Referring a Medicare Beneficiary to Home Health Services

New Hampshire State Home Health & Hospital Association Collaboration Session – April 21, 2016

Today's Presenters

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Acronyms

- Acronyms used in this presentation can be viewed on the **NGSMedicare.com** website. On the **Welcome** page, click on **Provider Resources > Acronyms**.

Objective

- Upon completion of this session, attendees will have a greater understanding of the most up-to-date Centers for Medicare & Medicaid Services (CMS) regulations regarding:

I. Home Health Benefit & Eligibility Criteria

II. Documentation of Home Health Eligibility Criteria

III. Certification of Home Health Eligibility Criteria

IV. Appropriate Documentation Collaboration

Pre-Test/True or False

1. A home health plan of care, face-to-face encounter and certification must all be documented on one mandatory form?
2. Face-to-face encounter documentation is no longer required in 2015?
3. The physician referring the patient to home health services must identify the physician in the community who has agreed to monitor the patients home care in the community?
4. Three eligibility criteria must be certified when a Medicare beneficiary is referred to home health services?
5. The HHA's generated medical record documentation for the patient, by itself, is sufficient in demonstrating the patient's eligibility for Medicare home health services?
6. A patient that requires the assistance of another person or mechanical device to get into and out of their home is automatically considered homebound & eligible for home health services through their Medicare benefit?

Agenda

A. Medicare HH benefit
B. HH regulatory changes 2015
C. Documenting the five HH eligibility criteria
D. Certification & recertification of eligibility criteria
E. Documentation collaboration
F. CERT task force
G. References & resources

Medicare HH Benefit

- Services that the Medicare patient/beneficiary may receive at home include:
  - SN on an **intermittent**/part-time basis
  - HH aides on an **intermittent**/part-time basis
  - PT, OT, SLP, MSW
- These services have not changed for 2015

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)

2015 Change Request 9119 Regulatory Changes

- 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 and/or the acute/post-acute care facility's medical records (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 HHA claim is denied, corresponding physician claim for certifying/re-certifying patient eligibility for Medicare-covered HH services is considered non-covered as well because there is no longer a corresponding claim for Medicare-covered HH services
- CMS clarified that a FTF encounter 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 HH, 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 certifying referring physician's medical records and/or the acute /post-acute care facility's medical records (if patient was directly admitted to HH) will be used as basis upon which patient eligibility for Medicare HH benefit will be determined**
- **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. Such documentation can include:**
  - **Referral/Order for HH Services identifying the physician that will be monitoring the POC with the home health agency**
  - **Discharge Plan or Initial POC**
  - **FTF Encounter Documentation – Example: Discharge Summary or Interoffice Progress note documenting the 1:1 physician visit**
  - **Documentation (anywhere in the medical record) supporting the need for skilled service & homebound status**

Documenting Eligibility

- HHA documentation should also be shared, as it compliments & supports documentation in referring, certifying & community physicians records. The certifying physician must review and sign off on anything generated by the HHA and 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).

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

Documenting Eligibility

- HHA must be able to provide, upon request, supporting documentation that substantiates eligibility for Medicare HH benefit to review entities and/or CMS
  - If documentation used as basis for certification of eligibility is not sufficient to demonstrate that patient is or was eligible to receive services under Medicare HH benefit, payment will not be rendered for HH services provided

Homebound Status

- An individual shall be considered "confined to the home" (homebound) if the criteria on next slide are met

Homebound Status

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

- Declaring any portion of the regulation as a blanket statement copied from the CMS manual is vague ("It's a taxing effort for the patient to leave home"). Documentation must:
  - 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 the distinct difference in the patients normal ability versus their normal inability
  - Describe exactly what effects are causing the considerable and taxing effort for this patients when leaving 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 SN, 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
  - The findings from the FTF encounter support the primary reason for home health services being provided.

Patient/Beneficiary Eligibility

- If the certifying physician is an acute/post-acute care physician and will not be following the patient while receiving home care, the medical record documentation **must identify the name of community physician who will be monitoring patient's HH services** and signing the plan of care.

Plan of Care

- The certifying physician must attest that a plan of care has been established and was or will be periodically reviewed by a physician
- As per CR 9189:
  - The referring/certifying physician's initial order for home health services **initiates the establishment of a POC** (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 POC**

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…
- The HHA staff will further develop and evolve the POC with the community physician

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

- CMS Form 485 is no longer an up-to-date or CMS endorsed document
- CERTIFICATION STATEMENT on CMS Form 485 does not encompass the F2F encounter:
  - *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*.
- Currently, there are no mandatory CMS forms for the POC

Plan of Care

- 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

FTF Encounters

- FTF encounter is part of the certification of patient eligibility
- A FTF encounter with the patient must be performed by the certifying referring physician himself or herself, a physician that cared for the patient in the acute or post-acute care facility or an allowed NPP
- Currently, there are no mandatory forms for the FTF encounter

FTF Encounter 2015 Changes

- 2014
  - **FTF Encounter Form**
    - Narrative mandatory regarding:
      - Need for skilled services, and
      - Homebound status
- 2015
  - **FTF Encounter**
    - Documentation from the patient's medical record providing proof that a visit occurred (example: discharge summary or office progress note)
    - Narrative required when:
      - Skilled oversight of unskilled care is ordered

Certifying Eligibility Criteria

The certifying physician must certify that:

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**
5. **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

- All 5 eligibility criteria will be verified via review of the referring/certifying physicians medical record
- **Reminder**: The F2F encounter is not captured in the certification statement on the CMS Form 485
- Electronic signatures are acceptable.
- When there is a narrative requirement regarding skilled oversight, it must be located above the certification statement.

Certification

- **Certification of all five eligibility criteria is a requirement for Home Health Services payment; therefore:**
  - Payment cannot be made for covered HH services that a HHA provides without physician certification that is obtained at time POC is established or as soon thereafter as possible
  - Certification (versus recertification) is considered to be anytime that a SOC OASIS is completed
  - Certification must be complete prior to when HHA bills. It is not acceptable for HHA to wait until end of 60 day episode to obtain certification/recertification
  - Rubber Stamp signatures are not acceptable
  - Electronic signatures are acceptable
  - When there is a narrative requirement regarding skilled oversight of unskilled care (Management & Evaluation nursing services), it must be located above the certification statement.
  - Certification by physician must be retained by HHA

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**

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 home health agency start of care assessment.
    - This means that if the subject claim is for a subsequent episode of home health service, the home health agency must submit all initial certification documentation as well as recertification documentation.

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** (certify the same eligibility criteria stated in the certification, with the exception of the FTF)
  - Be signed & dated by the physician who reviews the plan of care.

Recertification

- The form of the recertification and the manner of obtaining timely recertification's are up to the individual home health agency and the physician monitoring the patients care in the community.
- The Medicare Conditions of Participation (COPs), at 42 CFR 484.55(d)(1), require that the recertification assessment be done during the last 5 days of the previous episode (days 56-60).

Physician Billing for Certification and Recertification

- Physicians: HCPCS G0180 (Certification) & G0179 (Recertification) of "patient eligibility for Medicare-covered home health services under a home health plan of care (patient not present), including contacts with the HHA and review of reports of patient status required by physicians to affirm the initial implementation of the plan of care that meets patients' needs, per certification period"
  - If there are no covered services, these codes should not be billed or paid. As such, these claims will not be covered if the HHA claim itself was non-covered due to certification/recertification ineligibility or because there was insufficient documentation to support that the patient was eligible.

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 referring certifying physician and/or the acute/post-acute care facility that must support the patient's eligibility for home health services.**

Collaboration of Supporting Documentation

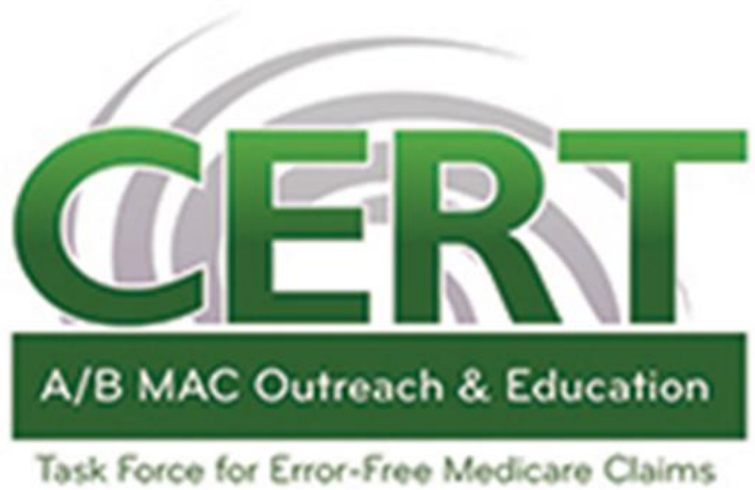
- Information from the HHA must be corroborated by other medical record entries and align with the time period in which services were rendered.
  - Information from the HHA can be incorporated into the certifying referring physician's and/or the community physician's medical record for the patient.
  - The certifying physician must review and sign any documentation incorporated into the patient's medical record that is used to support the certification.
  - If this documentation is to be used for verification of the eligibility criteria, **it must be dated prior to submission of the home health agency claim.**

- **Post-Test**

Pre-Test/True or False

1. A home health plan of care, face-to-face encounter and certification must all be documented on one mandatory form? **FALSE**
2. Face-to-face encounter documentation is no longer required in 2015? **FALSE**
3. The physician referring the patient to home health services must identify the physician in the community who has agreed to monitor the patients home care in the community? **TRUE**
4. Three eligibility criteria must be certified when a Medicare beneficiary is referred to home health services? **FALSE**
5. The HHA's generated medical record documentation for the patient, by itself, is sufficient in demonstrating the patient's eligibility for Medicare home health services? **FALSE**
6. A patient that requires the assistance of another person or mechanical device to get into and out of their home is automatically considered homebound & eligible for home health services through their Medicare benefit? **FALSE**

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.

Participating Contractors

- Cahaba Government Benefit Administrators, LLC/J10
- CGS Administrators, LLC/J15
- First Coast Service Options, Inc./JN
- National Government Services, Inc./J6 and JK
- Noridian Healthcare Solutions, LLC/JE and JF
- Novitas Solutions, Inc./JH and JL
- Palmetto GBA/J11
- Wisconsin Physicians Service Insurance Corporation/J5 and J8

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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

- CERT Task Force Web Page
  - Go to our website, http://www.NGSMedicare.com; in the **About Me** drop down box, select your provider type and applicable state, click on **Next**, **accept** the **Attestation**. Choose the **Medical Policy & Review** tab, then choose **CERT**, the **CERT Task Force** link is located to the right of the web page.
- Task Force Scenarios
  - Complying with medical record documentation requirements
  - Documenting therapy and rehabilitation services
  - Look for new articles added to this page and provided in your Email Updates

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

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

CMS Medicare Learning Network Article SE 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 Transmittal 92 & 208 in the CMS IOM Publications 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 IOM 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

NGS Educational Events

Upcoming Webinar Educational Events www.NGSMedicare.com

CLINICAL EDUCATION: **JK/J6 Ordering & Certifying Medicare Home Health Services**		
APRIL	**MAY**	**JUNE**
April 4, 2016 12pm Eastern	May 2, 2016 12pm Eastern	June 2, 2016 12pm Eastern
April 14, 2016 3pm Eastern	May 12, 2016 3pm Eastern	June 6, 2016 3pm Eastern
April 18, 2016 12pm Eastern	May 16, 2016 12pm Eastern	
April 28, 2016 3pm Eastern	May 26, 2016 3pm Eastern	

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CLINICAL EDUCATION: 30 Minute Lunch-Time (12 pm Eastern) Every Tuesday	
Home Health Qualifying Criteria	April 12, 2016 May 24, 2016
Home Health Face-to-Face Encounters & the Plan of Care	April 26, 2016 June 14, 2016
Home Health Homebound Status & the Need for Skilled Services	April 19, 2016 May 31, 2016
Home Health Certification & Recertification	May 3, 2016 June 21, 2016
Home Health Documentation & the Additional Development Request (ADR)	May 10, 2016 June 28, 2016

Computer Based Training Sessions www.Medicareuniversity.com

CLINICAL EDUCATION: **Home Health CBT's** **Medicare University**
Home Health Qualifying Criteria
Home Health Face-to-Face Encounters & the Plan of Care
Home Health Homebound Status & the Need for Skilled Services
Home Health Certification & Recertification
Home Health Documentation & the Additional Development Request (ADR)

Ask the Contractor Teleconferences JK/J6 2016 Home Health ACT's

- CMS Updates (CR's, MLM Articles, Regulatory changes)
- NGS Updates (Articles, Educational Sessions)
- Questions Answered Live
- Generate Dialogue with Home Health Peers

Jurisdiction K	Jurisdiction 6
July 7, 2016	July 26, 2016

Home Health Spring Conferences

Jurisdiction K	
May 10, 2016 Courtyard Marriott Hartford Cromwell	**May 12, 2016** Renaissance Providence Downtown

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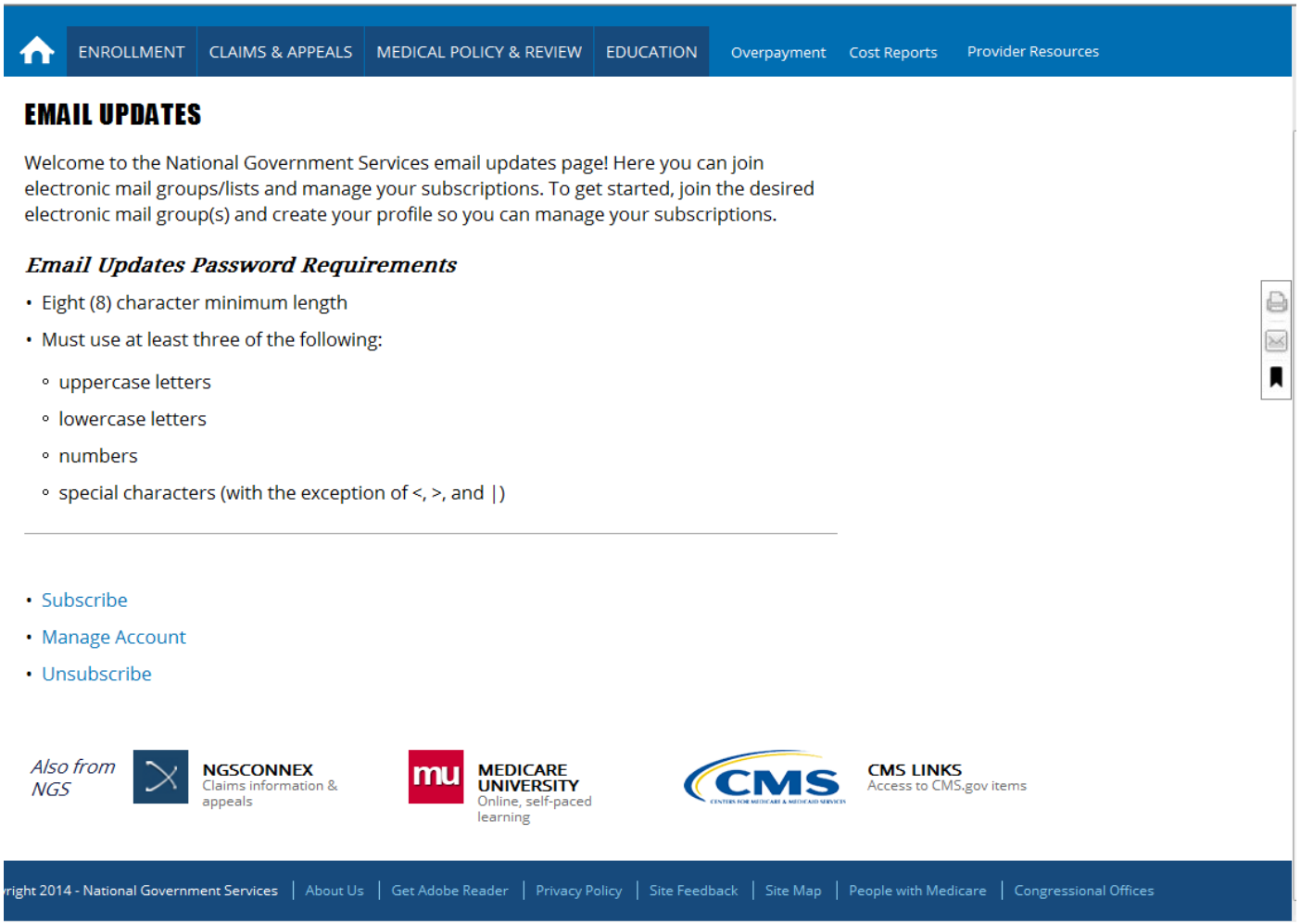

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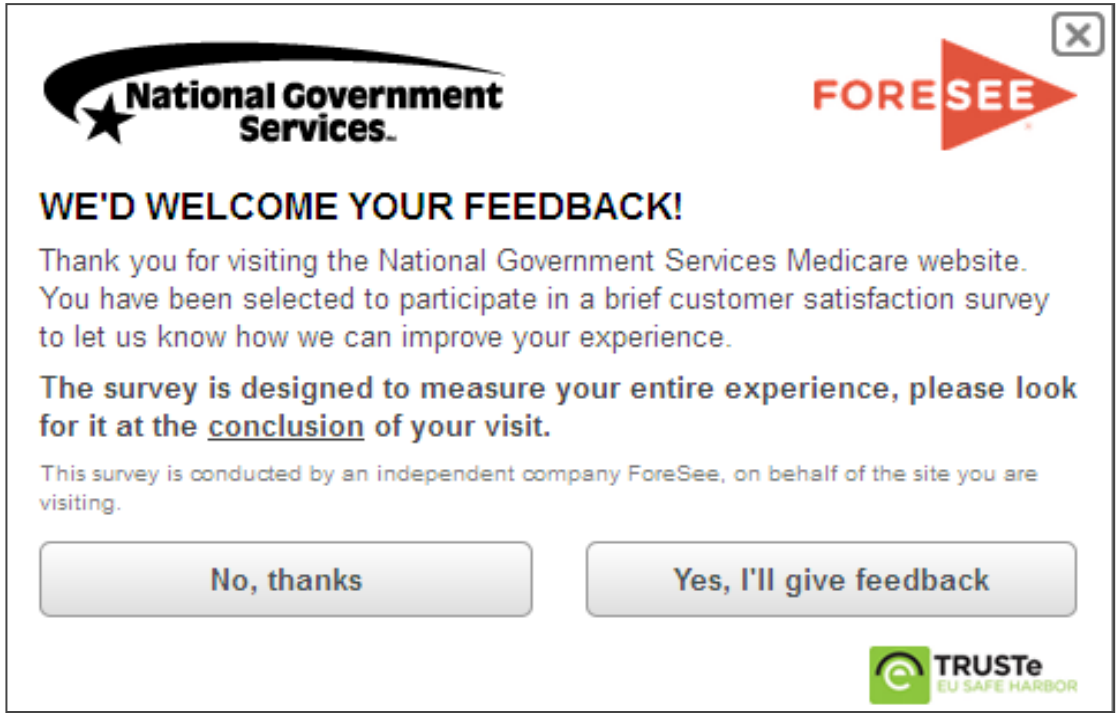

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  - Teleconferences, webinars, live seminars/face-to-face training
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Questions?

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