent hand or foot. The coverage of artificial arms and legs includes payment for terminal devices such as hands or hooks even though the patient may not require an artificial limb. The function of the prosthetic shoe is quite distinct from that of excluded orthopedic shoe and supportive foot devices which are used by individuals whose feet, although impaired, are essentially intact. (Section 1862(a)(8) of the Act excludes payment for orthopedic shoes or other supportive devices for the feet.)

See Intermediary Manual, §3110.5; Medicare Carriers Manual, §2133; and Hospital Manual, §228.5.

80 PATIENT EDUCATION PROGRAMS

80-1 INSTITUTIONAL AND HOME CARE PATIENT EDUCATION PROGRAMS

While the Act does not specifically identify patient education programs as covered services, reimbursement may be made under Medicare for such programs furnished by providers of services (i.e., hospitals, SNFs, HHAs, and OPT providers) to the extent that the programs are appropriate, integral parts in the rendition of covered services which are reasonable and necessary for the treatment of the individual's illness or injury. For example, educational activities carried out by nurses such as teaching patients to give themselves injections, follow prescribed diets, administer colostomy care, administer medical gases, and carry out other inpatient care activities may be reimbursable as a part of covered routine nursing care. Also, the teaching by an occupational therapist of compensatory techniques to improve a patient's level of independence in the activities of daily living may be reimbursed as a part of covered occupational therapy. Similarly, the instruction of a patient in the carrying out of a maintenance program designed for him/her by a physical therapist may be reimbursed as part of covered physical therapy.

However, when the educational activities are not closely related to the care and treatment of the patient, such as programs directed toward instructing patients or the public generally in preventive health care activities, reimbursement cannot be made since the Act limits Medicare payment to covered care which is reasonable and necessary for the treatment of an illness or injury. For example, programs designed to prevent illness by instructing the general public in the importance of good nutritional habits, exercise regimens, and good hygiene are not reimbursable under Medicare.

## 80-2 OUTPATIENT DIABETIC EDUCATION PROGRAMS

An outpatient hospital diabetic education program is a program which educates patients in the successful self-management of diabetes. An outpatient diabetic program includes education about performance of frequent self-monitoring of blood glucose, education about diet and exercise, an insulin treatment plan developed specifically for the patient who is insulin-dependent, and motivation to use the skills learned to enable self-management. Education programs should identify themselves as programs for non-insulin patients, insulin-dependent patients, or both.

Outpatient hospital diabetic education programs may be covered under Medicare provided the services are furnished under a physician's order by the provider's personnel and under medical staff supervision to individuals who are registered patients of that provider. The services must be closely related to the care and treatment of the individual patient and must provide the patient with essential knowledge that aids in the patient's active participation in his/her own treatment and the skills that enable self-management.

Do not substitute formally structured education programs for the more traditional and generally effective instruction included as a part of the basic care and treatment furnished to the patient by the health care professional.

The overall goal of outpatient hospital diabetic education programs is self-management of the disease, and each program must be sufficiently flexible to meet the individual needs of the patient. (This does not preclude some sessions of the programs to be given on an outpatient group basis.) The individual plan of care must indicate at a minimum the goals for the individual patient and how these goals will be realized.

Not all diabetic patients are eligible to participate in these programs. In general, the kinds of patients that are likely to be suitable candidates for outpatient education programs are newly diagnosed diabetics and/or unstable diabetics (e.g., a long-term diabetic with current management problems).

Entrance into these programs is by physician referral only. Self-referral is not covered. The duration of these programs should be sufficient to meet the goals of self-management within the timeframe indicated in the plan of treatment. It is not expected that any given patient could be eligible to reenter an education program unless new conditions warrant it.

After the intermediary determines that a program may be covered, the intermediary may request additional documentation to make a claims determination.

## 90 NURSING SERVICES

## 90-1 HOME HEALTH VISITS TO A BLIND DIABETIC

Many individuals who are blind and require daily insulin for the control of a diabetic condition are able to administer their injections without assistance (other than possibly that which may be furnished by family members or friends). There are organizations which encourage and train blind diabetics, both to fill their own syringes and to inject themselves. There are also a number of devices available for blind individuals to fill their syringes accurately. However, the individuals who may need assistance with prefilling their syringes may also require periodic observation and evaluation, even though their diabetes is fairly stabilized. In such cases, probably few in number, home health services may be required for this purpose.

To qualify for home health benefits, a blind diabetic must be confined to his home, under the care of a physician, and in need of either skilled nursing services on an intermittent basis or physical therapy or speech therapy. Effective July 1, 1981, a person may qualify for home health benefits based on his or her need for skilled nursing services on an intermittent basis, physical therapy, speech therapy, or occupational therapy. Effective December 1, 1981, occupational therapy is eliminated as a basis for entitlement to home health services. However, if a person has otherwise qualified for home health services because of the need for skilled nursing care, physical therapy or speech therapy, the patient's eligibility for home health services may be extended solely on the basis of the continuing need for occupational therapy. (See Intermediary Manual, §3116; Home Health Agency Manual, §203; Hospital Manual, §155.3.) There must be a plan of treatment, established and periodically reviewed by a physician, which indicates that there is a recurring need for home health services to supplement the physician's contacts with the patient; e.g., skilled nursing visits for observing and determining the need for changes in the level and type of care which has been prescribed. (See Intermediary Manual, §3117ff; Home Health Agency Manual, §204ff.) Once an initial regimen has been established, the frequency of need for further home health services can vary greatly from patient to patient, depending on their condition and the likelihood of its changing. Some may need visits only every 90 days, for example, while others may require them much more frequently. If a nurse makes a visit to provide skilled services, and also prefills syringes, the purpose of the visit, which was to provide skilled services, does not change. However, if the sole purpose of the nurse's visit is to prefill insulin syringes for a blind diabetic, it is not a skilled nursing visit although it may be reimbursed as such as indicated below.

Filling a syringe can be safely and effectively performed by the average nonmedical person without the direct supervision of a licensed nurse. Consequently, it would not constitute a skilled nursing service even if it is performed by a nurse. (See Intermediary Manual, §3117.2B; Home Health Agency Manual, §204.2B.) The personal care duties normally performed by home health aides include assisting the patient with medications ordered by a physician which are ordinarily self-administered. (See Intermediary Manual, §3119.2; Home Health Agency Manual, §206.2.) Performance of such a service by an aide is consistent with the Medicare conditions of participation for home health agencies. Therefore, home health aide services would be appropriate for those blind diabetics who are qualified for home health benefits and who cannot fill their syringes. An adequately trained home health aide could make intermittent visits, usually on a weekly basis, to the home for the purpose of filling that supply of insulin ordered by the physician.

If State law, however, precludes a home health aide from prefilling insulin syringes, payment may be made for this service as part of the cost of skilled nursing services when performed by a nurse for a blind diabetic who is otherwise unable to prefill his or her syringes. There are no adverse consequences with respect to reimbursement to the home health agency for providing the service in this manner.

If State law does not preclude a home health aide from prefilling insulin syringes, but the home health agency chooses to send a nurse to perform only this task, the visit is reimbursed as if made by a home health aide.

NOTE: As indicated, to qualify for home health benefits, a patient must require skilled nursing services on an intermittent basis or physical therapy or speech therapy. If a beneficiary does not qualify for home health benefits but only needs someone to prefill syringes with the correct dosage of insulin, then no program payment can be made.

Cross-refer: Intermediary Manual, §§3116, 3117.2B, 3117ff, 3119.2; Home Health Agency Manual, §§203, 204ff, 204.2B, 206.

#### 90-2 HOME HEALTH NURSES' VISITS TO PATIENTS REQUIRING HEPARIN INJECTIONS

Professional medical advice indicates that subcutaneous injections of low dose heparin can be,

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