Understanding the Medicare Home Health Benefit

1/7/2021

Today's Presenter

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Objective

- To offer federal Medicare regulatory direction to home health agencies/staff, as well as any/all provider types ordering/referring and monitoring home health services, in an effort to provide assistance in the comprehension of documentation requirements required to support home health eligibility criteria

Agenda

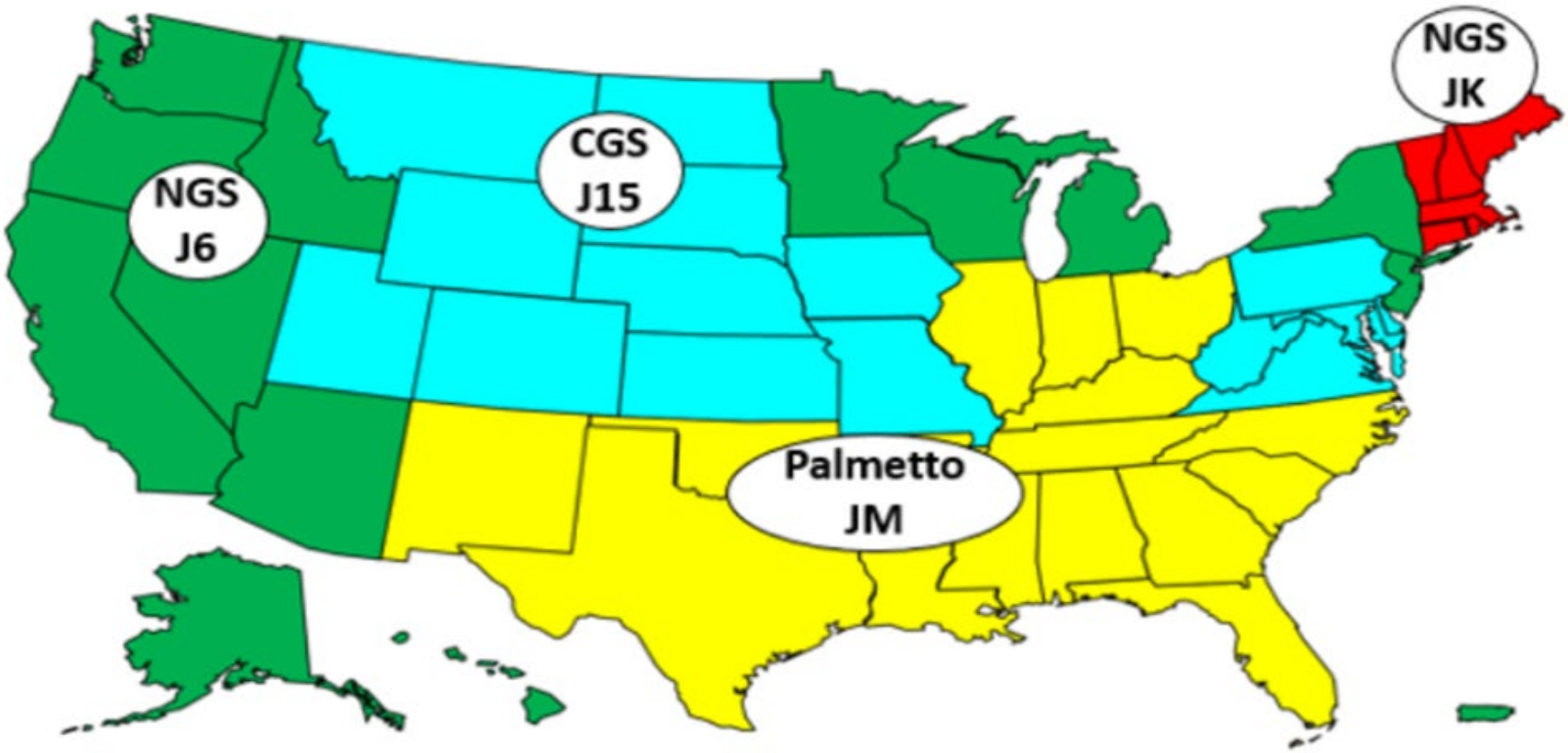
- Home Health & Hospice Medicare Jurisdictions
- Medicare Home Health Benefit
- Eligibility Requirements
  - Homebound Status
  - Need for Skilled Services
  - Under the Care of a Physician/NPP
  - Plan of Care
  - Face-to-Face (FTF) Encounter
- Certification
- Re-Certification
- Physician/NPP Billing for Certification and Recertification
- Documentation Collaboration
- References and Resources

Home Health & Hospice Medicare Jurisdictions

Home Health & Hospice Jurisdictions

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

Home Health & Hospice
Medicare Administrative Contractors (MACs)

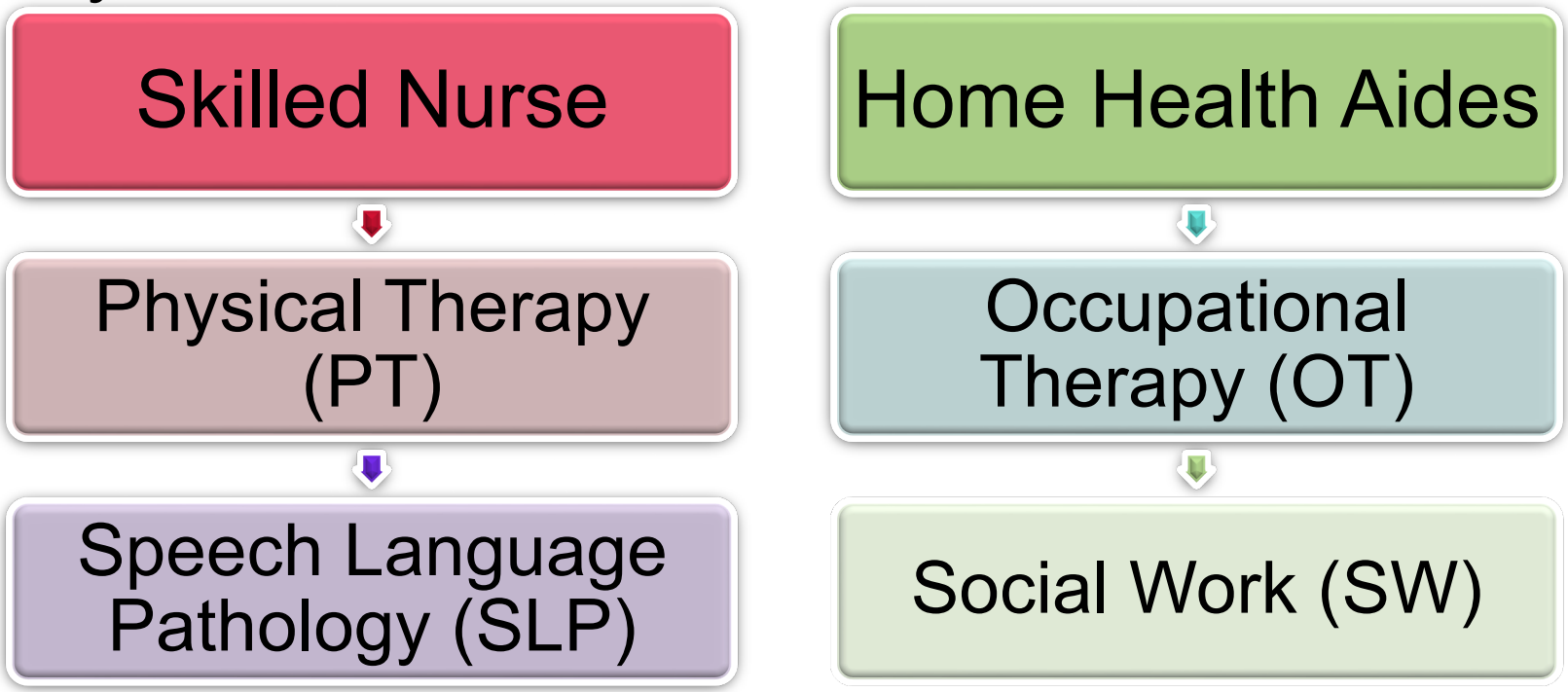


National Government Services

Medicare Home Health Benefit

The Medicare Home Health Benefit

- Services that the Medicare patient/beneficiary may receive at home include:



Eligibility Requirements

Eligibility Requirements

- When the physician or non-physician practitioner orders/refers a patient for home health services, the patient must meet all five of the following eligibility criteria:
  1. Be confined to the home (homebound status)
  2. Need skilled services
  3. Be under the care of a physician or NPP
  4. Receive services under POC established and reviewed by a physician or NPP
  5. Have had a face-to-face encounter for their current diagnosis with a physician/NPP

Eligibility Requirements: **Homebound Status**

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 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

Homebound Status

- **Criteria One**
  - Verify the **type of support and/or supportive device** or assistance required to assist the patient in leaving home

  or

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

Homebound Status

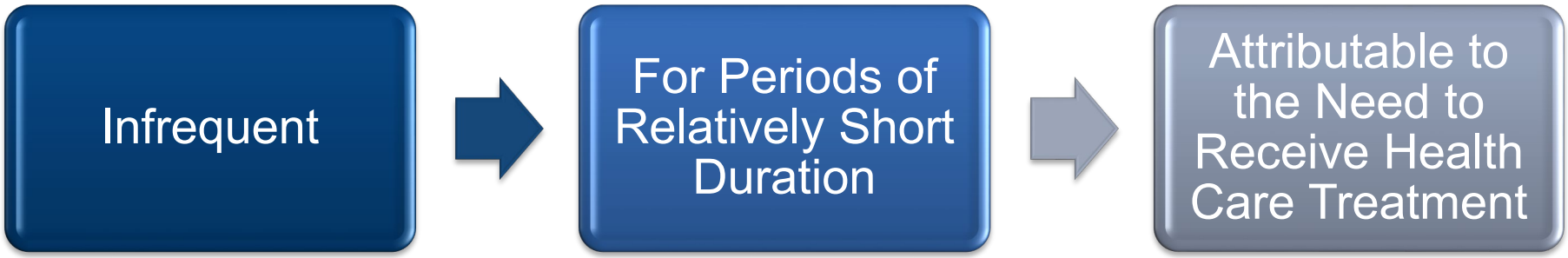
- **Criteria Two**
  - Clinical information about the patient's health status including their:
    - **Normal inability to leave the home**
    - **Leaving home requires a considerable and taxing effort**
      - Prior level of function
      - Current diagnosis
      - Duration of condition
      - Clinical course (worsening or improvement)
      - Prognosis
      - Nature and extent of functional limitations
      - Therapeutic interventions and results

Homebound Status

- Explain the patient's normal inability to leave home
- Define the taxing effort
- Ensure the information is patient specific
- For example:
  - Pain medications
  - Rest periods
  - Oxygen
  - Incontinence
  - Confusion
  - Safety concerns
  - Alternative accommodations

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:



  - 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

Homebound Status

- Documentation must:
  - **Include** information about the injury/illness and 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 patient's normal ability versus their normal inability
  - **Describe** exactly what effects are causing the considerable and taxing effort for this patient when leaving home

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.”
  - “The patient leaves home for periods of short duration.”
  - “The patient leaves home infrequently.”
  - “The patient leaves home for religious services.”
  - “The patient has a normal inability to leave their home.”

Eligibility Criteria:
Need for Skilled Services

Need for Skilled Services

- Documenting the need for any/all skilled services requested (including nursing/PT/OT/SLP/SW)
  - **Distinguish** exactly what services are going to be provided by the skilled professional in the patient's home
  - **Explain** why a "skilled professional" is required to provide the HH services requested
  - **Disclose** clinical information (beyond a list of recent diagnoses, injury or procedure) that is individual and specific to the patient
  - **Include** the findings from the face-to-face encounter to support the primary reason for the skilled services being provided

Need for Skilled Services

- **Skilled nursing services** are covered when an individualized assessment of the patient's clinical condition demonstrates that the specialized judgment, knowledge and skills of a registered nurse are necessary
- To be considered a skilled service, the service must be so inherently complex that it can be safely and effectively performed only by, or under the supervision of, professional or technical personnel

Eligibility Criteria:
Under the Care of a Physician/ Non-Physician Practitioner

Under the Care of a Physician/NPP

- The patient must be under the care of a physician/NPP who is qualified to sign the certification and plan of care
- It is expected that in most instances, the physician/NPP who certifies the patient's eligibility for Medicare home health services will be the same physician/NPP who establishes and signs the plan of care

Under the Care of a Physician/NPP

- Physician
  - A doctor of medicine, osteopathy, or podiatric medicine

- Non-Physician Practitioner (NPP)
  - Nurse Practitioner (NP)
  - Physician Assistant (PA)
  - Clinical Nurse Specialist (CNS)

Under the Care of a Physician/NPP

- **Plans of Care and Certifying/Recertifying Patient Eligibility**: In addition to a physician, section 3708 of the CARES Act allows a Medicare-eligible home health patient to be under the care of a nurse practitioner, clinical nurse specialist, or a physician assistant who is working in accordance with State law. These physicians/practitioners can:
  1. order home health services;
  2. establish and periodically review a plan of care for home health services (e.g., sign the plan of care),
  3. certify and re-certify that the patient is eligible for Medicare home health services
- This is a permanent change
- **These changes are effective for Medicare claims with a "claim through date" on or after 3/1/2020**
  - Home Health Agencies: CMS Flexibilities to Fight COVID-19

Under the Care of a Physician/NPP

- **Physician**
  - Ordering Home Health Services
  - Providing/Not-Providing Oversight of the Patient's Home Health Plan of Care & Services in the Home
  - Referring & then Identifying the Physician or NPP that has Agreed to Oversee the Home Health Services and Plan of Care
  - Ensuring Completion (or Completing) the Face-to-Face (FTF) Encounter
  - Certifying & Re-Certifying Eligibility
- **Non-Physician Practitioner**
  - Ordering Home Health Services
  - Providing/Not-Providing Oversight of the Patient's Home Health Plan of Care & Services in the Home
  - Referring & then Identifying the Physician or NPP that has Agreed to Oversee the Home Health Services and Plan of Care
  - Ensuring Completion (or Completing) the Face-to-Face (FTF) Encounter
  - Certifying & Re-Certifying Eligibility

Under the Care of a Physician/NPP

When Ordering/Referring, Certifying and overseeing Home Health Services

- Is the beneficiary **eligible** for home health (HH) services?
  - Is the patient homebound as per the CMS definition?
  - Is there a need for skilled services in the home (Nursing, PT, OT, SLP)?
  - Has a face-to-face encounter been completed?
  - Is the certification statement complete, signed & dated?
- Was all of this documentation shared with the home health agency upon referral?

Under the Care of a Physician/NPP

When Ordering/Referring a Patient to Home Health Services but not overseeing services or certifying home health eligibility:

- Is the beneficiary **eligible** for HH services?
  - Is the patient homebound as per the CMS definition?
  - Is there a need for skilled services in the home (Nursing, PT, OT, SLP)?
  - **Has a physician/NPP that will be monitoring the home health services been identified?**
  - Has a face-to-face encounter been completed?
- Was all of this documentation shared with the home health agency upon referral?

Eligibility Criteria:
Plan of Care

Plan of Care

- It is expected that in most instances, the physician/NPP who certifies the patient's eligibility for Medicare home health services will be the same physician/NPP who establishes and signs the plan of care
- The home health agency staff will further develop and evolve the plan of care in collaboration with the community physician/NPP

Plan of Care

- There are no federally mandated forms for the plan of care or the face-to-face encounter

Plan of Care

- All information required on the plan of care can be found in the federal Conditions of Participation
  - Federal Register
    - Medicare and Medicaid Program: Conditions of Participation for Home Health Agencies

Eligibility Criteria:
Face-to-Face Encounter (FTF)

Face-to-Face Encounter

- A FTF encounter with the patient must be performed by either
  - the certifying physician/NPP
  - a physician/NPP that cared for the patient in the acute or post-acute care facility
    - NPP: nurse practitioner, certified nurse midwife, certified nurse specialist or a physician's assistant

Face-to-Face Encounter

- For home health episodes with starts of care beginning 1/1/2011 and later, a FTF must
  - have occurred no more than 90 days prior to or within 30 days after the start of the home health care
  - be related to the primary reason the patient requires home health services,
  - have been performed by an allowed provider type

Face-to-Face Encounter

- Prior to 2015
  - **FTF "Form"**
    - Originated from the home health agency
    - Narrative mandatory regarding:
      - Need for skilled services
      - Homebound status

Face-to-Face Encounter

- Effective 1/1/2015
  - **FTF Documentation**
    - Clinical note such as a discharge summary or progress note
    - Documentation in the patient's medical record that supports a
      one-on-one visit occurred with a physician or non-physician practitioner

Face-to-Face Encounter

- Exception: A narrative is only required when skilled oversight of unskilled care is ordered

Face-to-Face Encounter

- When a physician/NPP refers a Medicare beneficiary to home health, documentation to support that a FTF encounter occurred should be provided to the home health agency

Certification of Eligibility Criteria

Certification of Eligibility Criteria

- Is the patient eligible to utilize their home health benefit?

- Does the patient meet all of the eligibility criteria?

Certification of Eligibility Criteria

- The certifying/re-certifying physician or non-physician practitioner is attesting to the fact that:
  1. The patient is confined to the home (homebound)
  2. The patient needs intermittent SN care, PT and/or SLP services
  3. A plan of care has been established and will be periodically reviewed by a physician/NPP
  4. Services will be furnished while the individual was or is under the care of a physician/NPP
  5. A face-to-face encounter occurred and the date it occurred

Certification of Eligibility Criteria

- **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 NPP** must be a nurse practitioner, clinical nurse specialist, or a physician assistant who is working in accordance with state law
- **Certifying physician/NPP** must be enrolled in PECOS
- **Certifying physician/NPP** cannot have financial relationship with the home health agency unless it meets one of exceptions within the Code of Federal Regulations: 42 CFR 411.355-42 and CFR 411.357

Certification of Eligibility Criteria

- The certification statement can be signed at the time of referral by the ordering/referring physician or by the community physician/NPP that has agreed to oversee home health services

Certification of Eligibility Criteria

- If the certifying physician/non-physician practitioner is an acute/post-acute care physician/non-physician practitioner **and will not be following the patient** while he/she is receiving home care, the medical record documentation **must identify the name of community physician who will be monitoring the home health services and signing the plan of care**

Certification of Eligibility Criteria

- The certification must be complete prior to when an HHA bills Medicare for reimbursement; however, physicians should complete the certification when the plan of care is established, or as soon as possible thereafter.
- It is not acceptable for HHAs to wait until the end of a 60-day certification period to obtain a completed certification/recertification.

Certification of Eligibility Criteria

- Certification Statement Example
- The ordering/referring physician/NPP is certifying eligibility for home health services, **but not overseeing** the 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 a physician/NPP that was related to the primary reason the patient requires home health services.*

Certification of Eligibility Criteria

Certification Statement Example

- The ordering physician/NPP is certifying eligibility and **will be overseeing** the home health care services
  - *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 (include date of face-to-face encounter) by an Medicare enrolled physician or non-physician practitioner that was related to the primary reason the patient requires home health services.*

Re-Certification of 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 who continue to be eligible for the HH benefit
- The physician/NPP recertifying the patient's eligibility is the physician/NPP that has been monitoring the plan of care and providing oversight of home health services

Recertification of Eligibility Criteria

Example of a Recertification Statement

I recertify 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 remains under my care, I have authorized the services on the plan of care, and will continue to periodically review the plan.

Physician/NPP
Billing for Certification & Re-Certification

Billing for Certification and Re-Certification

- HCPCS G0180 Certification and G0179 Re-Certification
  - The descriptions of these two codes indicate that they are used to bill for certification or re-certification of patient eligibility “for Medicare-covered home health services under a home health plan of care (patient not present), including contacts with the home health agency and review of reports of patient status required by physician/NPP to affirm the initial implementation of the plan of care that meets patient's needs, per certification period”
  - These claims will not be covered if the HHA claim itself was noncovered if there was insufficient documentation to support that the patient was eligible
  - These codes are being updated by CMS to include the NPP

Documentation Collaboration

Documentation Collaboration

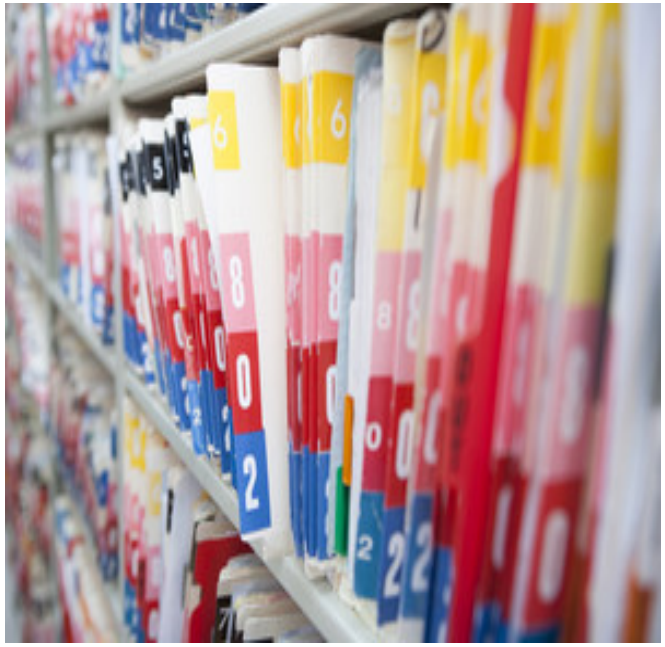
- Home health agencies require as much documentation from the certifying physician/NPP medical records and/or the acute/post-acute care facility's medical records as necessary to assure that the patient eligibility criteria have been met
- The home health agency must be able to provide it to CMS and its review entities upon request

Documentation Collaboration

- Documentation within the certifying physician/NPP 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 Collaboration

- Examples of documentation to share at the point of referral:
  - Order/Referral for HH services
  - Documentation (from anywhere in the medical record) supporting the need for skilled service and homebound status
  - FTF encounter documentation (Discharge summary or interoffice progress note documenting the one-on-one physician/NPP visit)



Documentation Collaboration

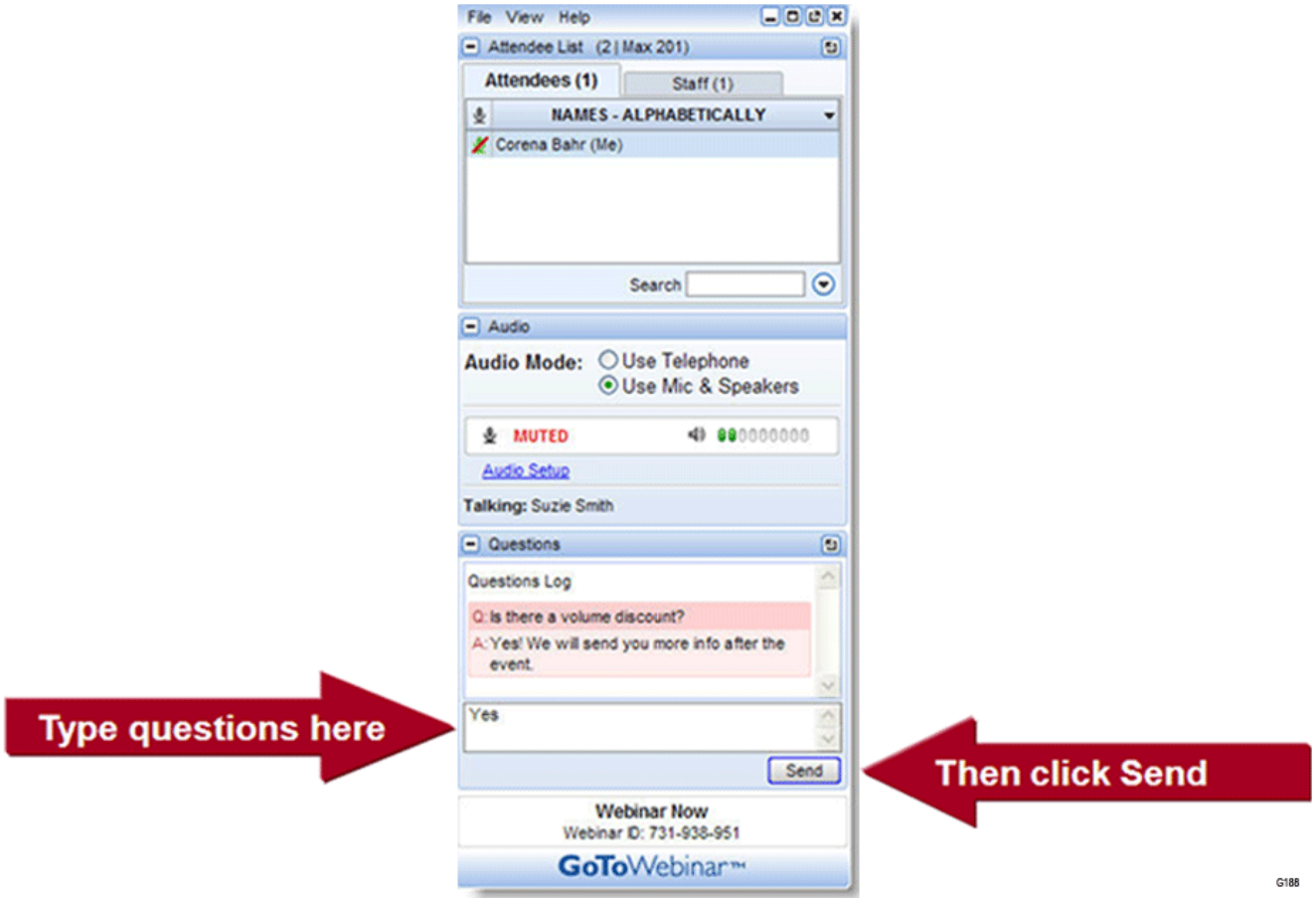
- As per CR 9189
  - The home health agency generated medical record documentation for the patient, by itself, is not sufficient in demonstrating the patient's eligibility for Medicare home health services
  - It is the patient's medical record held by the certifying physician/NPP and/or the acute/post-acute care facility that must support the patient's eligibility for home health services

Documentation Collaboration

- Incorporating home health agency documentation into the physician/NPP record
  - Information from the home health can be incorporated into the certifying physician/NPP medical record for the patient
  - The certifying physician/NPP must review and sign any documentation used to support the certification of eligibility criteria
  - If this documentation is to be used for verification of the eligibility criteria, it must be dated prior to submission of the claim

Questions

To Ask a Question
Using the Question Box



CMS & NGS Home Health References & Resources

CMS References and 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

CMS References and Resources

- HH PPS web page
- Medicare HHA website
- MLN® Publication, *"Home Health Prospective Payment System"*

NGS References & Resources

- NGS Website
  - Education
  - Job Aids
  - Manuals
  - Articles
  - And More

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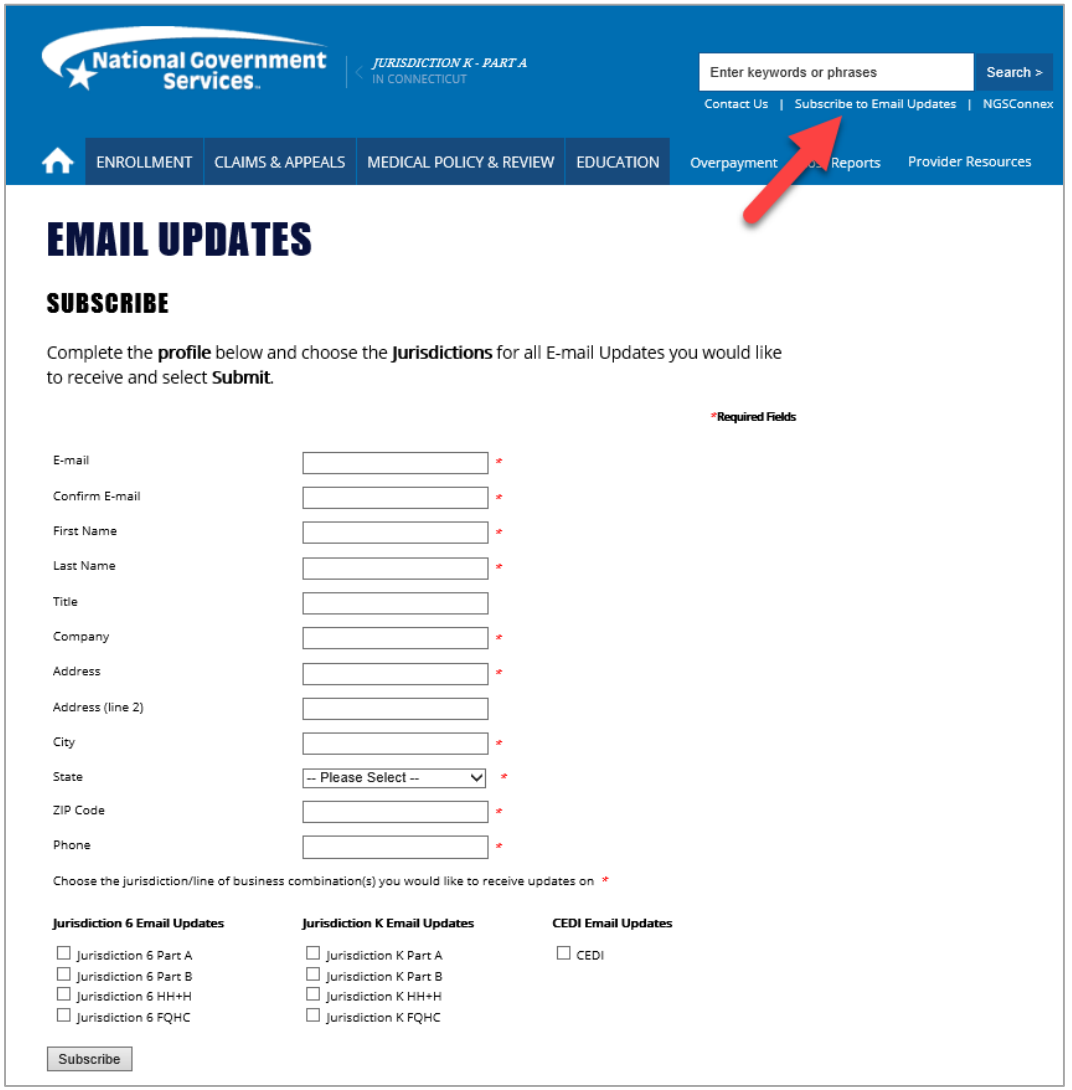

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Thank You!

- Follow-up email
  - Attendees will be provided a Medicare University Course Code
- Questions?

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