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Documenting Home Health Eligibility Criteria Series:
Certification & Recertification of Eligibility Criteria

3/30/2023

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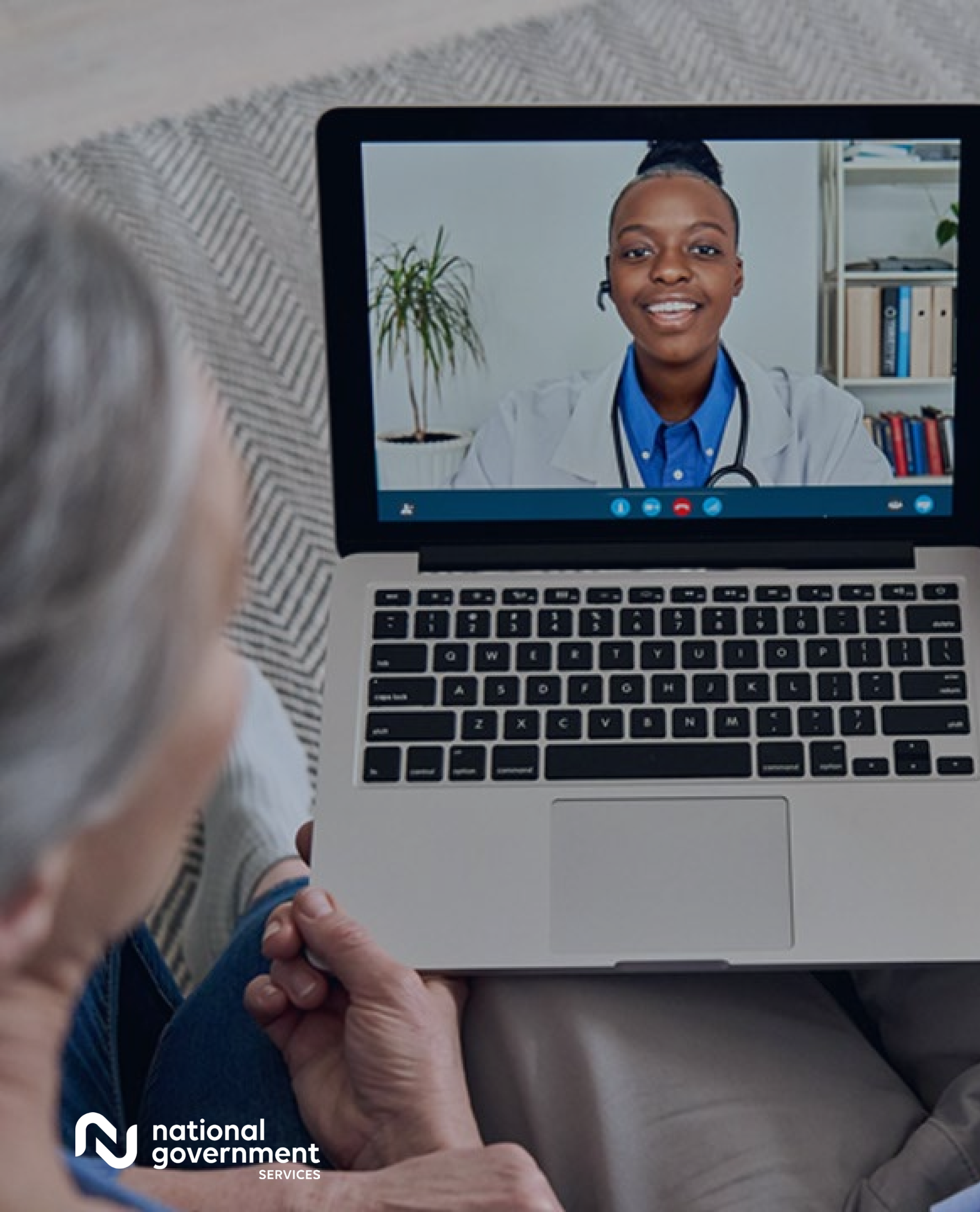

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Objective

Identify home health eligibility criteria certified and recertified by the physician or allowed practitioner for each episode of care received by the patient, explain how to support certification and recertification of eligibility criteria, and clarify the importance of documentation collaboration with all entities involved in patient care services.

Certification & Recertification

2023

AGENDA

NGS Home Health Jurisdictions

The Medicare Home Health Benefit & Eligibility Criteria

Certification & Recertification

References & Resources

Question & Answer Period

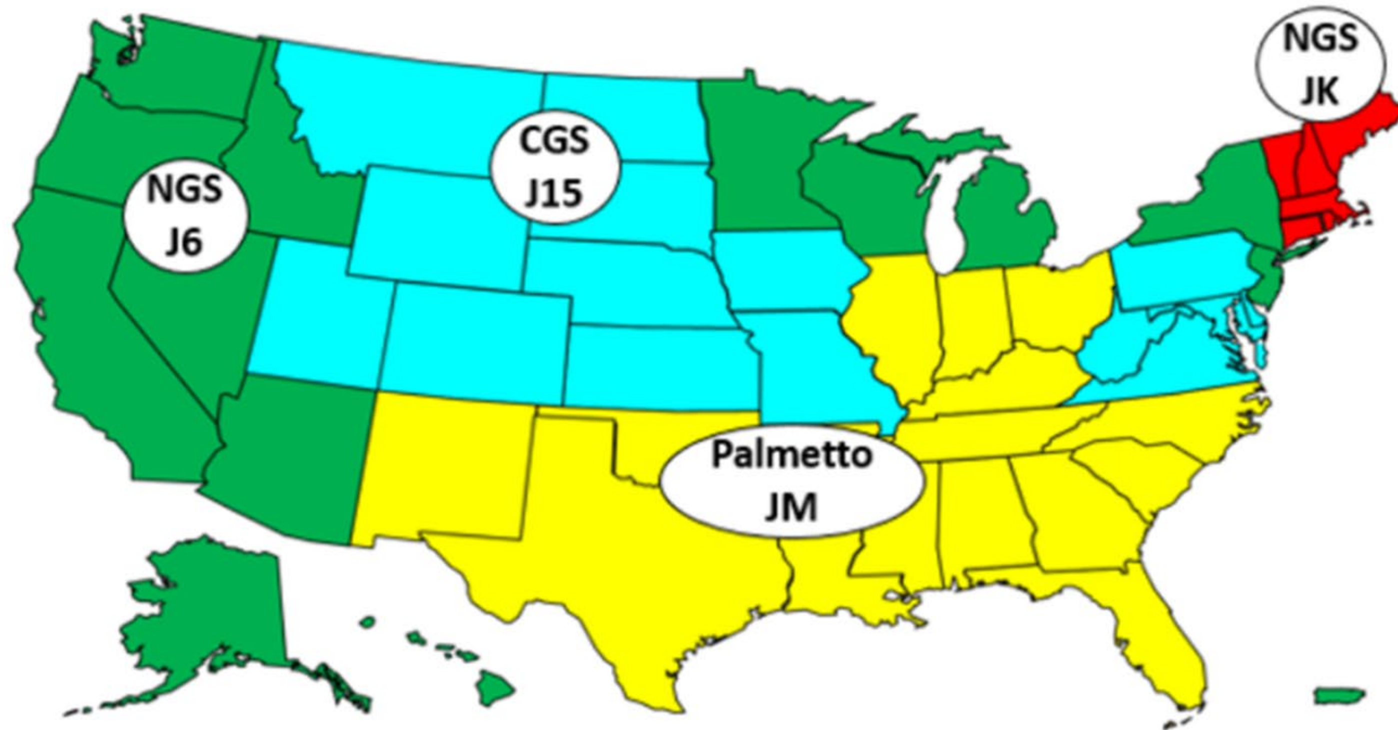
NGS Home Health Jurisdictions

NGS Home Health Jurisdictions

- National Government Services, Inc.

Jurisdiction K	Jurisdiction 6	
Maine New Hampshire Vermont Rhode Island Massachusetts Connecticut	New York New Jersey Michigan Wisconsin Minnesota Idaho Nevada Washington Oregon	California Arizona Alaska Hawaii Puerto Rico Mariana Islands American Samoa Virgin Islands Guam

NGS Home Health Jurisdictions



The Medicare Home Health Benefit & Eligibility Criteria

The Medicare Home Health Benefit

- Services that the Medicare beneficiary (patient) may receive at home include:
  - Skilled Nursing
  - Home Health Aides
  - Physical Therapy (PT)
  - Occupational Therapy (OT)
  - Speech Language Pathology (SLP)
  - Social Work (SW)

Home Health Eligibility Criteria

- Confined to the Home (Homebound)
- Have a Need for Skilled Services (in the Home)
- Remain Under the Care of a Physician and/or Allowed Practitioner (Oversight)
- Receive Services Following a Plan of Care
- Had a Face-to-Face Encounter

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
  - Have a condition such that leaving the home is medically contraindicated

Homebound Status

- Criteria Two (Both standards must be met):
  - There must exist a normal inability to leave home
  - Leaving home must require a considerable and taxing effort

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

The Need for Skilled Services

- Medical record documentation must **include** the reasons why the patient continues to require a skilled professional in their home.
- Home health agencies must continue to document the need for skilled services throughout the patient's medical record.

The Need for Skilled Services

- To be considered a **"skilled service,"** the service must be so inherently complex that it can only be safely and effectively performed by or under the supervision of a skilled professional.

Under the Care of a Physician or Allowed Practitioner

- The patient must be under the care of a physician or allowed practitioner who is qualified to sign the certification and plan of care
- The Plan of Care
  - A patient is expected to be under the care of the physician or allowed practitioner who signs the plan of care.
- Certification
  - It is expected that in most instances, the physician or allowed practitioner who certifies the patient’s eligibility for Medicare home health services, will be the same physician or allowed practitioner who establishes and signs the plan of care.

CMS IOM Publication 100-02, Medicare Benefit Policy Manual, Chapter 7, Section 30

Under the Care of a Physician or Allowed Practitioner

- One of the 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 or allowed practitioner;** otherwise, the certification of eligibility is not valid.

The Plan of Care

- The plan of care must include the identification of the responsible discipline(s), the frequency and duration of all visits, as well as those items listed in the Conditions of Participation (COPs) that establish the need for such services.
- All care provided to the patient by the home health agency must be in accordance with the POC.

Conditions of Participation 42 CFR 484.60(a)

The Plan of Care

- There are no mandatory forms for the POC.
- The CMS Form 485 is commonly utilized as the POC.
- The CMS Form 485 has an area where the physician or allowed practitioner certifies **all five eligibility criteria** (slide 11) have been met, including the requirements of the POC

24. Physician's Name and Address	26. I certify 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. This patient is under my care, and I have authorized the services on this plan of care, and will periodically review the plan. I further certify this patient had a face-to-face encounter that was performed on xx/xx/xxxx by a physician or Medicare allowed non-physician practitioner that was related to the primary reason the patient requires home health services. All five eligibility criteria must be listed within the certification statement
27. Attending Physician's Signature and Date Signed	28. Anyone who misrepresents, falsifies, or conceals essential information required for payment of Federal funds may be subject to fine, imprisonment, or civil penalty under applicable Federal laws.

The Face-to-Face Encounter

- The face-to-face encounter is one of the five eligibility criteria (slide 11).
- The physician or allowed practitioner certifies that the five criteria have been met (including the face-to-face encounter) and the patient is able to utilize their home health benefit.
  - The patient is **not eligible** to receive home health services if the face-to-face encounter is not completed.

The Face-to-Face Encounter

- As part of the certification of patient eligibility for the Medicare home health benefit, a face-to-face encounter with the patient must be performed by:
  - The certifying physician or allowed practitioner
    - ✓ A physician or allowed practitioner that cared for the patient in an acute or post-acute care facility from which the patient was directly admitted to home health

CMS IOM Publication 100/02, *Medicare Benefit Policy Manual*, Chapter 7, Section 30.5.1.1

Home Health Eligibility Criteria

Does the patient meet **all five** eligibility criteria?

- **Is the patient homebound?**
  - ✓ *Are they able to leave the home to receive services?*
- **Do they have a need for the skilled/professional services in the home?**
  - ✓ *Is the patient able to receive the "skilled" services on an outpatient basis in an office or clinic?*
- **Is there a physician and/or allowed practitioner that has agreed to monitor home health services?**
  - ✓ *Is that name identified within the referral and/or medical record documentation?*
- **Is there a plan of care in place or started?**
  - ✓ *What is the intent of the referral for home health services?*
- **Did the patient have a face-to-face encounter for their current primary diagnosis?**
  - ✓ *Is there a copy of the medical record documentation identifying the encounter?*

Certification of Home Health Eligibility Criteria

Certification of Eligibility Criteria

- Is the patient eligible to utilize their home health benefit?
- Does the patient meet **each** of the eligibility criteria?
  - Is the patient confined to the home (homebound)?
  - Do they have a need for skilled services?
  - Is there a plan of care in place?
  - Is there a physician or allowed practitioner that has agreed to oversee the home health services?
  - Has the patient had a face-to-face encounter?
- Does the home health agency have documentation from the acute or post-acute care facility, and/or the referring physician or allowed practitioner office) supporting each of the eligibility criteria?

Certification of Eligibility Criteria

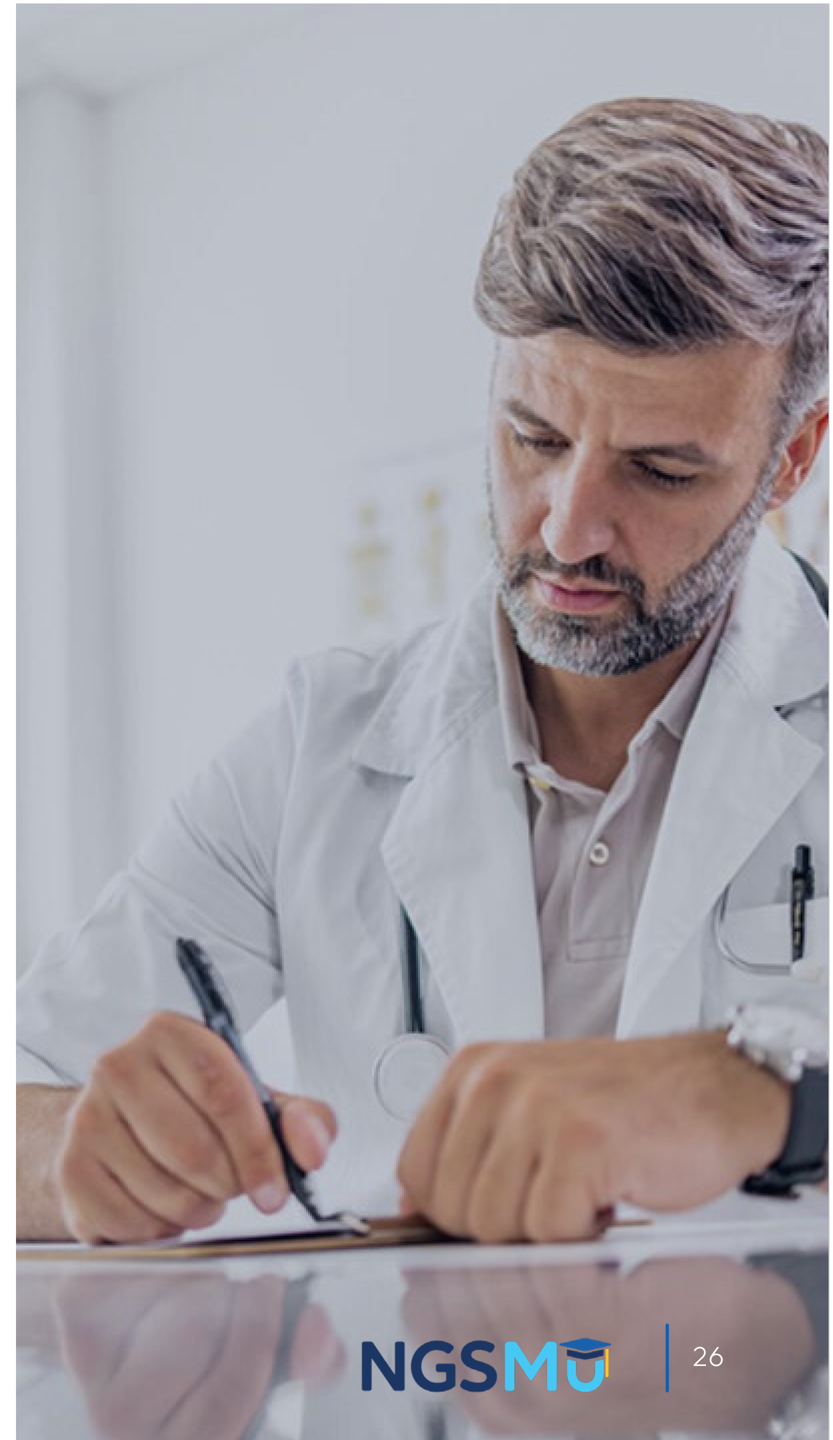
- When the physician or allowed practitioner signs the certification statement, they are attesting to the fact that all five eligibility criteria have been met:
  - Confined to the Home (Homebound)
  - Have a Need for Skilled Services (in the Home)
  - Remain Under the Care of a Physician and/or Allowed Practitioner (Oversight)
  - Receive Services Following a Plan of Care
  - Had a Face-to-Face Encounter

Certification of Eligibility Criteria

- The physician and/or allowed practitioner that performed the required face-to-face encounter must sign the certification of eligibility, **unless the patient is directly admitted to home health care from an acute or post-acute care facility** and the encounter was performed by a physician or allowed practitioner in such setting.
  - The certifying physician and/or allowed practitioner must be enrolled in the Medicare Program and be a Doctor of Medicine, Osteopathy, or Podiatry
  - The certifying allowed practitioner must be a Nurse Practitioner, clinical nurse specialist, or physician assistant who is working in accordance with state law
  - The certifying physician and/or allowed practitioner must be enrolled in PECOS.
  - The certifying physician and/or allowed practitioner cannot have a financial relationship with the home health agency as per 42 CFR

Certification of Eligibility Criteria

If the certifying physician or allowed practitioner is an acute/post-acute care provider and will not be following the patient while they are receiving home health services, the medical record documentation **must** identify the name of community physician who will be monitoring home health services within the medical record documentation (forwarded upon referral).



Certification of Eligibility Criteria

- Prior to Billing
  - Certification of eligibility criteria must be complete prior to when the home health agency bills Medicare.
- At the Time the Plan of Care is Established
  - Certification of eligibility should be completed when the plan of care is established, or as soon as possible thereafter
- Timeliness
  - It is not acceptable for the home health agency to wait until the end of a 60-day certification period to obtain a completed (signed and dated) certification or recertification of eligibility criteria.

Certification of Eligibility Criteria

- Certification Statement Example
  - The ordering/referring physician or allowed practitioner is certifying eligibility for home health services, **but is not monitoring** the patients home health care.
    - ✓ I certify 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**. I have authorized the services on the initial plan of care** which will be further developed by Dr. XXX **who has agreed to monitor home health services.** I further certify this patient had a face-to-face encounter that was performed on (include date) by (include name of physician or allowed practitioner that completed the face-to-face encounter) that was related to the primary reason the patient requires home health services.

Certification of Eligibility Criteria

- Certification Statement Example
  - The ordering physician or allowed practitioner is certifying eligibility and **will be monitoring** the patients home health care.
    - ✓ I certify 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. This patient is under my care. I have authorized the services on this plan of care and will continue to monitor home health services. I further certify this patient had a face-to-face encounter that was performed on (include date) by (include name of physician or allowed practitioner that completed the face-to-face encounter) that was related to the primary reason the patient requires home health services.

Recertification of Home Health Eligibility Criteria

Recertification of Eligibility Criteria

- Recertification is required at least every 60 days.
- Medicare does not limit the number of continuous episode re-certifications for patients.
- The patient must continue to meet all five eligibility criteria.
- The physician or allowed practitioner recertifying eligibility is the same provider that has been monitoring the plan of care and providing oversight of home health services.

Recertification of Eligibility Criteria

- Recertification Statement Example:
  - I recertify this patient continues to be confined to the home and has a continued need for skilled services. This patient remains under my care; I have authorized the services on the plan of care and will continue to monitor home health services. I also re-certify that this patient had a face-to-face encounter performed on (include date) by (include name of physician or allowed practitioner that completed the face-to-face encounter) that continues to be related to the primary reason the patient requires home health services.

Documentation Collaboration

Documentation Collaboration

- Documentation Collaboration
- Medicare reimbursement will not be rendered if pieces of the medical record documentation from the referring acute, post-acute care facilities, and certifying physician offices that supports eligibility criteria is not included within the medical record of the home health agency.
  - It is the responsibility of the home health agency to request documentation supporting eligibility criteria from all other entities providing care to the patient including the certifying/recertifying provider, acute/post-acute care facility, physician and/or allowed practitioner office, as well as the referring facility or provider office.

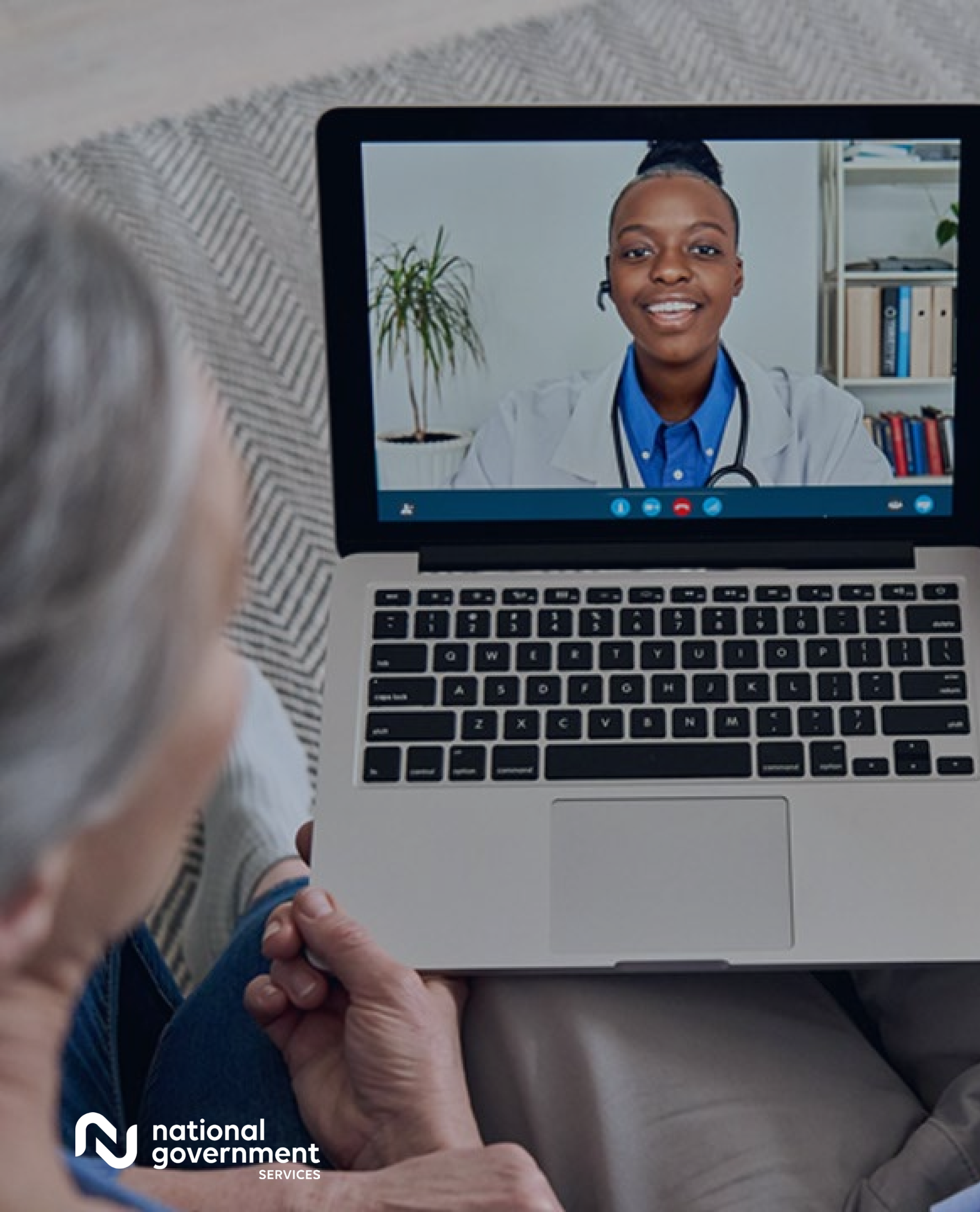
Documentation Collaboration

- Effective and efficient documentation collaboration between entities ensures:
  - The home health agency is able to obtain and provide medical record documentation **from all entities** that substantiates and supports all five eligibility criteria.
  - A smooth transition of healthcare services as well as an increased quality of care services for Medicare patients/beneficiaries.

Home Health References & Resources

CMS Home Health Resources

- CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 7
- CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 10
- CMS IOM Publication 100-08, *Medicare Program Integrity Manual*, Chapter 6
- Medicare & Medicaid Program: Conditions of Participation for Home Health Agencies
- HH PPS web page
- Home Health Agency (HHA) Center
- MLN® Publication, "*Home Health Prospective Payment System*"
- The Medicare Learning Network®

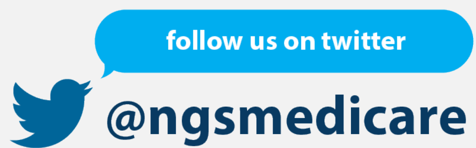


2023 HHH MAC Collaborative Summit

- Save the Date
- September 13, 14, 15
- Flamingo Las Vegas Hotel & Casino
  - 355 S. Las Vegas Boulevard
  - Las Vegas, NV 89109
- Early Bird Registration $249 (April 1 – June 1)
  - Includes 3 full days of education
- Rooms: $95/night
  - Group Name: 2023 HHH Medicare Summit
  - Processing fee incurred for telephone reservations

Questions?

Thank you! A follow-up email will be sent to attendees with the Medicare University Course Code.



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