



INDIANA HEALTH COVERAGE PROGRAMS

PROVIDER REFERENCE MODULE

Home Health Services

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1.0	Policies and procedures as of October 1, 2015 Published: February 25, 2016	New document	FSSA and HPE
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2.0	Policies and procedures as of May 1, 2017 Published: November 7, 2017	Scheduled update: <ul style="list-style-type: none"> • Reorganized and edited text as needed for clarity • Replaced Hewlett Packard Enterprise references with DXC Technology • Changed speech therapy references to speech-language pathology • Updated the definition of home health services in the Introduction section and as needed throughout the module • Updated information in the IHCP Coverage for Home Health Services section and subsection • Updated documentation needed in the Home Health PA Documentation section • Updated requirements in the PA for Home Health Nursing Services section • Added the PA for Home Health Therapy Services section 	FSSA and DXC

Version	Date	Reason for Revisions	Completed By
		<ul style="list-style-type: none"> • Removed the Medical Plan of Care section and subsection; moved relevant information to elsewhere in the module • Updated the PA Exception for Hospital Discharge section • Updated Table 1 – Revenue Codes Crosswalked to Procedure Codes for Home Health Services • Updated the Home Health Reimbursement section • Updated Table 2 – Home Health Services • Clarified PA requirements in the Initial Evaluations for Physical Therapy, Occupational Therapy, and Speech-Language Pathology in Home Settings section • Updated Table 3 – Codes for Billing Initial Evaluations for Physical Therapy, Occupational Therapy, and Speech-Language Pathology in Home Settings • Updated the Home Uterine Monitoring Device section 	

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Home Health Services

Note: For policy information regarding coverage of home health services, see the [Medical Policy Manual](#) at indianamedicaid.com.

Introduction

In accordance with *Code of Federal Regulations 42 CFR 440.70*, the Indiana Health Coverage Programs (IHCP) defines “home health services” as services provided to Medicaid members in the member’s place of residence. A place of residence for home health services does not include a hospital, nursing facility, or intermediate care facility for individuals with intellectual disabilities (ICF/IID). Members may receive home health services in any setting in which normal life activities take place other than a hospital, nursing facility, ICF/IID, or any setting in which payment is, or could be, made under Medicaid for inpatient services that include room and board. Home health services cannot be limited to members who are homebound.

The following sections provide specific IHCP coverage, prior authorization, coverage, billing, and reimbursement procedures for home health services.

IHCP Coverage for Home Health Services

Home health services are available to IHCP members of any age when the services are medically necessary, ordered in writing from a physician, and performed on a part-time and intermittent basis in accordance with a written plan of treatment. For dates of service on or after May 1, 2017, documentation of a face-to-face encounter in accordance with *42 CFR 440.70(f)* is required for IHCP coverage of home health services, including certain medical equipment and supplies as home health services:

- To initiate home health services, the face-to-face encounter must occur no more than 90 days before or 30 days after the start of services.
- For coverage of the following items, the face-to-face visit must occur and be recorded no more than six months before the start of services:
 - Compression devices
 - Decubitus care equipment
 - Hospital beds and accessories
 - Humidifiers, compressors, nebulizers
 - Infusion supplies
 - Monitoring devices
 - Nerve stimulators and devices
 - Oxygen and related respiratory equipment
 - Patient lifts
 - Speech generating devices
 - Traction equipment
 - Ultraviolet light devices
 - Wheelchairs and wheelchair accessories
 - Whirlpool equipment

IHCP home health benefits include covered services performed by providers such as registered nurses (RNs), licensed practical nurses (LPNs), home health aides, physical therapists, occupational therapists, and speech-language pathologists.

Noncovered Services

The following services are not covered for home health, except as specified under applicable IHCP waiver programs:

- Transporting the member to grocery stores, pharmacies, banks, and so forth
- Homemaker services (including shopping, laundry, cleaning, meal preparation, and so on)
- Chores (including picking up prescriptions and running other errands)
- Sitter or companion services (including activity planning)
- Respite care

Home Health Prior Authorization Policies

All home health services require prior authorization (PA), except as outlined in [PA Exception for Hospital Discharge](#) section.

A request to increase home health services, except in the case of urgent or emergency services, requires a written request with supporting documentation of medical necessity.

Providers can contact Cooperative Managed Care Services (CMCS) to request PA for fee-for-service members:

**Cooperative Managed Care Services
Prior Authorization Department
P.O. Box 56017
Indianapolis, IN 46256**
**Toll-Free Telephone: 1-800-269-5720
Fax: 1-800-689-2759**

Note: For Healthy Indiana Plan, Hoosier Care Connect, and Hoosier Healthwise members, contact the appropriate MCE to obtain PA. The contact information can be found in the [IHCP Quick Reference Guide](#) at indianamedicaid.com.

Home Health PA Documentation

An authorized representative of the home health agency submits PA requests for home health agency services. See the [Prior Authorization](#) module for information about completing the *Indiana Health Coverage Programs Prior Authorization Request Form*, which is available on the [Forms](#) page at indianamedicaid.com. See the [Provider Healthcare Portal](#) module for information about submitting a PA request online via the Provider Healthcare Portal (Portal), for fee-for-service members.

In addition to the PA request itself, the following information must be submitted:

- Copy of the written plan of treatment, developed by the attending physician, home health agency personnel, and (if applicable) therapists, signed by the attending physician, current through date of request, including the following:
 - Date of onset of the medical problems
 - Progress notes regarding the necessity, effectiveness, and goals of therapy services
 - Mental status
 - Types of services and equipment required

- Frequency of visits
- Prognosis
- Rehabilitation potential
- Functional limitations
- Activities permitted
- Nutritional requirements
- Medications and treatments
- Safety measures to protect against injury
- Instructions for timely discharge or referral
- Other appropriate items
- Documentation of a face-to-face encounter (see the [IHCP Coverage for Home Health Services](#) section for details)
- Estimate of costs for the required services as ordered by the physician and set out in the written plan of treatment
 - The cost estimate must be provided on or with the plan of treatment and signed by the attending physician.
 - The estimate must reflect the cost of each service requested, plus the overhead rate for the time periods requested, as reflected on the plan of treatment.
- Number and availability of nonpaid caregivers that assist in member care (even if the number is zero), and availability of each nonpaid caregiver, including
 - Whether the caregiver works outside the home and, if so, a copy of the caregiver’s work schedule from the employer
 - Whether the caregiver attends school outside of the home and, if so, a copy of the caregiver’s class schedule from the school
 - Whether the caregiver has additional child care responsibilities
 - Reasonably predictable or long-term physical limitations of that limit the caregiver’s ability to provide care to the member
- Number of members receiving home health services in a single household, so that care can be coordinated to use services in the most efficient manner
- Amount of time required to complete treatment tasks (number of hours per day, number of visits per day, and number of days per week the service is to be provided)
- Intensity of care required to meet needs
- Documentation of whether the member works or attends school outside the home, including what assistance is required
- Number of hours per day and number of days per week the member receives *other* home health service, from non-Medicaid sources including (but not limited to) the following:
 - Medicare
 - Community and Home Option to Institutional Care for the Elderly and Disabled (CHOICE) program
 - Medicaid waiver programs
 - Private insurance
 - Vocational rehabilitation

The IHCP allows electronic signatures on supporting documents, including physician orders and plans of treatment, submitted with PA requests for home health and hospice services. An original signature or signature stamp is still required on the *Indiana Health Coverage Programs Prior Authorization Request Form*, as well as on all State forms submitted as attachments to the request.

For specific PA criteria for home health services, see *Indiana Administrative Code 405 IAC 5-16*.

PA for Home Health Nursing Services

IHCP reimbursement is available for intermittent or part-time nursing provided in the home by home health nurse services. PA is required for all nursing services rendered by RNs, LPNs, and home health aides from agencies that are IHCP providers, with the exception of services ordered in writing by a physician before the member's discharge from an inpatient hospital. These services may continue without PA for a period not to exceed 120 hours within 30 days of discharge. (See the [PA Exception for Hospital Discharge](#) section for details.)

Home health services provided by an RN, LPN, home health aide, or renal dialysis aide employed by a home health agency must meet the following criteria:

- Prescribed or ordered in writing by a physician
- Provided in accordance with a written plan of treatment developed by the attending physician
- Intermittent or part-time, except for ventilator-dependent members with a developed plan of home healthcare
- Health-related nursing care (Homemaker, chore services, and sitter/companion service are not covered, except as specified under applicable Medicaid waiver programs.)
- Medically reasonable and necessary
- Less expensive than any alternate mode of care
- Provided in accordance with all other requirements for nursing services as laid out in *405 IAC 5-22-2*

Written evidence of physician involvement and personal patient evaluation are required to document the acute medical needs. A current plan of treatment and progress notes as to the necessity and effectiveness of nursing services must be attached to the prior authorization request and available for postpayment audit purposes. The attending physician must review the plan of treatment every 60 days and reorder the service if medically necessary.

The IHCP only issues PA for home health nursing based on procedure code 99600 TD – *Unlisted home visit, service, or procedure – registered nurse*. PA requests for home nursing do not need to indicate whether an RN or an LPN is to perform the service, because that level of detail is reported on the claim.

Home health providers can bill 99600 TE – *Unlisted home visit or service – LPN/LVN* or 99600 TD – *Unlisted home visit, service, or procedure – registered nurse*, and the IHCP Core Medicaid Management Information System (*CoreMMIS*) uses the approved PA units for the RN service 99600 TD.

PA for Home Health Therapy Services

PA is required for all home health therapy services, with the exception of occupational therapy, physical therapy, and speech-language pathology services ordered in writing by a physician before the member's discharge from an inpatient hospital, limited to a combined total of 30 units of service within 30 days of discharge. If additional services are required, PA must be obtained. (See the [PA Exception for Hospital Discharge](#) section for details.)

Physical therapy, occupational therapy, respiratory therapy, and speech pathology services provided by a home health agency must meet the following criteria:

- Prescribed or ordered in writing by a physician
- Provided by an appropriately licensed, certified, or registered therapist employed or contracted by the home health agency
- Provided in accordance with a written plan of treatment developed cooperatively between the therapist and the attending physician
- Medically necessary
- Provided in accordance with all other requirements for these services (see the [Therapy Services](#) module)

Orders for therapy services must include the specific procedures and modalities to be used, and the amount, frequency, and duration of each.

Written evidence of physical involvement and personal member evaluation is required to document the acute medical needs. A current plan of treatment and progress notes about the necessity and effectiveness of therapy must be attached to the PA request, and a copy must be available for postpayment audit.

PA Exception for Hospital Discharge

Providers can perform certain home health services without PA following a member's discharge from an inpatient hospital within the following parameters:

- RNs, LPNs, and home health aides may provide home health services without PA if a physician orders the service in writing prior to the patient's hospital discharge and does not exceed 120 units within 30 calendar days following discharge. The hospital discharge date is counted as day one.
- Any combination of therapy services ordered in writing by a physician prior to the patient's hospital discharge cannot continue beyond 30 units in 30 calendar days without PA.

For dates of service on or after February 13, 2017, providers should use **occurrence code 42** with the corresponding date of discharge in the occurrence code and occurrence date fields of the institutional claim (fields 31a–34b on the *UB-04* claim form) to bypass PA requirements associated with the preceding parameters. For dates of service before February 13, 2017, providers should use occurrence code 50 with the corresponding date of discharge.

When a provider bills for services exceeding the limitations established in the IAC, and the provider has not received PA for additional units, *CoreMMIS* automatically denies or cuts back units on the RA.

The IHCP does not require PA for an emergency visit, but providers must request a Prior Authorization System Update from the PA Department to continue service provision.

Home Health Billing Procedures

Home health providers follow the general billing directions for completing the *UB-04* claim form or electronic equivalent (837I transaction or Portal institutional claim), as described in the [Claim Submission and Processing](#) module, with the exception of the service date, local codes, and the additional type of bill codes. In the *HCP/CS/Rates* field (field 44 of the *UB-04* claim form), providers must enter the Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT®¹) procedure code for the service provided, not the rate. Table 1 lists revenue codes and the crosswalked procedure codes.

¹ CPT copyright 2016 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association.

Table 1 – Revenue Codes Crosswalked to Procedure Codes for Home Health Services

Revenue Code	Procedure Code	Revenue Code	Procedure Code
420	G0151	439	G0152
421	G0151	440	G0153
422	G0151	441	G0153
423	G0151	442	G0153
424	97001*, 97161, 97162, 97163	443	G0153
429	G0151	444	92521– 92524
430	G0152	449	G0153
431	G0152	552	99600 TD, 99600 TE
432	G0152	559	99601, 99602
433	G0152	572	99600
434	97003**, 97165, 97166, 97167		
<p>* 97001 was end-dated on December 31, 2016. Effective for dates of service on or after January 1, 2017, this code was replaced by 97161, 97162, and 97163.</p> <p>** 97003 was end-dated on December 31, 2016. Effective for dates of service on or after January 1, 2017, this code was replaced by 97165, 97166, and 97167.</p>			

Submit home health claims electronically or mail them to the following address for processing:

**DXC Home Health Claims
P.O. Box 7271
Indianapolis, IN 46207-7271**

Note: For Healthy Indiana Plan (HIP), Hoosier Care Connect, and Hoosier Healthwise members, bill the appropriate managed care entity (MCE). Contact information can be found in the [IHCP Quick Reference Guide](#) at indianamedicaid.com.

Unit of Service

Each line item identifies services billed using procedure codes and service dates. Providers must bill each date of service as a separate line item and bill each level of service, such as RN or LPN, provided on the same date as a separate line item. The procedure code description defines the unit of service. When home health providers perform the same service, such as multiple RN visits on the same date of service, they must bill those services on the same claim form and on one detail with the total number of units of services provided. Billing separate lines for the same service with the same date of service causes claims to be denied as exact duplicates. The Family and Social Services Administration (FSSA) sets the rate for each procedure code.

The billing units of home health visits for therapists, home health aides, LPNs, and RNs are as follows:

- For therapy visits – Therapy codes are measured as one unit equals 15 minutes. If the therapist is in the home eight minutes or more, the provider can round the visit up to the 15-minute unit of service. If the therapist is in the home for seven minutes or less, the provider cannot round this up and, therefore, cannot bill for it.
- For home health aides, LPN, or RN visits – Nursing services are measured as one unit equals one hour. If the home health aide, LPN, or RN is in the home for fewer than 29 minutes, providers can bill for the entire first hour only if they provided a service. For subsequent hours in the home, providers should round up any partial unit of service of 30 minutes or more to the next highest unit, and round down any partial unit of service of 29 minutes or less to the next lowest unit. (For example, 85 minutes spent on billable patient care activities is rounded down to one unit, and 95 minutes spent on billable patient care activities is rounded up to two units.)

If the therapist, home health aide, LPN, or RN enters the home and the member refuses service, providers cannot bill for any unit of service. Overheads are linked with reimbursement for services provided. When the provider does not render a service, the IHCP does not reimburse the provider for overhead.

Overhead Rate

Providers may report only one overhead per provider, per member, per day. Providers use the appropriate occurrence code and corresponding dates to indicate the appropriate overhead fee for a claim. Providers must bill home health overhead with occurrence code 73 for dates of service on or after February 13, 2017. For earlier dates of service, use occurrence code 61.

Occurrence code 73 (or 61 for dates of service before February 13, 2017) indicates that one encounter with the member occurred on the date shown: Providers should use the following guidance when billing the overhead occurrence code for nonconsecutive and consecutive dates of service on the *UB-04* claim form or Portal institutional claim:

- If the dates of service billed are not consecutive:
 - On the *UB-04* claim form, for each nonconsecutive date of service billed, providers should enter the occurrence code and the corresponding date in the Occurrence Code and Date fields (31a–34b).
 - On the Portal institutional claim, for each nonconsecutive date of service billed, in the Occurrence Codes panel, providers should enter the occurrence code and the corresponding date, using the same date in both the From Date and To Date fields for each entry.
- If the dates of service billed are consecutive, and one encounter was provided every day:
 - On the *UB-04* claim form, providers should enter the appropriate occurrence code and the first and last dates of service being billed in the Occurrence Span Code, From, and Through fields (35a–36b).
 - On the Portal institutional claim, use the same occurrence code fields as are used for nonconsecutive dates, but use the From Date and To Date fields to indicate that the single code entry represents a span.

Note: Providers cannot bill overhead for an occurrence span that includes dates of service before February 13, 2017, in combination with dates of service on or after February 13, 2017; overhead for these encounters must be billed separately with the appropriate occurrence code (61 or 73).

Providers that submit more than one claim in a multiple-member care situation should attach the overhead to only one of the submitted claims. As long as the overhead is attached to only one member, it does not matter to which member it is attached.

Note: Providers should not add the dollar figures associated with the overhead rates to the claim when calculating total charges. The Remittance Advice (RA) or 835 transaction automatically reflects the appropriate overhead amounts.

Multiple-Visit Billing

When providers make multiple visits for the same prior-authorized service to a member during one day, providers should bill all visits on the same claim form and on one detail with the total number of units of service provided. If providers bill these services on separate claim forms or on separate claim details, the IHCP denies one or more of the services as a duplicate service.

If additional hours of the same service are identified after a claim has been adjudicated and paid, providers must submit a paid claim adjustment. Procedures for submitting a paid claim adjustment are in the [Claim Adjustments](#) module.

Home health agency providers should be aware that rotating personnel in the home merely to increase billing is not appropriate.

Example: A home health agency sent an RN to a member's home in the morning and an LPN to the same home in the evening of March 15, 2017. The first nurse performed two hours of RN services in the morning, and the second nurse performed two hours of LPN services in the evening of March 15, 2017.

Detail 1: Revenue code 552 with CPT code 99600 TD. The date of service is 3/15/17 and the unit of service is 2.

Detail 2: Revenue code 552 with CPT code 99600 TE. The date of service is 3/15/17 and the unit of service is 2.

Home Health Reimbursement

Home health agency rates are calculated on a rate-setting methodology that is based on 95% of the unweighted median as the basis for rates. See *405 IAC 1-4.2-4(b)*. Effective for *from* dates of service of January 1, 2014, through June 30, 2017, the IHCP implemented a 3% reimbursement reduction for home health services, as indicated on the [Professional Fee Schedule](#) at indianamedicaid.com. See *405 IAC 1-4.2-4(l)*.

Table 2 – Home Health Services

Code	Service Performed By	Billing Unit
Occurrence code 73 (occurrence code 61 for dates of service before February 13, 2017)	Overhead	One unit per provider per recipient per day
Procedure code and modifier 99600 TD	Registered nurse	Hourly
Procedure code and modifier 99600 TE	Licensed practical nurse	Hourly
Procedure code 99600	Home health aide	Hourly
Procedure code G0151	Physical therapist	15-minute increments
Procedure code G0152	Occupational therapist	15-minute increments
Procedure code G0153	Speech-language pathologist	15-minute increments

Pursuant to *405 IAC 1-4.2*, home health providers are reimbursed for covered and prior-authorized services provided to IHCP members through standard, statewide rates computed by adding the following:

- Overhead cost rate
- Staffing cost rate multiplied by the number of hours spent performing billable patient care activities

Reimbursement is limited to one overhead per day, using occurrence code 73 for dates of service on or after February 13, 2017 (occurrence code 61 for earlier dates of service). See the [Professional Fee Schedule](#) at indianamedicaid.com for coverage, billing, and rate information.

Providers can obtain the current wage rate from Customer Assistance toll-free at 1-800-457-4584. Providers can also visit the [Bulletin Search](#) page at indianamedicaid.com, and search by keywords “home health” for the most current publication containing home health rates.

Registered Nurse Delegation to Home Health Aides

The IHCP has specific guidelines for tasks that are to be performed by RNs versus those performed by home health aides. Providers are expected to staff according to these guidelines. The *IHCP Provider Agreement* specifies that providers follow all applicable federal and state regulations in addition to the policies and procedures outlined in the *IHCP Provider Reference Modules*, bulletins, and banner pages, all available at indianamedicaid.com. Note that the IHCP periodically amends its policies and procedures. It is the provider’s responsibility to use the most up-to-date information. For federal and state regulations, see *42 CFR 484.36* and *410 IAC 17-14-1(g)-(n)*.

The IHCP may grant PA for skilled services under the home health benefit; however, the home health agency must bill the IHCP for services that were provided as follows: **The skilled nurse renders home health aide services because the agency was unable to contract a home health aide.**

The agency must then document that the nurse rendered the home health aide service. The agency must bill the IHCP using the appropriate code for home health aide services. If the postpayment review identifies that the agency billed for skilled nursing services rather than for home health aide services, the IHCP recoups the overpayment.

Initial Evaluations for Physical Therapy, Occupational Therapy, and Speech-Language Pathology in Home Settings

Home health providers should use the CPT procedure code and corresponding revenue code listed in the following table, as appropriate, when billing for initial evaluations for physical therapy, occupational therapy, or speech-language pathology in home settings. Although PA is generally not required for initial evaluations for therapy services, PA is required if initial evaluation is performed in the home.

Table 3 – Codes for Billing Initial Evaluations for Physical Therapy, Occupational Therapy, and Speech-Language Pathology in Home Settings

Therapy Service	Procedure Code and Description	Revenue Code and Description
Physical	97001* – <i>Physical therapy evaluation</i>	424 – <i>Evaluation or re-evaluation (for physical therapy)</i>
	97161 – <i>Physical therapy evaluation: low complexity</i>	
	97162 – <i>Physical therapy evaluation: moderate complexity</i>	
	97163 – <i>Physical therapy evaluation: high complexity</i>	
Occupational	97003** – <i>Occupational therapy evaluation</i>	434 – <i>Evaluation or re-evaluation (for occupational therapy)</i>
	97165 – <i>Occupational therapy evaluation, low complexity</i>	
	97166 – <i>Occupational therapy evaluation, moderate complexity</i>	
	97167 – <i>Occupational therapy evaluation, high complexity</i>	
Speech-Language	92521 – <i>Evaluation of speech fluency (eg, stuttering, cluttering)</i>	444 – <i>Evaluation or re-evaluation (for speech therapy – language pathology)</i>
	92522 – <i>Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria)</i>	
	92523 – <i>Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria); with evaluation of language comprehension and expression (eg, receptive and expressive language)</i>	
	92524 – <i>Behavioral and qualitative analysis of voice and resonance</i>	
<p>* 97001 was end-dated on December 31, 2016. Effective for dates of service on or after January 1, 2017, this code was replaced by 97161, 97162, and 97163.</p> <p>** 97003 was end-dated on December 31, 2016. Effective for dates of service on or after January 1, 2017, this code was replaced by 97165, 97166, and 97167.</p>		

Telehealth Services

The IHCP covers telehealth services provided by home health agencies. See the [Telemedicine and Telehealth Services](#) module for more information.

Home Infusion and Enteral Therapy Services

Home infusion includes the following:

- Enteral feeding within, or by way of, the intestine
- Enteral tube feeding that includes the provision of nutritional requirements through a tube into the stomach or small intestine
- Parenteral therapy that includes any route other than the alimentary canal, such as intravenous, subcutaneous, intramuscular, or mucosal
- Total parenteral nutrition therapy (TPN)

Billing for Home Infusion and Enteral Therapy

The following provider types may bill for home infusion and enteral therapy services and supplies:

- DME and home medical equipment (HME) providers
- Home health agencies
- Pharmacies

Providers should bill separately for the following three components of home infusion and enteral therapy:

- DME and HME providers bill all supplies, equipment, and formulas required to administer home infusion and enteral therapy on a *CMS-1500* claim form or electronic equivalent (Portal professional claim or 837P transaction) using the appropriate HCPCS code.
- HHAs bill only for services provided in the home by an RN or LPN on the *UB-04* claim form or electronic equivalent using the appropriate HCPCS codes.
- Pharmacies bill for compound drugs or any drugs used in parenteral therapy on an *Indiana FSSA Drug Claim Form* or electronic equivalent using the appropriate National Drug Code (NDC).

Home health agency may bill all three components using the proper billing forms and appropriate codes if the agency maintains multiple enrollments as a home health agency, a pharmacy, and a DME or HME provider.

Home Uterine Monitoring Device

Home health agencies can bill for infusion therapy using a home uterine monitor with the following procedure codes:

- 99601 – *Home infusion/specialty drug administration, per visit (up to 2 hours)*
- 99602 – *Home infusion/specialty drug administration, per visit (up to 2 hours); each additional hour*

Providers are allowed to bill one unit of service daily and should use revenue code 559 when billing 99601 or 99602.

Codes 99601 and 99602 cover the following items:

- Home uterine monitor
- Skilled nursing services that include the following:
 - Initial nursing assessment
 - Instructions given to the patient about the proper use of the monitor
 - Home visits to monitor signs and symptoms of preterm labor
 - Twenty-four hour telephone support for troubleshooting the monitoring equipment and for reporting patient symptoms

Any costs involved in transmitting reports to the physician electronically, such as fax or telephone modem, are included in the payment. In addition, all supplies for each therapy are bundled into a daily rate, and home health agencies are not allowed to bill separately for any supplies associated with these therapies. Home health agencies are also not allowed to bill an overhead charge when daily infusion services do not include an actual encounter in the home.