Certifying Home Health Care

2015

Today's Presenters

Shelly Bernardini RN, CPHM

- HH Clinical Consultant
- Jurisdiction K & Jurisdiction 6

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Agenda

Medicare HH Benefit

Beneficiary/patient eligibility

FTF Encounters

Certification requirements

Recertification

References & resources

Medicare HH Benefit

CMS IOM Publication 100-04, *Medicare Benefit Policy Manual,* Chapter 7 - HH Services Section 30 - Conditions Patient Must Meet to Qualify for Coverage of HH Services

- To qualify for the Medicare HH benefit, under §§1814(a)(2)(C) and 1835(a)(2)(A) of the Act, a Medicare beneficiary must meet the following requirements:
  - Be confined to the home;
  - Under the care of a physician;
  - Receiving services under a POC established and periodically reviewed by a physician;
  - Be in need of skilled nursing care on an intermittent basis (see next slide) or PT or SLP; or
  - Have a continuing need for OT.
- A patient must meet each of the criteria specified in this section. Patients who meet each of these criteria and have this information documented in their medical records are eligible to have payment made on their behalf for services discussed in §§40 and 50.

Medicare HH Benefit

For purposes of benefit eligibility, under §§1814(a)(2)(C) and 1835(a)(2)(A) of the Act, “intermittent” means skilled nursing care that is either provided or needed on fewer than 7 days each week or less than 8 hours of each day for periods of 21 days or less (with extensions in exceptional circumstances when the need for additional care is finite and predictable).

Medicare HH Benefit

Medicare HH services include (Per §1861(m) of the SS Act):

- Routine & non-routine medical supplies
  - Catheters & catheter care supplies, ostomy bags & ostomy care supplies
- DME
  - Paid separately from the HH payment rates
- An osteoporosis drug--injectable calcitonin
  - As per §1861(kk)… reimbursed on a reasonable cost basis & the patient must meet certain criteria

Excluded from the Medicare HH Benefit

Services that are **excluded** from the Medicare HH benefit include:

- Drugs and biologicals
  - Covered under Part B and Part D
- Transportation
- Housekeeping services
- Services covered under ESRD program
  - Example: wound care for an active shunt site

Patient/Beneficiary Eligibility

Medicare Part A and/or Part B & §1814(a)(2)(C) and §1835(a)(2)(A) state that the patient/beneficiary:

- Be confined to the home
- Need skilled services
- Be under the care of a physician
- Receive services under POC established and reviewed by a physician
- Have had a FTF encounter for their current diagnosis with a physician or allowed NPP

Reminder: All home care services must be furnished by or under arrangements made by a Medicare-participating HHA

Patient/Beneficiary Eligibility Proper Documentation Process

HHA and physician who will be following patient's care in community should receive the following documentation from referring physician or facility in a timely fashion, in an effort to provide timely and appropriate initial start of care procedures:

- Referral/Order for HH Services
- Basic Initial POC
- FTF Encounter Documentation
- Documentation Supporting the Need for Skilled Service
- Documentation Supporting the Homebound Status
- Certification &/or Recertification Statement

Patient/Beneficiary Eligibility Proper Documentation Process

It is the sole responsibility of the referring, certifying & community physicians to record all pertinent HH information in the medical record and share the documentation with the HHA

HHA documentation should also be shared, as it compliments & supports documentation in referring, certifying & community physicians records

Patient/Beneficiary Eligibility Collaboration of Documentation

HH Agency

- Referring Physician
- Therapists
- DME Providers, Pharmacies
- Community Physician

Patient/Beneficiary Eligibility Homebound Status

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

Criteria Two **Both Standards Must Be Met**
There must exist a normal inability to leave home.
AND
Leaving home must require a considerable and taxing effort.

Patient/Beneficiary Eligibility Homebound Status

The patient may be considered “confined to the home” (homebound) if absences from the home are:

- Infrequent and relatively short in duration
- For medical appointments/treatments
- For religious services
- To attend adult daycare programs
- For other unique or infrequent events
  - funeral, graduation, hair care

Patient/Beneficiary Eligibility Homebound Status

Documenting the need for homebound status

- Include information about the injury/illness & the type of support and/or supportive device/assistance required for illness/injury to assist the patient in leaving home
- Explain in detail how the patient's current condition makes leaving home medically contraindicated
- Clarify exactly what about the illness qualifies the patient as homebound

Reminder: Declaring any portion of this regulation as a blanket statement copied from the CMS manual is vague. An explanation is required that describes the patients normal inability to leave home and exactly what effects are causing the considerable and taxing effort to leave home.

Patient/Beneficiary Eligibility
Need for Skilled Services

Documentation in the patient's HH medical records should include details about the patient's need for **any/all skilled services requested** (including NSG, PT/OT/SLP, SW) and should corroborate with the referring and/or certifying physician documentation

- Distinguish exactly what services are going to be provided by the skilled professional in the patients home
- Explain why a skilled professional is required to provide the HH care services requested
- Disclose clinical information (beyond a list of recent diagnoses, injury, or procedure) that is individual and specific to the patient
- Clarify why the findings from the FTF encounter with the patient support the medical necessity of the services being requested

Patient/Beneficiary Eligibility Under the Care of a Physician

- Per §1814(a)(2)(C) and §1835(a)(2)(A) of the Act, the patient must receive HH services under POC established and periodically reviewed by a physician
- When a beneficiary/patient is referred to HH services, it is beneficial to have an initial basic POC prior to their SOC. HHA will further develop the POC with the assistance of the community physician following the patient's care
- Form 485 is not an official current CMS document
- There are no mandatory CMS forms for the POC or Certification of the POC/F2F

Patient/Beneficiary Eligibility Under the Care of a Physician

- F2F encounter and POC can be certified in one certification statement
- Certifying physician must be enrolled in the Medicare Program and be a Doctor of Medicine, a Doctor of Osteopathy; or a Doctor of Podiatric Medicine
- Certifying physician cannot have financial relationship with HHA unless it meets one of exceptions in 42CFR411.355-42CFR411.357
- If a NPP provides the F2F encounter, a certifying physician must review & countersign the document. Allowed NPPs include: PA, CNS, NP, and CNM
- Reminder: Because residents do not have privileges, if a resident is performing the FTF encounter, he/she must inform the certifying physician of the encounter through the supervising teaching physician who must review & countersign

FTF Encounters

Currently there are no mandatory forms for F2F encounters

Must be a documented F2F encounter in the patient's medical records which collaborates with all of the other medical entities referring to and providing home care services

Narrative information required on the F2F encounter document in 2014 regarding the need for skilled services & homebound status are no longer required beginning 1/1/2015

Narrative portion of F2F encounter beginning 2015 is only required when specific skilled nursing services are ordered (refer to Certification Requirements: Skilled Nursing Services)

FTF Encounter 2015 Changes

2014

- F2F Encounter
  - Narrative mandatory regarding:
    - Need for skilled services, and
    - Homebound status

2015

- F2F Encounter
  - Narrative only if information regarding:
    - RN ensuring essential non-skilled care is achieving its purpose, and/or
    - RN development, management or evaluation of a POC

FTF Encounters Timing Requirement

Timing requirements for “in-person” encounter:

- Up to 90 days prior to the SOC
  - If the visit was for the same diagnosis/condition that now requires HH services
- Within 30 days after the SOC
  - For the diagnosis/condition that requires the HH services

Exception to timing requirements

- If the patient dies shortly after admission to HH
  - There must be a documented good faith effort to facilitate/coordinate the F2F encounter, and
  - All other certification requirements must have been met

FTF Encounters Documentation Requirements

F2F encounter is a condition of payment

HHA should maintain written documentation that the F2F encounter occurred

F2F should contain:

- Title (as the F2F encounter)
- Patient's full name
- Date of the actual F2F encounter
- Narrative information required only if patient requires specific skilled nursing services (See Skilled Nursing Documentation)
- Dated signature of physician (completing encounter)

FTF Encounters Reminders

- Physician certifies that the patient was seen and had a F2F encounter for the current diagnosis
- F2F encounter is part of the certification
- Certification statement may be on F2F encounter form, POC or separate form of its own
- SN narrative must be above the certification statement
- Electronic signatures are acceptable

Certifying HH Services

Condition of payment

- Requires skilled services
- Homebound
- Had a documented F2F
- Under care of physician
- POC for current illness

Certifying HH Services

The physician certification must state (Per 42 CFR 424.22(a)(1)(i-v):

- Patient needs intermittent SN care, PT, and/or SLP services
- Patient is homebound
- POC has been established (for the current diagnosis) and will be periodically reviewed by a physician
- Services will be furnished while the individual was or is under the care of a physician
- Patient had a dated FTF encounter that
  - Occurred meeting the timing requirements
  - Was related to the primary reason the patient requires HH services
  - Was performed & signed by a physician or allowed NPP

Certification Requirements

Certification should be complete when POC is established & prior to submission of Medicare claim 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 Skilled Nursing Services

If patient/beneficiary care requires RN to ensure that essential nonskilled care is achieving its purpose and/or the RN is involved in the development, management, and evaluation of a patient's care plan, the physician must 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 & date."
- "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 & date immediately following the narrative in the addendum."

Certification Requirements Skilled Nursing Services

CMS Examples can be viewed in the details from the December 16, 2014 HH Provider call: “Certifying Patients for the Medicare HH Benefit”

- http://www.cms.gov/Outreach-and-Education/Outreach/NPC/National-Provider-Calls-and-Events-Items/2014-12-16-Home-Health-Benefit.html?DLPage=1&DLSort=0&DLSortDir=descending

Certification Requirements Supporting Documentation

Documentation in the certifying physician's medical records (and/or the acute/post-acute care facility's medical records) shall be used as the basis for certification of HH eligibility.

- If this documentation is not sufficient to demonstrate that the patient is or was eligible to receive services under the Medicare HH benefit, payment will not be rendered for HH services provided.

Certification Requirements Supporting Documentation

Certifying physicians and acute/post-acute care facilities **must provide the medical record documentation** that supports the certification of patient eligibility

- Certifying physicians who show patterns of noncompliance 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

Information from the HHA **must be corroborated** by other medical record entries and align with the time period in which services were rendered.

- 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
  - The certifying physician must review and sign any documentation incorporated into the patient's medical record that is used to support the certification

Certification Requirements Supporting Documentation

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 HH services. This includes documentation that substantiates the patient's:
  - Need for the skilled services
  - Homebound status
- Actual clinical note for the FTF encounter visit that demonstrates that the encounter:
  - Occurred within the required timeframe
  - Was related to the primary reason the patient requires HH services
  - Was performed by an allowed provider type.

This information may be found in clinical progress notes and/or discharge summaries

CMS has provided Certification Supporting Documentation Examples

- (Please refer to the CMS Link Provided for examples)

Example Certification Statement

I certify/recertify that the above stated patient is homebound and that upon completion of the/this FTF encounter, has a need/continued need for intermittent skilled nursing, physical therapy and/or speech or occupational therapy services in their home for their current diagnosis as outlined in their initial plan of care. These services will continue to be monitored by myself or another physician who will periodically review and update the plan of care as required.

John Smith, MD

1/1/2015

Sample Documentation Process from Physician Office

- Forwards order/referral, initial POC & F2F documentation immediately to the HHA
- HH Agency carries out SOC & assists in further development of the POC
- Monitors the patient's care, updates & recertifies the POC in collaboration with the HHA as required
- Maintains up-to-date home care documentation in the patients office medical record
- PCP or Specialist sees the patient **in their office**
- Completes an order/referral and certifies an initial basic POC & F2F encounter

Sample Documentation Process from Acute or Post Acute Facility

- Forwards order/referral, initial POC & F2F documentation immediately to HHA & office of physician in the community that will be following the home care services – ensuring both entities are aware of services ordered, documenting follow-through
- HHA carries out SOC & assists in further development of the POC
- Community physician monitors patient's care and updates & recertifies the POC in collaboration with the HHA as required
- Community physician maintains up-to-date home care documentation in the patient's office medical record
- Physician or NPP discharges the patient from their acute or post acute facility (Hospital/SNF/Inpatient Rehabilitation Center/Surgery Center)
- Completes an order/referral and certifies an initial basic POC & F2F encounter

Recertification

Recertification is required at least every 60 days when there is a need for continuous HH care after an initial 60-day episode unless there is a:

- Patient-elected transfer
- Discharge with goals met with no expectation of a return to HH care for the current diagnosis
  - These situations would trigger a new certification, rather than a recertification

Medicare does not limit the number of continuous episode re-certifications for patients who continue to be eligible for the HH benefit.

Recertification

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 - Skilled Nursing Services

If patient/beneficiary care continues to require a RN during the recertification period to ensure that essential non-skilled care is achieving its purpose and/or the RN is involved in the development, management, and evaluation of a patient's care plan, the physician must 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 & date."
- "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 & date immediately following the narrative in the addendum."

2015 Federal Register Reference

Federal Register Vol. 79, No. 215

Released: Thursday, November 6, 2014

Page 66117

- http://www.gpo.gov/fdsys/pkg/FR-2014-11-06/pdf/2014-26057.pdf

CMS MLN Matters Article SE1436

"Certifying Patients for the Medicare HH Benefit"

- http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1436.pdf

CMS References & Resources

CMS IOM Publication 100-08 *Medicare Program Integrity Manual* Chapter 6

- https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c06.pdf

CMS IOM Publication 100-02 *Medicare Benefit Policy Manual* Chapter 7

- https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c07.pdf

CMS Publication 100-04 *Medicare Claims Processing Manual* Chapter 10

- https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c10.pdf

HH PPS Web Page

- http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/index.html

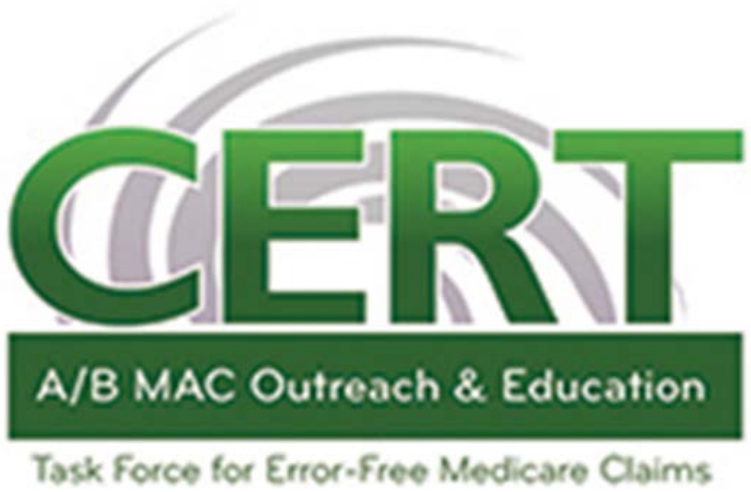
Medicare HH Agency Web Site

- http://www.cms.gov/Center/Provider-Type/Home-Health-Agency-HHA-Center.html

Medicare Learning Network® Publication titled “HH Prospective Payment System”

- http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/HomeHlthProsPaymt.pdf

CERT A/B MAC Outreach & Education Task Force



CERT A/B MAC Outreach & Education Task Force

- A joint collaboration of the A/B MACs to communicate national issues of concern regarding improper payments to the Medicare Program
- Shared goal of reducing the national improper payment rate as measured by the CERT program
- Partnership to educate Medicare providers on widespread topics affecting most providers and complement ongoing efforts of CMS, the MLN and the MACs individual error-reduction activities within its jurisdictions

Disclaimer

The CERT A/B MAC Outreach & Education Task Force is independent from the CMS CERT team and CERT contractors, which are responsible for calculation of the Medicare fee-for-service improper payment rate.

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- Novitas Solutions, Inc./JH and JL
- Palmetto GBA/J11
- Wisconsin Physicians Service Insurance Corporation/J5 and J8

CERT A/B MAC Outreach & Education Task Force

The CERT Task Force educates on common billing errors and contributes educational Fast Facts to the CMS website

- CMS MLN Provider Compliance Fast Facts web page
  - http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/ ProviderCompliance.html
- In addition, the CERT Task Force section on the NGSMedicare.com website provides a link to the CMS MLN Provider Compliance Fast Facts

CERT A/B MAC Outreach & Education Task Force

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Task Force Scenarios

- Complying with medical record documentation requirements
- Documenting therapy and rehabilitation services

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National Government Services

CERT A/B MAC Outreach & Education Task Force

CMS works closely with the CERT A/B MAC Task Force and the CERT DME MAC Outreach & Education Task Force

- CMS has a web page dedicated to education developed by the CERT A/B MAC Outreach & Education Task Force
  - http://www.cms.gov/Medicare/Medicare-Contracting/FFSProvCustSvcGen/CERT-Outreach-and-Education-Task-Force.html

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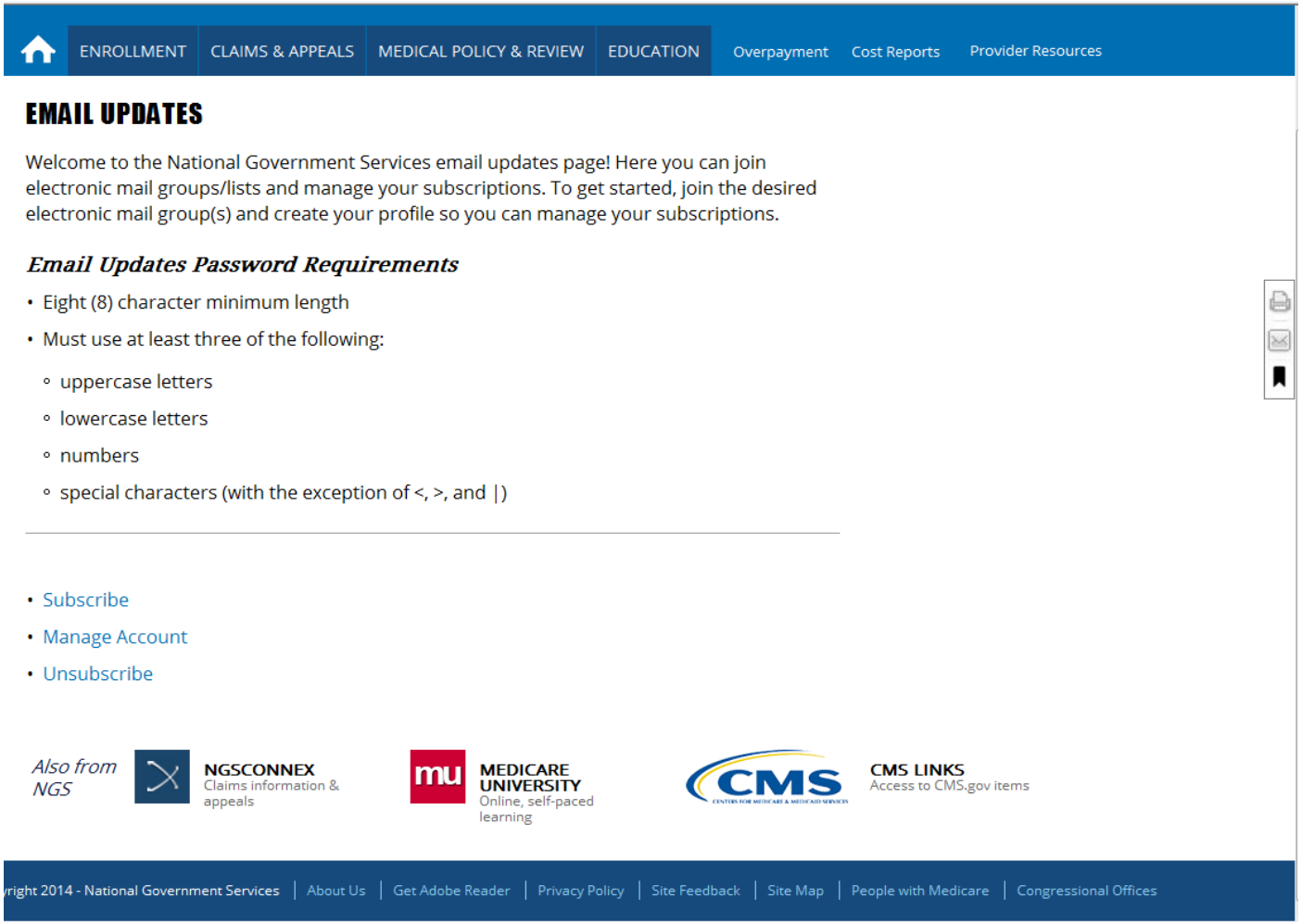

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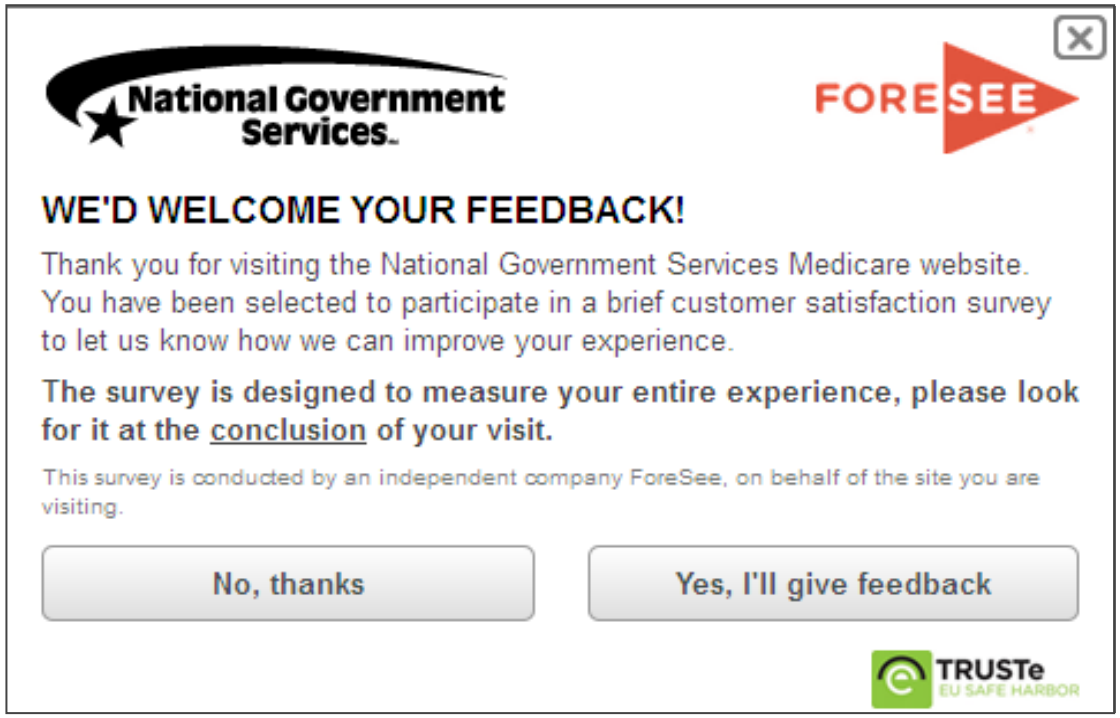

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- http://www.MedicareUniversity.com

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Log on to the National Government Services Medicare University

- http://www.MedicareUniversity.com
  - Topic = **Certifying Home Health Care**
  - Medicare University Credits (MUCs) = **1**
  - Catalog Number = To be provided
  - Course Code = To be provided
- Visit our website for step-by-step instructions on self-reporting.
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Questions?

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

REVISED product from the Medicare Learning Network® (MLN)

- **"Safeguarding Your Medical Identity"** Web-based Training (WBT)

MLN Matters® Number: SE1436 Revised

Related Change Request (CR) #: NA

Related CR Release Date: NA

Effective Date: NA

Related CR Transmittal #: NA

Implementation Date: NA

Certifying Patients for the Medicare Home Health Benefit

Note: This article was revised on December 31, 2014, to add clarifying language. All other information remains unchanged.

Provider Types Affected

This MLN Matters® Special Edition (SE) 1436 is intended for Medicare-enrolled physicians who certify patient eligibility for home health care services and submit claims to Medicare Administrative Contractors (MACs) for those services provided to Medicare beneficiaries.

What You Need to Know

This MLN Matters® SE1436 article gives Medicare-enrolled providers an overview of the Medicare home health services benefit, including patient eligibility requirements and certification/recertification requirements of covered Medicare home health services.

Key Points

To be eligible for Medicare home health services a patient must have Medicare Part A and/or Part B per Section1814(a)(2)(C) and Section 1835(a)(2)(A) of the Social Security Act (the Act):

- Be confined to the home;
- Need skilled services;
- Be under the care of a physician;
- Receive services under a plan of care established and reviewed by a physician; and
- 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 Home

Section 1814(a) and Section 1835(a) of the Act specify that an individual is considered "confined to the home" (homebound) if the following two criteria are met:

First Criteria One of the Following must be met:	Second Criteria Both of the following must be met:
1. Because of illness or injury, the individual needs 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.	1. There must exist a normal inability to leave home.
2. Have a condition such that leaving his or her home is medically contraindicated.	2. Leaving home must require a considerable and taxing effort.

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 (for example, funeral, graduation, trip to the barber).

Some examples of persons confined to home are:

- 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; and
- 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—Need Skilled Services

According to Section 1814(a)(2)(C) and Section1835(a)(2)(A) of the Act, the patient must be in need of one of the following services:

- Skilled nursing 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 Section 1861(m) of the Act);
- Physical Therapy (PT);
- Speech-Language Pathology (SLP) services; or
- Continuing Occupational Therapy (OT).

Patient Eligibility—Under the Care of a Physician and Receiving Services Under a Plan of Care

Section 1814(a)(2)(C) and Section 1835(a)(2)(A) of the Act require that the patient must be under the care of a Medicare-enrolled physician, defined at at42 CFR 424.22(a)(1)(iii) as follows:

- 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).

According to Section 1814(a)(2)(C) and Section 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. Based on 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.

Certification Requirements, Including the Required Face-to-Face Encounter are as follows:

As a condition for payment, according to 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); and

- 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 a physician certifies that the following five requirements, outlined in 42 CFR Section 424.22(a)(1), are met:

1. The patient needs intermittent SN care, PT, and/or SLP services;
2. The patient is confined to the home (that is, homebound);
3. A plan of care has been established and will be periodically reviewed by a physician;
4. Services will be furnished while the individual was or is under the care of a physician; and
5. A face-to-face encounter:
   a. 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;
   b. Was related to the primary reason the patient requires home health services; and
   c. Was performed by a physician or allowed Non-Physician Practitioner.

According to 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.

Certification Requirements: Face-to-Face Encounter

According to 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.

According to 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 and Evaluation Narrative

According to 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.

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" at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c07.pdf** on the CMS website.

Certification Requirements: Supporting Documentation

- 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.
- According to 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.
- Information from the HHA, such as the patient's comprehensive assessment, 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).
- 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:
    1. Occurred within the required timeframe;
    2. Was related to the primary reason the patient requires home health services; and
    3. 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.

Please review the following examples included at the end of this article:

1. Discharge Summary;
2. Progress Note;
3. Progress Note and Problem List; or
4. Discharge Summary and Comprehensive Assessment.

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. According to 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 episodes of recertification for patients who continue to be eligible for the home health benefit.

Recertification Requirements:

1. Must be signed and dated by the physician who reviews the plan of care;
2. Indicate the continuing need for skilled services (the need for OT may be the basis for continuing services that were initiated because the individual needed SN, PT or SLP services); and

3. Estimate how much longer the skilled services will be required.

Physician Billing for /Certification/Recertification

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 patient's needs.

1. 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).
2. 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 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.

Additional Information

If you have questions, please contact your MAC at their toll-free number. The number is available at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html** under - How Does It Work?

More information is available at the Medicare Home Health Agency website at **http://www.cms.gov/Center/Provider-Type/Home-Health-Agency-HHA-Center.html** on the CMS website.

Attached are a number of examples that illustrate some of the key points of this article.

Seasonal Flu Vaccinations - Generally, Medicare Part B covers one flu vaccination and its administration per flu season for beneficiaries without co-pay or deductible. Now is the perfect time to vaccinate beneficiaries. Health care providers are encouraged to get a flu vaccine to help protect themselves from the flu and to keep from spreading it to their family, co-workers, and patients. Note: The flu vaccine is not a Part D-covered drug. For more information on coverage and billing of the influenza vaccine and its administration, please visit MLN Matters® Article #MM8890, "Influenza Vaccine Payment Allowances - Annual Update for 2014-2015 Season" and MLN Matters® Article #SE1431, "2014-2015 Influenza (Flu) Resources for Health Care Professionals."

While some providers may offer flu vaccines, those that don't can help their patients locate flu vaccines within their local community. The HealthMap Vaccine Finder is a free online service where users can search for locations offering flu and other adult vaccines. If you provide vaccination services and would like to be included in the HealthMap Vaccine Finder database, register for an account to submit your information in the database. Also, visit the CDC Influenza (Flu) web page for the latest information on flu including the CDC 2014-2015 recommendations for the prevention and control of influenza.

Example 1

AAA HOSPITAL DISCHARGE SUMMARY
-DEPARTMENT OF SURGERY-

Date of Encounter

DOE, JANE	00000123	02-13-2014	02-17-2014
Patient Name	Med Rec No.	Admit Date	Discharge Date

Physician: John A. Doe, M.D.
Dictated By: John A. Doe, M.D.

Allowed Provider Type

ADMISSION DIAGNOSIS:
Right knee osteoarthritis.

DISCHARGE DIAGNOSIS:
Right knee osteoarthritis.

CONSULTATIONS:
1. Physical Therapy
2. Occupational Therapy

PROCEDURES:
02/14/2014: Total Right knee arthroplasty.

HISTORY OF PRESENT ILLNESS:
Mrs. Doe is a pleasant 60-year old female who has had a longstanding history of right knee arthritis. She has complained of right sided knee pain since January 2013. Since then, her ambulation has been limited by pain and she has pain at night that interrupts sleep. Pain medication, ibuprofen and hydrocodone, have been unsuccessful in relieving her pain for the last 6 months. Workup did show reduction in the right knee joint space. She initially failed conservation treatment and has elected to proceed with surgical treatment.

PAST MEDICAL HISTORY:
Hypertension, Gout.

PAST SURGICAL HISTORY:
Hysterectomy.

Meets the requirements for documenting: (1) the need for skilled services; (2) the patient was/is confined to the home (homebound); and (3) that the encounter was related to the primary reason the patient requires home health services.

DISCHARGE MEDICATIONS:
Colace 100 mg daily, Percocet 5/325 every 4 hours as needed for pain, Lisinopril 10 mg daily, Coumadin 4 mg daily; blood draw for INR ordered for 2/20/2014.

DISCHARGE CONDITION:
Upon discharge Mrs. Doe is stable status post right total knee replacement and has made good progress with her therapies and rehabilitation. Mrs. Doe is to be discharged to home with home health services, physical therapy and nursing visits, ordered. The patient is temporarily homebound secondary to status post total knee replacement and currently walker dependent with painful ambulation. PT is needed to restore the ability to walk without support. Short-term skilled nursing is needed to monitor for signs of decomposition or adverse events from the new Coumadin medical regimen.

PATIENT INSTRUCTION:
The patient is discharged to home in the care of her son. Diet is regular. Activity, weight bear as tolerated right lower extremity. The patient prescribed Coumadin 4 mg a day as the INR was 1.9 on discharge with twice weekly lab checks. Resume home medications. Call the office or return to the emergency room for any concerns including increased redness, swelling, drainage, fever, or any concerns regarding operation or site of incision. The patient is to follow up with Dr. Doe in two weeks.

Transcribed by: A.M 02/17/2014
Electronically signed by: John A. Doe, M.D. 02/17/2014 17:52

Example 2

Progress Notes

Patient: Smith, Jane
DOB: 04/13/1941
Address: 1714 Main Street, Plano TX 15432

Provider: John Doe, M.D.
Date: 05/03/2013

Allowed Provider Type

Date of Encounter

Subjective:
CC:

1. Wound on left heel.

HPI:

Pt is here for evaluation of wound on left heel. Patient reports her daughter noticed the wound on patient's heel when she was washing her feet. Patient states she has difficulty with reaching her feet and her daughter will sometimes clean them for her. She reports she uses a shoe horn to put on her shoes.

ROS:

General:
No weight change, no fever, no weakness, no fatigue.
Cardiology:
No chest pain, no palpitations, no dizziness, no shortness of breath.
Skin:
Wound on left lower heel, no pain.

Medical History: HTN, hyperlipidemia, hypothryroidism, DJD.

Medications: zolpidem 10 mg tablet 1 tab(s) once a day (at bedtime), Diovan HCl 12.5 mg-320 mg tablet 1 tab(s) once a day, Lipitor 10 mg tablet 1 tab(s) once a day.

Allergies: NKDA

Objective:
Vitals: Temp 96.8, BP 156/86, HR 81, RR 19, Wt 225, Ht 5'4"
Examination: General appearance pleasant. HEENT normal. Heart rate regular rate and rhythm, lungs clear, BS present, pulses 2+ bilaterally radial and pedal. Diminished pinprick sensation on bilateral lower extremities from toes to knees. Left heel wound measures 3 cm by 2 cm and 0.4 cm deep. Wound bed is red, without slough. Minimal amount of yellow drainage noted on removed bandage.

Assessment:
1. Open wound left heel

Plan:
1. **OPEN WOUND** Begin hydrocolloid with silver dressing changes. Minimal weight bear on left leg with a surgical boot on left foot. Begin home health for wound care, family teaching on wound care, and patient education on signs and symptoms of infection. The patient is now homebound due to minimal weight bearing on left foot and restrictions on walking to promote wound healing, she is currently using a wheelchair. Short-term nursing is needed for wound care, monitor for signs of infection, and education on wound care for family to perform dressing changes.

Follow Up: Return office visit in 2 weeks.

Provider: John Doe, M.D.
Patient: Smith, Jane **DOB**: 04/13/1941 **Date**: 05/03/2013
Electronically signed by John Doe, M.D. on 05/03/2013 at 10:15 AM
Sign off status: Completed

Meets the requirements for documenting: (1) the need for skilled services; (2) why the patient was/is confined to the home (homebound); and (3) that the encounter was related to the primary reason the patient requires home health services.

Example 3 – Part 1 of 2

Progress Notes

Patient: Rogers, Buck
DOB: 08/13/1925
Address: 234 Happy Lane, Teamwork, MD 12345

Provider: Jane Doe, M.D.
Date: 09/01/2014

Allowed provider type

Date of Encounter

Subjective:

CC:

Weakness

HPI:

Pt was hospitalized 2 weeks ago for pneumonia. He was treated with IV antibiotics for 5 days and discharged on oral antibiotics for 10 days. His caregiver is present with him for the visit. The patient reports that his appetite has been decreased since the hospitalization and he has noticed increasing weakness and difficulty walking. The patient has lost 2 lbs. since his last visit. He has stayed in bed for most of the time since his hospitalization. He used a wheelchair to move from the front of the office building to the exam room. The patient has not needed a wheel chair previously. The patient denies any fever, chills, cough, rhinorrhea, sore throat, ear pain, difficulty drinking liquids, nausea, vomiting or diarrhea.

ROS:

General:
2 lb weight change, positive for weakness, positive for fatigue.
Pulmonary: As per the HPI
Cardiology:
No chest pain, no palpitations, no dizziness, no shortness of breath.

Medical History: HTN; hyperlipidemia; Diabetes Mellitus

Medications: ASA 325 mg once a day, Diovan HCl 12.5 mg-320 mg tablet 1 tab(s) once a day, Lipitor 10 mg tablet 1 tab(s) once a day. Metformin 1000 mg once a day.

Allergies: NKDA

Objective:

Vitals: Temp 98.6, BP 120/80, HR 71, RR 12, Wt 200, Ht 5'9" pulse ox 99% on room air
Examination: The patient is awake and alert and in no acute distress. He is in a wheelchair. HEENT: Pupils do not react to light. Heart rate regular rate and rhythm, lungs clear, BS present, Extremities: pulses 2+ bilaterally radial and pedal. Diminished pinprick sensation on bilateral lower extremities from toes to knees ; Muscle Strength 3/5 in all 4 extremities(normal 5/5). The patient's get up and to test was 35 seconds(normal <10)

Assessment:

1. Muscle Weakness secondary to deconditioning due to pneumonia

Plan:

1. Prior to the patient's hospitalization for pneumonia, the patient could ambulate in his residence with assistance and was able to rise from a chair without difficulty. The patient requires a home health PT program for gait training and increasing muscle strength to restore the patient's ability to walk in his residence.

Follow Up: Return office visit in 6 weeks.

Provider: Jane Doe, M.D.
Electronically signed by Jane Doe, M.D. on 09/02/2014 at 10:15 AM
Sign off status: Completed

Meets the requirements for documenting: (1) the need for skilled services; and (2) that the encounter was related to the primary reason the patient requires home health services.

Please see problem list (Part 2 of 2) for homebound status.

Example 3 – Part 2 of 2

Problem List*

Patient: Rogers, Buck
DOB: 08/13/1925
Address: 234 Happy Lane, Teamwork, MD 12345

401.1 HTN - 1999
272.2 Hyperlipidemia -1999
250.5 Diabetes Mellitus with ophthalmic manifestations -2000
369.22 Blindness - 2002 (requires a caregiver assistance in order to leave the home)

482.31 Pneumonia- Streptococcus- 2014

<u>In conjunction with the progress note</u>, this meets the requirements for documenting why the patient was/is confined to the home (homebound).

***A problem list would not be acceptable by itself to demonstrate skilled need and/or homebound status.**

Date of Encounter

AAA HOSPITAL DISCHARGE SUMMARY
-DEPARTMENT OF SURGERY-

Smith, John	00000124	04-14-2014	04-18-2014
Patient Name	Med Rec No.	Admit Date	Discharge Date

Physician: Sam Bone, M.D.
Dictated By: Sam Bone, M.D.

Allowed Provider Type

ADMISSION DIAGNOSIS:
Left knee osteoarthritis.

DISCHARGE DIAGNOSIS:
Left knee osteoarthritis.

CONSULTATIONS:
1. Physical Therapy
2. Occupational Therapy

PROCEDURES:
04/14/2014: Left knee arthroplasty.

HISTORY OF PRESENT ILLNESS:
Mr. Smith is 70 y.o. male who presents with left knee osteoarthritis for 10 years. Over the past three years the pain has steadily increased. It was initially controlled by ibuprofen and steroid injections. In the last year he has required ibuprofen and Percocet to ambulate and this treatment has been unsuccessful in relieving pain for the last 6 months. His ambulation has been limited by pain and he has pain at night that interrupts sleep. Workup did show reduction in the left knee joint space. He has failed conservative treatment and has elected to proceed with surgical treatment.

PAST MEDICAL HISTORY:
Hypertension

PAST SURGICAL HISTORY:
Inguinal hernia repair

Meets the requirements for documenting: (1) the need for skilled services; and (2) that the encounter was related to the primary reason the patient requires home health services.

Please see OASIS (Part 2 of 2) for homebound status.

DISCHARGE MEDICATIONS:
Colace 100 mg daily, Percocet 5/325 every 4 hours as needed for pain, Lisinopril 10 mg daily, Lovenox 30mg sq every 12hours for 6 more days.

DISCHARGE CONDITION:
Upon discharge Mr. Smith is stable status post left total knee replacement and has made good progress with his therapies and rehabilitation. Mr. Smith is to be discharged to home with home health services, physical therapy and nursing visits, ordered. PT is needed to restore the ability to walk without support. Short-term skilled nursing is needed to monitor for signs of decomposition and teaching of Lovenox injections.

PATIENT INSTRUCTION:
The patient is discharged to home in the care of his wife. Diet is regular. Activity, weight bear as tolerated left lower extremity. Call the office or return to the emergency room for any concerns including increased redness, swelling, drainage, fever, or any concerns regarding operation or site of incision. The patient is to follow up with Dr. Bone in two weeks.

Transcribed by: A.M 04/18/2014
Electronically signed by: Sam Bone, M.D. 04/18/2014 18:31

Generic Home Health Agency
Excerpt from Comprehensive Assessment (OASIS-C)

Patient Name: John Smith
HH Record Number: 4433225

ADL/IADLs continued

(M1845) Toileting Hygiene: Current ability to maintain perineal hygiene safely, adjust clothes and/or incontinence pads before and after using toilet, commode, bedpan, urinal. If managing ostomy, includes cleaning area around stoma, but not managing equipment.

☐ 0 - Able to manage toileting hygiene and clothing management without assistance.

X 1 - Able to manage toileting hygiene and clothing management without assistance if supplies/implements are laid out for the patient.

☐ 2 - Someone must help the patient to maintain toileting hygiene and/or adjust clothing.

☐ 3 - Patient depends entirely upon another person to maintain toileting hygiene.

Comments: *Patient requires clothes to be laid out on bed. He is able to dress himself from a seated position at foot of bed.*

(M1850) Transferring: Current ability to move safely from bed to chair, or ability to turn and position self in bed if patient is bedfast.

☐ 0 - Able to independently transfer.

X 1 - Able to transfer with minimal human assistance or with use of an assistive device.

☐ 2 - Able to bear weight and pivot during the transfer process but unable to transfer self.

☐ 3 - Unable to transfer self and is unable to bear weight or pivot when transferred by another person.

☐ 4 - Bedfast, unable to transfer but is able to turn and position self in bed.

☐ 5 - Bedfast, unable to transfer and is unable to turn and position self.

Comments: *Patient requires one-arm assistance to transfer from bed to chair.*

(M1860) Ambulation/Locomotion: Current ability to walk safely, once in a standing position, or use a wheelchair, once in a seated position, on a variety of surfaces.

☐ 0 - Able to independently walk on even and uneven surfaces and negotiate stairs with or without railings (i.e., needs no human assistance or assistive device).

☐ 1 - With the use of a one-handed device (e.g. cane, single crutch, hemi-walker), able to independently walk on even and uneven surfaces and negotiate stairs with or without railings.

X 2 - Requires use of a two-handed device (e.g., walker or crutches) to walk alone on a level surface and/or requires human supervision or assistance to negotiate stairs or steps or uneven surfaces.

☐ 3 - Able to walk only with the supervision or assistance of another person at all times.

☐ 4 - Chairfast, unable to ambulate but is able to wheel self independently.

Example 4 – Part 2 of 2

☐ 5 - Chairfast, unable to ambulate and is unable to wheel self.

☐ 6 - Bedfast, unable to ambulate or be up in a chair.

Comments: *Pt. with a shuffling gait and frequently trips while ambulating. Pt. requires a wheeled walker and requires frequent cueing to remind him to not shuffle when he walks and to look up to avoid environmental hazards. Unable to go up and down stairs without his daughter assisting him. Daughter states that patient needs 24/7 supervision and is only able to leave his home for doctor appointments and only when she and her husband assist him. Patient is an increased fall risk because of inability to safely navigate stairs, uneven sidewalks and curbs.*

In conjunction with the discharge summary, this meets the requirements for documenting why the patient was/is confined to the home (homebound).

Sam Bone, M.D. 4/20/2014

Signed and dated by certifying physician indicating review and incorporation into the patient's medical record.