



MLN ConnectsTM

National Provider Call

Certifying Patients for the Medicare Home Health Benefit

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Agenda

- Benefit Overview
- Patient Eligibility
- Certification Requirements,
Including the Required Face-to-Face
Encounter
- Recertification Requirements
- Resources

Benefit Overview

Covered Medicare Home Health Services

Per §1861(m) of the Social Security Act (the Act), the following are covered Medicare home health services :

- Skilled nursing (SN) care (other than solely venipuncture for the purposes of obtaining a blood sample) on part-time or intermittent basis;
- Home health aides on a part-time or intermittent basis;
- Physical therapy (PT);
- Occupational therapy (OT);
- Speech-language pathology (SLP);
- Medical social services;

Covered Medicare Home Health Services (cont.)

- Routine & non-routine medical supplies (for example, catheters, catheter care supplies, ostomy bags, and ostomy care supplies);
- Durable medical equipment (paid separately from the home health payment rates); and
- An osteoporosis drug (injectable calcitonin) as defined in §1861(kk) of the Act (reimbursed on a reasonable cost basis and the patient must meet certain criteria).

Excluded from Coverage under the Home Health Benefit

Excluded services include:

- Drugs and biologicals (covered under Part B and Part D);
- Transportation;
- Housekeeping services; and
- Services covered under End Stage Renal Disease (ESRD) program (for example, wound care for an active shunt site).

Patient Eligibility

Patient Eligibility for Medicare Home Health Services

To be eligible for Medicare home health services, a patient must have Medicare Part A and/or Part B and, per §1814(a)(2)(C) and §1835(a)(2)(A) of the Act:

- 1. Be confined to the home;**
- 2. Need skilled services;**
- 3. Be under the care of a physician;**
- 4. Receive services under a plan of care established and reviewed by a physician; and**
- 5. Have had a face-to-face encounter with a physician or allowed non-physician practitioner (NPP).**

Care must be furnished by or under arrangements made by a Medicare-participating Home Health Agency (HHA).

Patient Eligibility: Confined to the Home

Per §1814(a) and §1835(a) of the Act, an individual shall be considered “confined to the home” (homebound) if the following two criteria are met:

Criteria One

One Must Be Met:

Because of illness or injury, need the aid of supportive devices such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the assistance of another person to leave their place of residence.

Have a condition such that leaving his or her home is medically contraindicated.

Criteria Two

Both Must Be Met:

There must exist a normal inability to leave home.

Leaving home must require a considerable and taxing effort.

Patient Eligibility: Confined to the Home

- The patient may be considered homebound (that is, confined to the home) if absences from the home are:
 - infrequent;
 - for periods of relatively short duration;
 - for the need to receive health care treatment;
 - for religious services;
 - to attend adult daycare programs; or
 - for other unique or infrequent events (e.g., funeral, graduation, trip to the barber).

Patient Eligibility: Examples of Confined to the Home

- A patient who is blind or senile and requires the assistance of another person in leaving their place of residence.
- A patient who has just returned from a hospital stay, involving surgery, who may be suffering from resultant weakness and pain and; therefore, their actions may be restricted by their physician to certain specified and limited activities such as getting out of bed only for a specified period of time or walking stairs only once a day.
- A patient with a psychiatric illness that is manifested, in part, by a refusal to leave home or is of such a nature that it would not be considered safe for the patient to leave home unattended, even if they have no physical limitations.

Patient Eligibility: Skilled Service Need

- Per §1814(a)(2)(C) and §1835(a)(2)(A) of the Act, the patient must be in need of one of the following:
 - SN care on an intermittent basis (furnished or needed on fewer than 7 days each week or less than 8 hours each day for periods of 21 days or less, with extensions in exceptional circumstances when the need for additional care is finite and predictable per §1861(m) of the Act); or
 - PT; or
 - SLP services; or
 - Continuing OT services.

Patient Eligibility: Under the Care of a Physician

- Per §1814(a)(2)(C) and §1835(a)(2)(A) of the Act, the patient must be under the care of a physician. Per §1861(r) of the Act and the Code of Federal Regulations (CFR) at 42 CFR 424.22(a)(1)(iii), a “physician” is a:
 - Doctor of Medicine;
 - Doctor of Osteopathy; or
 - Doctor of Podiatric Medicine (may perform only plan of treatment functions that are consistent with the functions he or she is authorized to perform under State law).
- In addition, the physician must be enrolled as a Medicare provider.

Patient Eligibility: Receiving Services Under a Plan of Care

- Per §1814(a)(2)(C) and §1835(a)(2)(A) of the Act, the patient must receive home health services under a plan of care established and periodically reviewed by a physician.
- Per the regulations at 42 CFR 424.22(d)(1), a plan of care may not be established and reviewed by any physician who has a financial relationship with the HHA.
- The physician cannot have a financial relationship, as defined in 42 CFR 411.354, with the HHA, unless the physician's relationship meets one of the exceptions in §1877 of the Act.

Certification Requirements, Including the Required Face-to-Face Encounter

Certification Requirements

- As a condition for payment, per the regulations at 42 CFR 424.22(a)(1):
 - A physician must certify that a patient is eligible for Medicare home health services according to 42 CFR 424.22(a)(1)(i)-(v).
 - The physician who establishes the plan of care must sign and date the certification.
- The Centers for Medicare & Medicaid Services (CMS) does not require a specific form or format for the certification as long as the five certification requirements, outlined in 42 CFR §424.22(a)(1), are met.

Certification Requirements (cont.)

- Per the regulations at 42 CFR 424.22(a)(2), physicians should complete the certification when the plan of care is established, or as soon as possible thereafter. The certification must be complete prior to when an HHA bills Medicare for reimbursement.
- It is not acceptable for HHAs to wait until the end of a 60-day episode of care to obtain a completed certification.

Certification Requirements (cont.)

The certifying physician must certify that:

1. The patient needs intermittent SN care, PT, and/or SLP services (42 CFR 424.22(a)(1)(i));
2. The patient is confined to the home (that is, homebound) (42 CFR 424.22(a)(1)(ii));
3. A plan of care has been established and will be periodically reviewed by a physician (42 CFR 424.22(a)(1)(iii));
4. Services will be furnished while the individual was or is under the care of a physician(42 CFR 424.22(a)(1)(iv)); and

Certification Requirements (cont.)

The certifying physician must certify that:

5. Per 42 CFR 424.22(a)(1)(v), a face-to-face encounter:

- occurred no more than 90 days prior to the home health start of care date or within 30 days of the start of the home health care,
- was related to the primary reason the patient requires home health services, and
- was performed by a physician or allowed non-physician practitioner.

The certifying physician must also document the date of the encounter.

Certification Requirements: Face-to-Face Encounter

- Per 42 CFR 424.22(a)(1)(v)(A), the face-to-face encounter can be performed by:
 - The certifying physician;
 - The physician who cared for the patient in an acute or post-acute care facility (from which the patient was directly admitted to home health);
 - A nurse practitioner or a clinical nurse specialist who is working in collaboration with the certifying physician or the acute/post-acute care physician; or
 - A certified nurse midwife or physician assistant under the supervision of the certifying physician or the acute/post-acute care physician.
- Per 42 CFR 424.22(d)(2), the face-to-face encounter cannot be performed by any physician or allowed NPP (listed above) who has a financial relationship with the HHA.

Certification Requirements: Management & Evaluation Narrative

- Per 42 CFR 424.22(a)(1)(i), if a patient's underlying condition or complication requires a registered nurse (RN) to ensure that essential **non-skilled** care is achieving its purpose and a RN needs to be involved in the development, management, and evaluation of a patient's care plan, the physician will include a brief narrative describing the clinical justification of this need.
- If the narrative is part of the certification form, then the narrative must be located immediately prior to the physician's signature. If the narrative exists as an addendum to the certification form, in addition to the physician's signature on the certification form, the physician must sign immediately following the narrative in the addendum.

Skilled Nursing for Management & Evaluation

- For skilled nursing care to be reasonable and necessary for management and evaluation of the patient's plan of care, the complexity of the necessary unskilled services that are a necessary part of the medical treatment must require the involvement of a registered nurse to promote the patient's recovery and medical safety in view of the patient's overall condition.
- For more information about SN for management and evaluation, refer to Section 40.1.2.2, Chapter 7, of the “Medicare Benefit Policy Manual” (Publication 100-02).

Skilled Nursing for Management & Evaluation – Example

Example: An aged patient with a history of diabetes mellitus and angina pectoris is recovering from an open reduction of the neck of the femur. He requires, among other services, careful skin care, appropriate oral medications, a diabetic diet, a therapeutic exercise program to preserve muscle tone and body condition, and observation to notice signs of deterioration in his condition or complications resulting from his restricted, but increasing mobility.

- Although a properly instructed person could perform any of the required services, that person would not have the capability to understand the relationship among the services and their effect on each other. Since the combination of the patient's condition, age, and immobility create a high potential for serious complications, such an understanding is essential to ensure the patient's recovery and safety.
- The management of this plan of care requires skilled nursing personnel until nursing visits are not needed to observe and assess the effects of the non-skilled services being provided to treat the illness or injury until the patient recovers.

Certification Requirements: Supporting Documentation

Per the regulations at 42 CFR 424.22(c):

- Documentation in the certifying physician's medical records and/or the acute/post-acute care facility's medical records (if the patient was directly admitted to home health) shall be used as the basis for certification of home health eligibility.
- If the documentation used as the basis for the certification of eligibility is not sufficient to demonstrate that the patient is or was eligible to receive services under the Medicare home health benefit, payment will not be rendered for home health services provided.

Certification Requirements: Supporting Documentation (cont.)

- Per the regulations at 42 CFR 424.22(c), certifying physicians and acute/post-acute care facilities must provide, upon request, the medical record documentation that supports the certification of patient eligibility for the Medicare home health benefit to the home health agency, review entities, and/or CMS.
- Certifying physicians who show patterns of non-compliance with this requirement, including those physicians whose records are inadequate or incomplete for this purpose, may be subject to increased reviews, such as provider-specific probe reviews.

Certification Requirements: Supporting Documentation (cont.)

- Information from the HHA can be incorporated into the certifying physician's and/or the acute/post-acute care facility's medical record for the patient.
 - Information from the HHA must be **corroborated** by other medical record entries and align with the time period in which services were rendered.
 - The certifying physician must review and sign off on anything incorporated into the patient's medical record that is used to support the certification of patient eligibility (that is, agree with the material by signing and dating the entry).

Certification Requirements: Supporting Documentation (cont.)

- The certifying physician's and/or the acute/post-acute care facility's medical record for the patient must contain information that **justifies the referral** for Medicare home health services. This includes documentation that substantiates the patient's:
 1. Need for the skilled services; and
 2. Homebound status;
- The certifying physician's and/or the acute/post-acute care facility's medical record for the patient must contain the **actual clinical note for the face-to-face encounter visit** that demonstrates that the encounter:
 3. Occurred within the required timeframe,
 4. Was related to the primary reason the patient requires home health services; and
 5. Was performed by an allowed provider type.

This information can be found most often in, but is not limited to, clinical and progress notes and discharge summaries.

Certification Supporting Documentation - Examples

- Please refer to the separate hand-outs to review four examples of supporting documentation.
 - Example 1: Discharge Summary
 - Example 2: Progress Note
 - Example 3: Progress Note and Problem List
 - Example 4: Discharge Summary and Comprehensive Assessment

Recertification Requirements

Recertification

- At the end of the initial 60-day episode, a decision must be made as to whether or not to recertify the patient for a subsequent 60-day episode.
- Per the regulations at 424.22(b)(1), recertification is required at least every 60 days when there is a need for continuous home health care after an initial 60-day episode and unless there is a:
 - Patient-elected transfer; or
 - Discharge with goals met and/or no expectation of a return to home health care.(These situations trigger a new certification, rather than a recertification)
- Medicare does not limit the number of continuous episode recertifications for patients who continue to be eligible for the home health benefit.

Recertification Requirements

Per the regulations at 42 CFR 424.22(b)(2), the Recertification Must :

- Be signed and dated by the physician who reviews the plan of care.
- Indicate the continuing need for skilled services.
 - Need for OT may be the basis for continuing services that were initiated because the individual needed SN, PT or SLP services.
- Estimate how much longer the skilled services will be required.

Recertification Requirements: Management & Evaluation Narrative

- Per 42 CFR 424.22(b)(2), if a patient's underlying condition or complication requires a RN to ensure that essential **non-skilled** care is achieving its purpose and a RN needs to be involved in the development, management, and evaluation of a patient's care plan, the physician will include a brief narrative describing the clinical justification of this need.
- If the narrative is part of the recertification form, then the narrative must be located immediately prior to the physician's signature. If the narrative exists as an addendum to the recertification form, in addition to the physician's signature on the recertification form, the physician must sign immediately following the narrative in the addendum.

Physician Billing for Certification/Recertification

- Healthcare Common Procedure Coding System (HCPCS) code G0180 - Physician certification home health patient for Medicare-covered home health service under a home health plan of care (patient not present)
- HCPCS code G0179 - Physician recertification home health patient for Medicare-covered home health services under a home health plan of care (patient not present)

Physician Billing for Certification/Recertification (cont.)

- Certifying/recertifying patient eligibility can include contacting the home health agency and reviewing of reports of patient status required by physicians to affirm the implementation of the plan of care that meets patients needs.
- Physician claims for certification/recertification of eligibility for home health services (G0180 and G0179, respectively) are not considered to be for “Medicare-covered” home health services if the HHA claim itself was non-covered because the certification/recertification of eligibility was not complete or because there was insufficient documentation to support that the patient was eligible for the Medicare home health benefit.

Resources

Resources

- Medicare Home Health Agency Web Site
<http://www.cms.gov/Center/Provider-Type/Home-Health-Agency-HHA-Center.html>
- Home Health PPS Web Page
<http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/index.html>

Resources

- Medicare Learning Network® Publication titled “Home Health Prospective Payment System”
<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/HomeHlthProsPaymt.pdf>
- Chapter 6 of the “Medicare Program Integrity Manual” (Publication 100-08)
<https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c06.pdf>

Resources

- Chapter 10 of the “Medicare Claims Processing Manual” (Publication 100-04)
<https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c10.pdf>
- Chapter 7 of the “Medicare Benefit Policy Manual” (Publication 100-02)
<https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c07.pdf>

Question & Answer Session

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