Certifying Home Health Care

2015

Today's Presenters

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Agenda

- Regulatory Changes 2015
  - CR 9119
  - CR 9189
- Eligibility
- Homebound Status
- Need for Skilled Services
- Plan of Care
- FTF Encounters
- Certification
- Recertification
- Collaboration
- References & Resources

2015 Change Request 9119 Regulatory Changes

- The Centers for Medicare & Medicaid Services (CMS) has eliminated the narrative requirement (regarding the patients' homebound status & need for skilled services).

- For medical review purposes, CMS requires documentation from the certifying physician's medical records *(referring physician)* and/or the acute/post-acute care facility's medical records (*community physician*) if the patient was directly admitted to home health, to be used as the basis for certification of patient eligibility.

2015 Change Request 9119 Regulatory Changes

- If a Home Health Agency (HHA) claim is denied, the corresponding physician claim for certifying/re-certifying patient eligibility for Medicare-covered home health services is considered non-covered as well because there is no longer a correspond ding claim for Medicare-covered home health services.
- CMS clarified that a face-to-face encounter (FTF) is required for certifications, rather than initial episodes; and that a certification (versus a recertification) is generally considered to be any time a new start of care assessment is completed to initiate care.

2015 Change Request 9189 Regulatory Changes

- Highlights the eligibility criteria that are to be identified at the time of certification.
- Details the information that is to be reviewed by the contractor to uphold patient eligibility & medical necessity.
- Outlines the certification and recertification documentation requirements.

Patient/Beneficiary Eligibility

Medicare Part A and/or Part B & §1814(a)(2)(C) and §1835(a)(2)(A) state that when the physician refers a patient to home health, the patient must:

1. Be confined to the home
2. Need skilled services
3. Be under the care of a physician
4. Receive services under POC established and reviewed by a physician
5. 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.

Documenting Eligibility

- **Documentation in the certifying referring *physician*'s medical records** and/or the acute /post-acute care facility's medical records (if the patient was directly admitted to home health) **will be used as the basis upon which patient eligibility for the Medicare home health benefit will be determined.**
  - **Documentation from the certifying referring *physician*'s medical records** and/or the acute /post-acute care facility's medical records (if the patient was directly admitted to home health) **used to support the certification of home health eligibility** must be provided, upon request, to the home health agency, review entities, and/or the Centers for Medicare and Medicaid Services (CMS).

Documenting Eligibility

The referring physician must identify (in writing) the name of the community physician who will be monitoring the patients home health services.

Documenting Eligibility

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

Documenting Eligibility

- It is the sole responsibility of the certifying referring & 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.

Documenting Eligibility

- A Home Health Agency must be able to provide, upon request, the supporting documentation that substantiates the eligibility for the Medicare home health benefit to review entities and/or CMS.
  - 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.

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.

Homebound Status

Documenting 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.

Homebound Status

If the patient does in fact leave the home, the patient may nevertheless be considered homebound if the absences from the home are infrequent or for periods of relatively short duration, or are attributable to the need to receive health care treatment.

- For medical appointments/treatments
- For religious services
- To attend adult daycare centers for medical care
- For other unique or infrequent events

  funeral, graduation, hair care

Need for Skilled Services

Documenting the need for any/all skilled services requested (including NSG, PT/OT/SLP, SW):

- 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

Plan of Care

It is expected that in most instances, the physician who certifies the patient's eligibility for Medicare home health services will be the same physician who establishes and signs the POC

Plan of Care

If the patient is starting home health services directly after discharge from an acute/post-acute care setting where the referring physician, with privileges, that cared for the patient in that setting is certifying the patient's eligibility for the home health benefit, **but will not be following the patient after discharge**, then the certifying referring physician **must identify the community physician who will be following the patient after discharge.**

Reminder: One of the eligibility criteria that must be met for a patient to be considered eligible for the home health benefit is that the patient must be under the care of a physician. Otherwise, the certification is not valid.

Plan of Care

As per CR 9189:

The referring/certifying physician's initial order for home health services initiates the establishment of a plan of care (for example: discharge plan) as part of the certification of patient eligibility.

The physician's initial order must specify the medical treatments to be furnished and does not eliminate the need for the plan of care.

Plan of Care

- 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.

Plan of Care

There are no mandatory forms for the POC.

The CMS Form 485 is no longer endorsed by CMS, as the certification statement does not encompass that a face-to-face encounter occurred.

IMPROPER CERTIFICATION STATEMENT on CMS Form 485:

I certify/recertify that this patient is confined to his/her home and needs intermittent skilled nursing care, physical therapy and/or speech therapy or continues to need occupational therapy. The patient is under my care, and I have authorized the services on this plan of care and will periodically review the plan.

Plan of Care

- FTF encounter and POC can be certified in one certification statement on a DC Summary
- 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 resident or NPP provides the FTF encounter, a certifying physician must review & countersign the document. Allowed NPPs include: PA, CNS, NP, and CNM

FTF Encounters

- FTF encounter is part of the certification of patient eligibility.
- A FTF encounter with the patient must be performed by the certifying physician (*the referring physician*) himself or herself, a physician that cared for the patient in the acute or post-acute care facility (with privileges who cared for the patient in an acute or post- acute care facility from which the patient was directly admitted to home health) or an allowed non-physician practitioner (NPP).
- Currently, there are no mandatory forms for the FTF encounter.

FTF Encounters

- There must be a documented FTF encounter in the patient's medical records which collaborates with all of the other medical entities (Referring Physician, HHA & Community Physician) involved in the HH services.

FTF Encounter 2015 Changes

2014

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

2015

- FTF Encounter
  - Narrative required when:
    - Skilled oversight of unskilled care is ordered

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 FTF encounter, and
  - All other certification requirements must have been met

FTF Encounters Documentation Requirements

FTF should contain:

- Patient's full name
- Date of the actual FTF encounter
- Narrative information required only when skilled oversight of unskilled care is ordered by the physician

The certification statement may be on this FTF document, it may be on the POC, or it may be a separate document, such as a discharge summary.

FTF Encounters Reminders

- FTF encounter is component of the certification.
- Along with the other eligibility criteria, the physician certifies that the patient was seen and had a FTF encounter for the current diagnosis.
- Skilled oversight narrative must be above the certification statement.
- Electronic signatures are acceptable.

Certification

The physician certifies/recertifies that the patient has met all 5 of the eligibility criteria when referring to Home Health:

1. Confined to his/her home
2. Requires intermittent skilled services
   - *Where a patient's sole skilled service need is for skilled oversight of unskilled services (management and evaluation of the care plan as defined in §40.1.2.2), the physician must include a brief narrative describing the clinical justification of this need as part of the certification, or as a signed addendum to the certification*
3. A POC has been established and is periodically reviewed by a physician;
4. Services that are furnished under the care of a physician
5. The individual had a FTF encounter

Certification

Per CR 9189:

- The certifying physician must also document the date of the face-to-face encounter as part of the certification.
- **There is no specific form or format for the certification, as long as the five certification requirements are met.**

CR 9189 Certification

Home health agencies should obtain as much documentation from the certifying physicians medical records and/or the acute/post-acute care facility's medical records as they deem necessary to assure that the patient eligibility criteria have been met and must be able to provide it to CMS and its review entities upon request.

Certification

- **Certification of the FTF and POC is a requirement for eligibility of services ordered and delivered via HH; Therefore,**
  - The **referring physician must identify the physician in the community that will be monitoring the patients home care.
  - Payment cannot be made for covered home health services that a HHA provides without physician **certification that is obtained at the time the plan of care is established** or as soon thereafter as possible.

Certification

- A certification (versus recertification) is considered to be anytime that a Start of Care (SOC) OASIS is completed.
- Certification must be complete prior to when the HHA bills.
- Rubber Stamp signatures are not acceptable.
- Certification by the physician must be retained by the HHA.

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

Pre Conference Question: *Can you give an example of a certifying statement that we can add to our Plan of Care (POC) orders that complies with the 2015 changes?*

Sample Documentation Process from Physician Office

- PCP or Specialist sees the patient **in their office/clinic**
- Completes an order/referral and certifies an initial POC & FTF encounter
- Forwards the order/referral, certified initial POC & FTF documentation immediately to the HHA
- HH Agency carries out SOC & assists in further development of the POC
- The physician monitors the patient's care, updates & recertifies the POC in collaboration with the HHA as required
- The physician and HHA maintain up-to-date home care documentation in the patients medical records

Sample Documentation Process from Acute or Post Acute Facility

- Physician or NPP discharges the patient from their acute or post acute facility **(Hospital/SNF/Inpatient Rehabilitation Center/Surgery Center**), identifying in the documentation the physician who will be monitoring the patients care in the community
- Completes an order/referral and certifies a discharge plan & FTF encounter
- Forwards order/referral, certified POC & FTF documentation immediately to HHA & office of physician in the community that agreed to follow the home care services
- HHA carries out SOC & assists in further development of the POC with the community physician
- Community physician monitors patient's care and updates & recertifies the POC in collaboration with the HHA as required
- Community physician & HHA maintain up-to-date home care documentation in the patient's office medical record

Recertification

Per CR 9189 - For all medical necessity reviews, the Medicare review contractors shall:

- Determine whether the supporting documentation addresses each of the 5 certification criteria.
- Review the certification documentation for any episode initiated with the completion of a start of care OASIS assessment. This means that **if the subject claim is for a subsequent episode of care, the home health agency must submit all certification documentation as well as recertification documentation.**

CR 9189: Recertification of Skilled Oversight

If a patient's underlying condition or complication requires a registered nurse to ensure that essential non-skilled care is achieving its purpose, and necessitates a registered nurse be involved in the development, management, and evaluation of a patient's care plan, a physician must document 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.

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 obtained at the time the plan of care is reviewed since the same interval (at least once every 60 days) is required for the review of the plan.
- **Include an estimate of how much longer the skilled services will be required****
- Be signed & dated by the physician who reviews the plan of care.

***Pre Conference Question**: Can the HHA get the estimate length of services for the recert from an NP if we send the verbal order out and have signed by the covering MD?*

Recertification

- The form of the recertification and the manner of obtaining timely recertification's are up to the individual agency.

Pre Conference Question: *During the recert visit the assessment is done and the information is called to the Physician for discussion and verification to continue another cert period. We document "Estimate length of stay" in a clinical note; however do not send out an interim order for signature. The date that this was discussed with the physician is put on the plan of care orders/485 as the verbal order, which the Physician signs. Will this suffice as the signed verbal order for the Estimate length of stay or do we also need to send an interim order to the Physician on the date we made the call?*

Recertification

Per CR 9189 - For all medical necessity reviews, the Medicare review contractors shall:

- Consider all documentation from the home health agency that has been signed off in a timely manner and incorporated into the physician/hospital record when making its coverage determination.
- Home health agency documentation that is used to support the certification must corroborate with the rest of the patients medical record and is considered to be incorporated timely when it is signed off **prior to or at the time of** the certification.

Therapy

- For multi-discipline therapy cases, a qualified therapist from each of the disciplines must functionally reassess the patient. The therapist must document the measurement results which correspond to the therapist's discipline and care plan goals in the clinical record.
- CMS has eliminated the 13th and 19th visit therapy reassessment requirements.
- For episodes beginning on or after January 1, 2015; at least every 30 calendar days a qualified therapist (instead of an assistant) must provide the needed therapy service and functionally reassess the patient.

Therapy

Per CR 9189:

- The need for occupational therapy may be the basis for continuing services that were initiated because the individual needed skilled nursing care or physical therapy or speech therapy.
- Documentation must substantiate the need for continued occupational therapy when the needed skilled nursing care or physical therapy or speech therapy that were initially needed, are no longer need.

Collaboration of Supporting Documentation

- Certifying (Referring) physicians and acute/post-acute care facilities **must provide the medical record documentation** that justifies the referral and 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.

Collaboration of 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.

Collaboration of 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.

Collaboration of Supporting Documentation

As per CR 9189:

- The HHA's generated medical record documentation for the patient, by itself, is not sufficient in demonstrating the patient's eligibility for Medicare home health services.
- It is the patient's medical record held by the certifying physician and/or the acute/post-acute care facility that must support the patient's eligibility for home health services.

Questions

Please type in any questions you may have to the question box at this time and they will be addressed momentarily…

References & Resources

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

Change Request 9119

"Manual Updates to Clarify Requirements for Physician Certification and Recertification of Patient Eligibility for Home Health Services"

http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9119.pdf

***In accordance with its references to the Pub Manual 100-01 and 100-02*

Change Request 9189

The purpose of this Change Request (CR) is to manualize policies in the calendar year 2015 Home Health Prospective Payment System Final Rule published on November 6, 2014, in which the CMS finalized clarifications and revisions to policies regarding physician certification and recertification of patient eligibility for Medicare home health services.

https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R602PI.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

CMS References & Resources

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

Upcoming Educational Events

Date	Event
June through December Bi-Monthly	Certifying HH 2015 Webinars (HHA's)
June through December Bi-Monthly	Ordering HH Services for a Medicare Beneficiary/Patient 2015 (Referring Physicians)
September/October	J6 - Fall Road Show Manhattan October 7th

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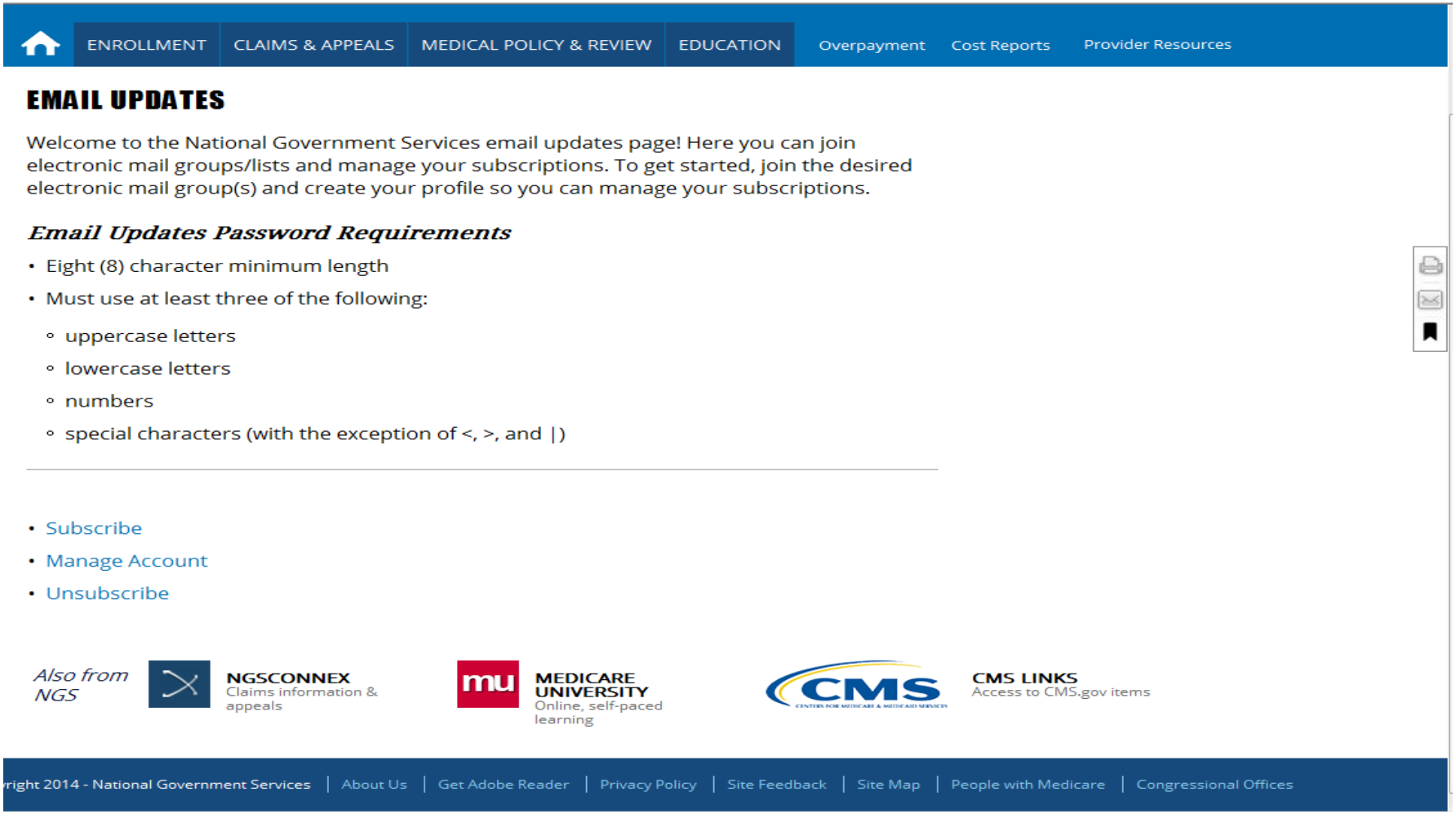

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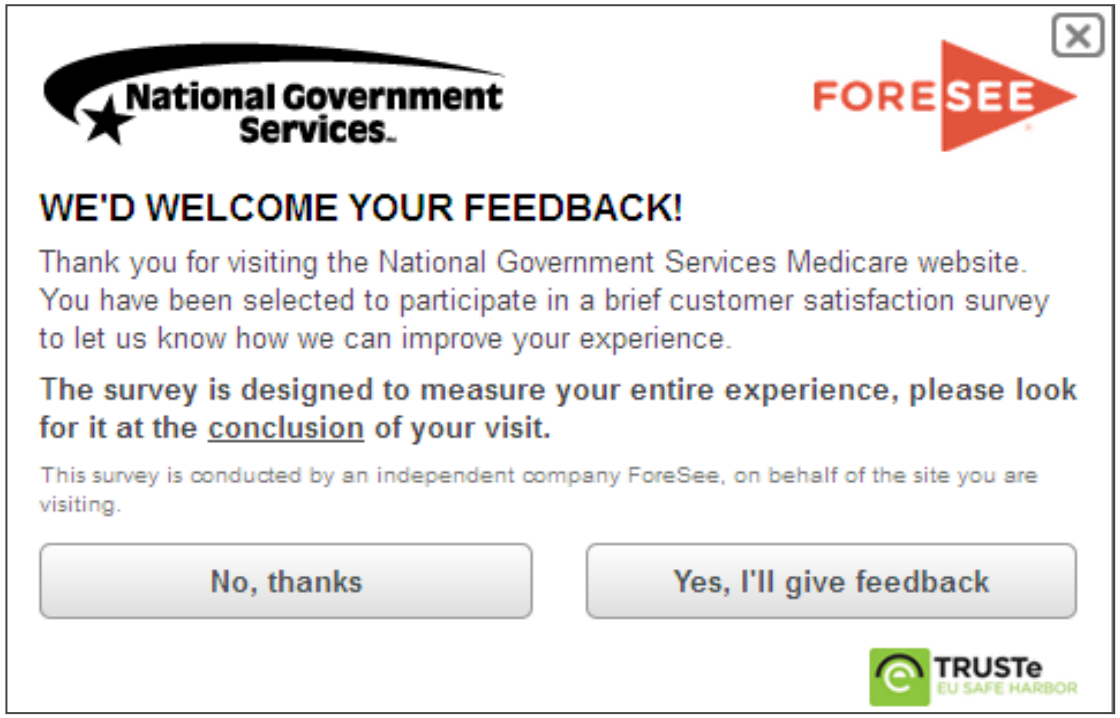

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