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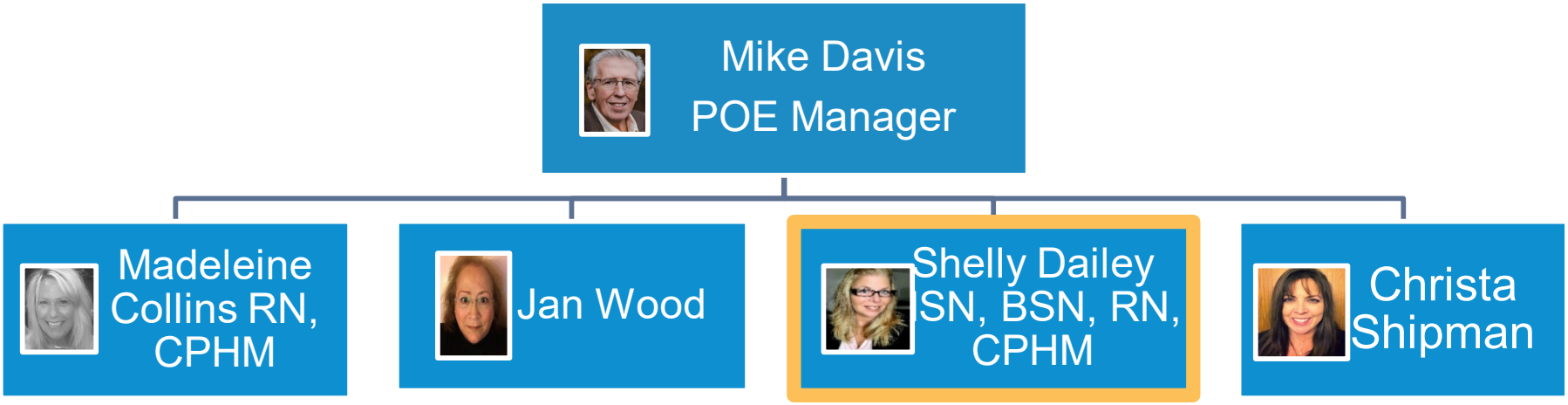
Home Health Eligibility Criteria:

Documenting Homebound Status and the Need for Skilled Services - 1/20/2022

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Today's Presenters

National Government Services Provider Outreach and Education Home Health and Hospice Team



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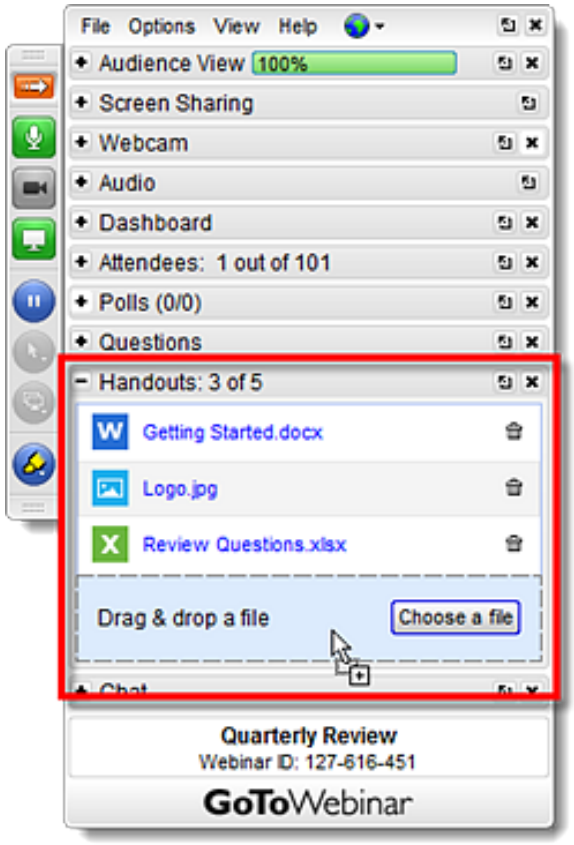


Objectives

- To offer federal Medicare regulatory direction to home health agencies (*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 homebound status and the need for skilled services eligibility criteria.

Agenda

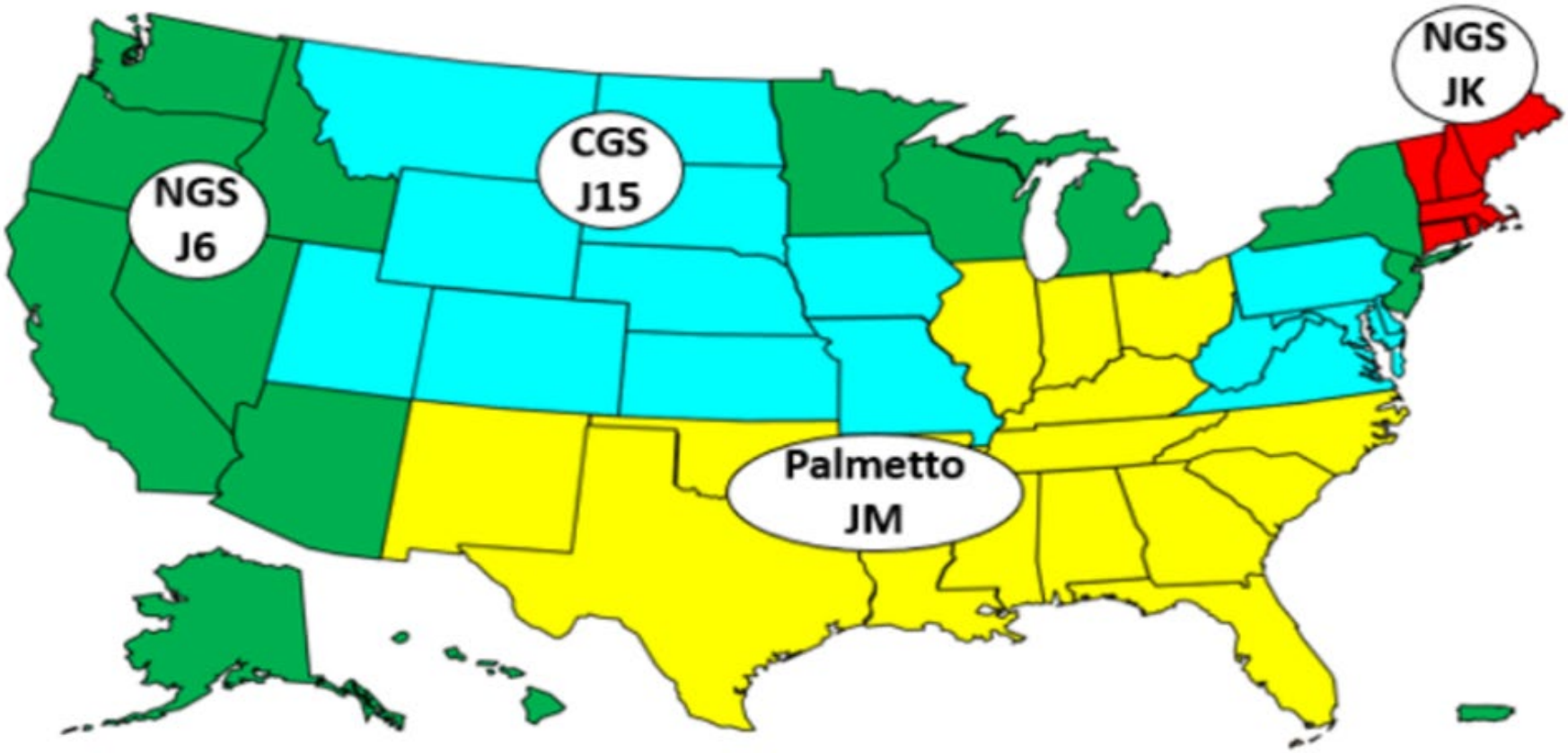
- NGS Home Health and Hospice Medicare Jurisdictions
- Medicare Home Health Benefit
- Eligibility Requirements
- Homebound Status
- The Need for Skilled Services
- Documentation Collaboration
- References and Resources
- Question and Answer Period

Home Health and Hospice Medicare Jurisdictions

Home Health and 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 and Hospice
Medicare Administrative Contractors (MACs)



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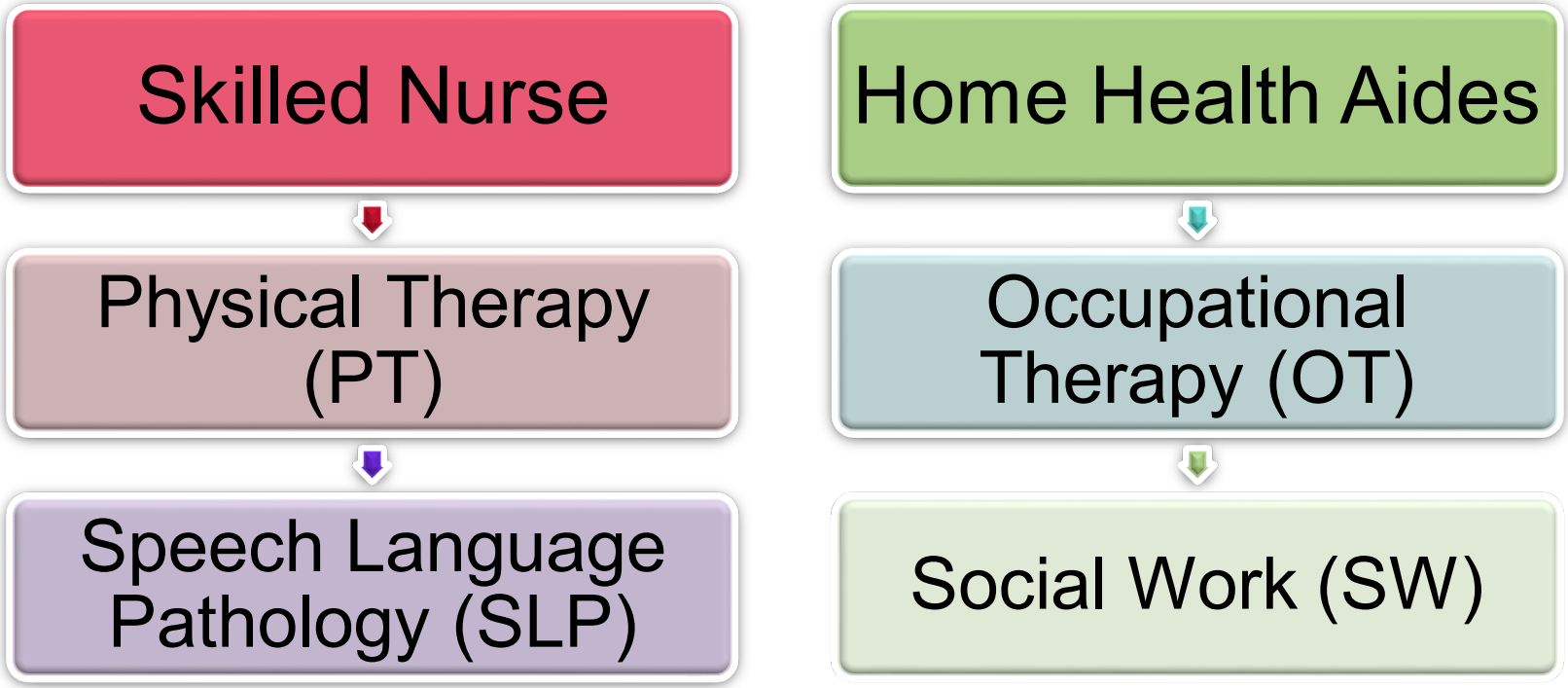
The Medicare Home Health Benefit

The Medicare Home Health Benefit

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



Need for Skilled Services

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 their home?** *Is the patient able to receive the "skilled" services on an outpatient basis?*
- **Is there a physician or allowed practitioner that has agreed to monitor home health services?** *Is that name identified within the referral information?*
- **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 that information within the documentation that was sent with the referral?*

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Home Health Eligibility Requirements

Eligibility Requirements

- When the physician or allowed 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)**
  2. **Need skilled services**
  3. Be under the care of a physician/allowed practitioner
  4. Receive services under a plan of care established and reviewed by a physician/allowed practitioner
  5. Have had a face-to-face encounter for their current diagnosis with a physician/allowed practitioner

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

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Homebound Status

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

or

  - Verify the reason why leaving home is **medically contraindicated**

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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

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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

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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 **or**
  - **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."

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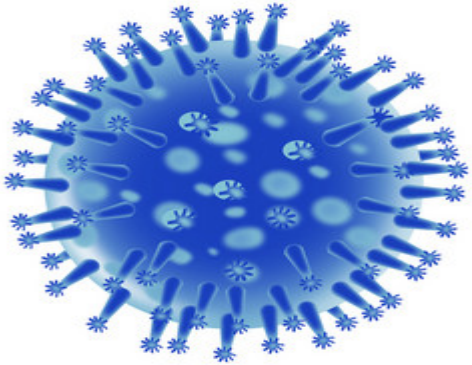
Public Health Emergency

- Homebound Definition
  - A beneficiary is considered homebound when their physician advises them not to leave the home because of a confirmed or suspected COVID-19 diagnosis or if the patient has a condition that makes them more susceptible to contract COVID-19
  - As a result, if a beneficiary is homebound due to COVID-19 and needs skilled services, a home health agency can provide those services under the Medicare home health benefit



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The Need for Skilled Services

Need for Skilled Services

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

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Need for Skilled Services

- Distinguish exactly what services are going to be provided by the skilled professional in the patient's home

Registered Nurse for Daily Sacral Wound Dressing Changes x3 weeks

Need for Skilled Services

- Explain why a “skilled professional” is required to provide the home health services requested

Need for Skilled Services

- **Disclose** clinical information (beyond a list of recent diagnoses, injury or procedure) that is individual and specific to the patient

Need for Skilled Services

- **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

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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

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Need for Skilled Services

- A skilled professional must document the services specific to the care provided as it pertains to the current diagnosis relative to the reason for home health services during every visit

Need for Skilled Services

- When the patient no longer meets eligibility criteria and skilled services are no longer required, the reason for discharge from home health services should be documented within the medical record and the provider monitoring patient care should be notified

Certification and Recertification 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?

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Certification of Eligibility Criteria

The certifying/re-certifying physician or allowed practitioner is attesting to the fact that all five eligibility criteria have been met:

1. **The patient is confined to the home (homebound)**
2. **Has a need for skilled services in the home**
3. A plan of care has been established and will be periodically reviewed by a physician or allowed practitioner
4. Services will be furnished while the patient is under the care of a physician or allowed practitioner
5. A face-to-face encounter occurred by a physician or allowed practitioner for the current diagnosis

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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 allowed practitioner** must be a nurse practitioner, clinical nurse specialist, or a physician assistant who is working in accordance with state law
  - **Certifying physician/allowed practitioner** must be enrolled in PECOS
  - **Certifying physician/allowed practitioner** 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/allowed practitioner that has agreed to oversee the patients home health services

Certification of Eligibility Criteria

- If the certifying 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 the home health services and signing the plan of care**

Certification of Eligibility Criteria

- The certification must be complete prior to when the home health agency bills Medicare for reimbursement
- Certification should be completed when the plan of care is established, or as soon as possible thereafter
- It is not acceptable for the home health agency to wait until the end of a 60-day certification period to obtain a completed certification or recertification

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.*

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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 or allowed practitioner recertifying the patient's eligibility is the same provider that has been continually monitoring the plan of care and providing oversight of home health services

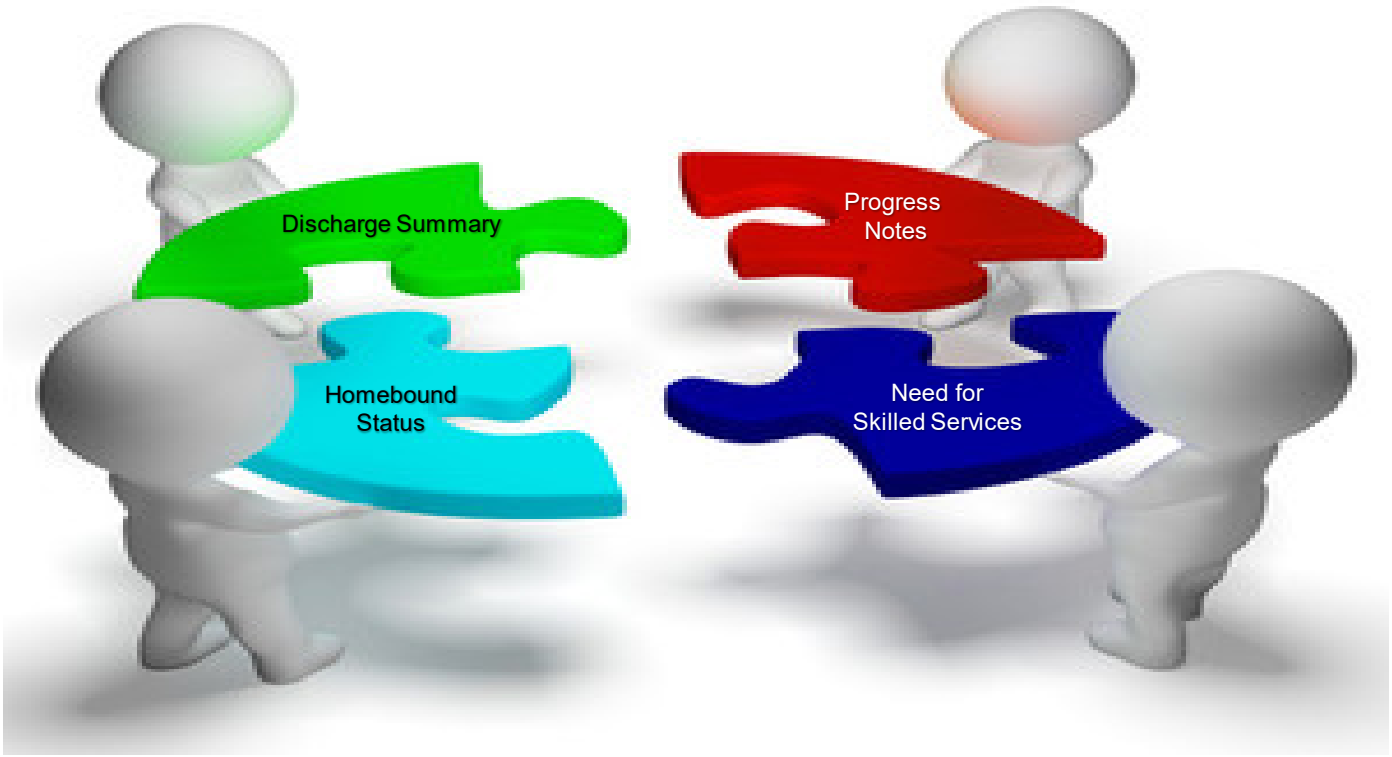
Recertification of Eligibility Criteria

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

Acute Care Facility	• Must forward any & all supporting documentation
Post-Acute Care Facility	• Must forward any & all supporting documentation
Physician's Office	• Must forward any & all supporting documentation
Other Services (including Ambulance, Oxygen, Intravenous therapy, etc.)	• Must forward any & all supporting documentation

Home Health Agency

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Documentation Collaboration

Documentation Collaboration

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Documentation Collaboration

- Home health agencies require as much documentation from the certifying physician/allowed practitioner 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 all documentation to CMS and its review entities upon request

Documentation Collaboration

- Documentation within the certifying physician/allowed practitioner 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**
  - Referral and orders for home health services
  - Documentation (from anywhere in the medical record) supporting homebound status and the need for skilled services
  - The face-to-face encounter documentation which would Include a discharge summary or interoffice progress notes documenting the one-on-one physician/allowed practitioner visit

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Documentation Collaboration

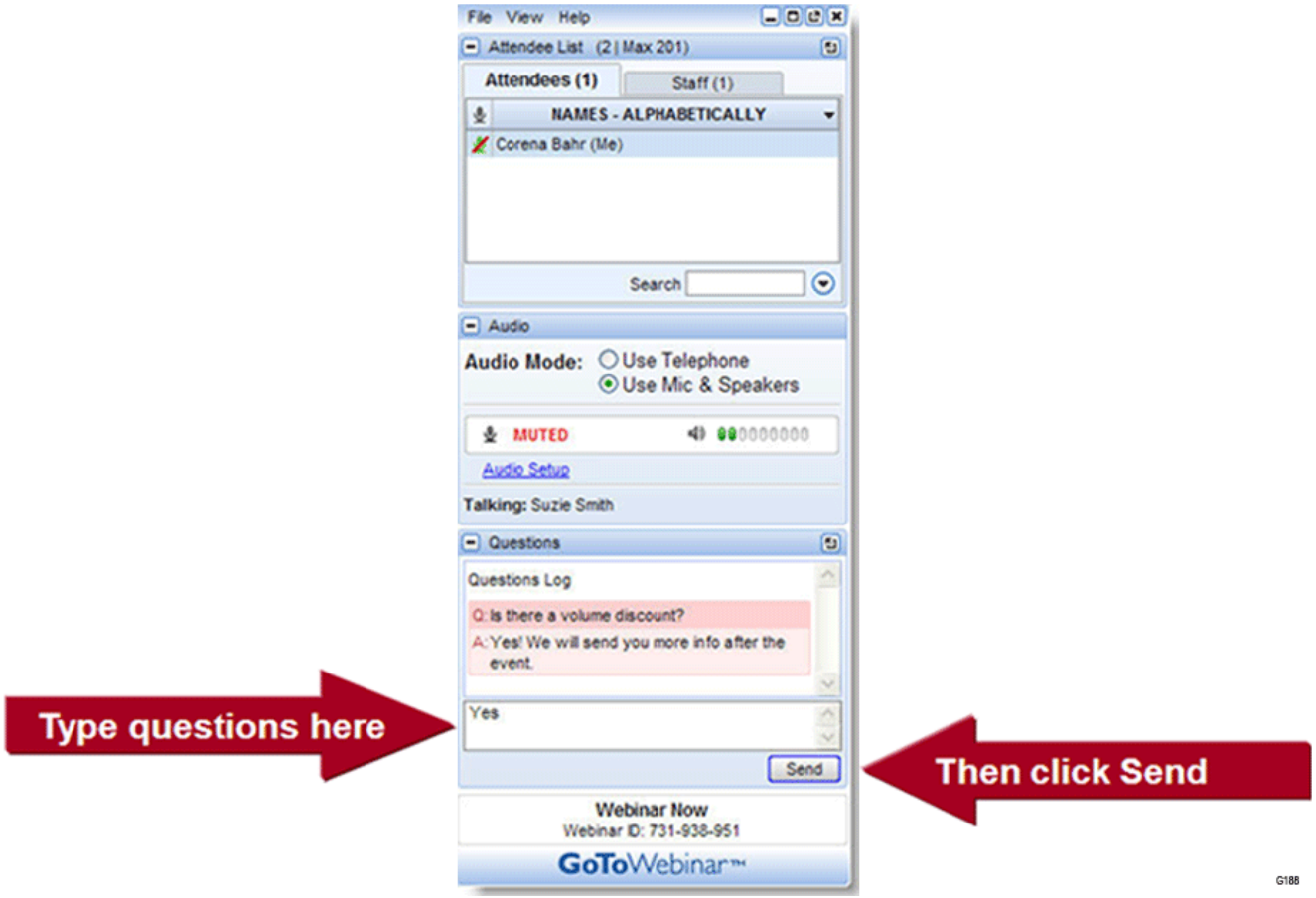
- The home health agency generated medical record documentation for the patient, by itself, is not sufficient in demonstrating the patient's eligibility for Medicare home health services
- It is the patient's medical record held by the certifying physician/allowed practitioner and/or the acute/post-acute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

Documentation Collaboration

- Incorporating home health agency documentation into the physician/allowed practitioner record
  - Information from the home health can be incorporated into the certifying physician/allowed practitioner medical record for the patient
  - The certifying physician/allowed practitioner 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

Wrap Up

To Ask a Question
Using the Question Box



CMS and NGS Home Health References and Resources

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CMS References and Resources

- CMS IOM Publication 100-01, *Medicare General Information, Eligibility and Entitlement Manual*, Chapter 4, Section 30
- 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
- HH PPS web page

CMS References and Resources

- Medicare HHA website
- MLN® Publication, *"Home Health Prospective Payment System"*
- MLN Matters® *MM9119 Revised: Manual Updates to Clarify Requirements for Physician Certification and Recertification of Patient Eligibility for Home Health Services*
- Change Request 9119 Transmittal 92
- Change Request 9119 Transmittal 208

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NGS References and Resources

- NGS website
  - Education
  - Medicare Topics
    - Billing
    - Documentation

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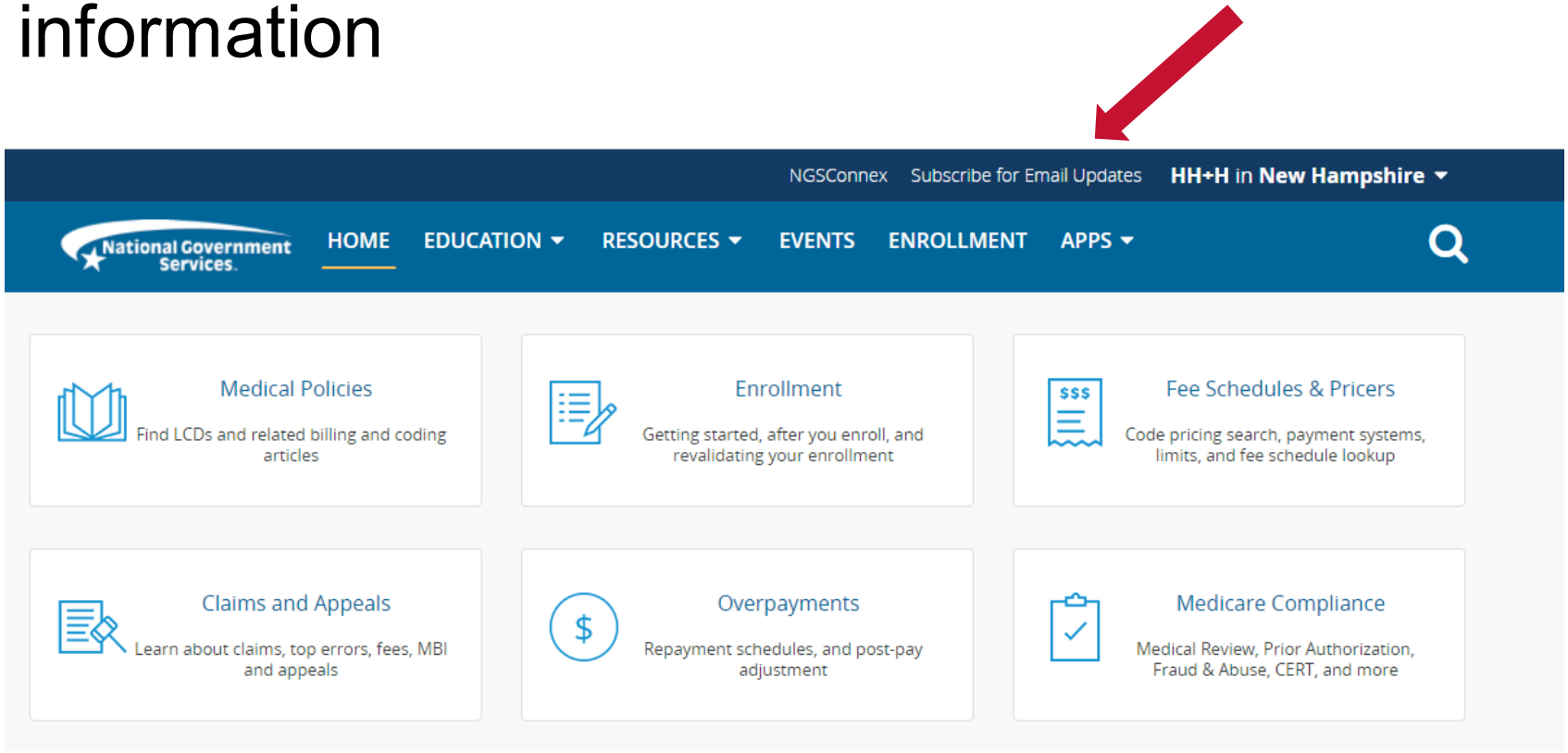

Medicare University

- Interactive online system available 24/7
- Educational opportunities available
  - Computer-based training courses
  - Teleconferences, webinars, live seminars/face-to-face training
- Self-report attendance
- Medicare University website

Continuing Education Credits

- All National Government Services Part A and Part B Provider Outreach and Education attendees can now receive one CEU from AAPC for every hour of National Government Services education received
- If you are accredited with a professional organization other than AAPC, and you plan to request continuing education credit, please contact your organization, not National Government Services, with your questions concerning CEUs

Medicare University Self-Reporting Instructions

- Log on to the National Government Services Medicare University site
  - Topic = **Home Health Eligibility Criteria: Documenting Homebound Status & the Need for Skilled Service**
  - Medicare University Credits (MUCs) = **1**
  - Catalog Number = **##########**
  - Participant Code = **##########**
  - For step-by-step instructions on self-reporting please visit Self-Reporting for Webinars, Teleconferences and Events on the NGS website

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Provider Contact Center Procedures

- The PCC should always be your first option when contacting the MAC
  - Required to log and track all incoming inquires
- Tiered system to respond accurately to all provider inquiries

Contact NGS

For future questions contact the Provider Call Center:

State/Region	Toll-Free Number	IVR	PCC Hours of Service
Alaska, Arizona, California, Hawaii, Idaho, Nevada, Oregon, Washington, American Samoa, Guam, Northern Mariana Island	866-590-6724 TTY: 888-897-7523	866-277-7287	Monday–Friday 8:00 a.m.–4:00 p.m. PT Thursday, closed for training 12:00–2:00 p.m. PT
Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont	866-289-0423 TTY: 866-786-7155	866-275-7396	Monday–Friday 8:00 a.m.–4:00 p.m. ET Thursday, closed for training 2:00–4:00 p.m. ET
Michigan, Minnesota, New York, New Jersey, Wisconsin, Puerto Rico, U.S. Virgin Islands	866-590-6728 TTY: 888-897-7523	866-275-3033	Monday–Friday 8:00 a.m.–5:00 p.m. CT 9:00 a.m.–6:00 p.m. ET Thursday, closed for training 2:00–4:00 p.m. CT 3:00–5:00 p.m. ET

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Thank You!

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

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