

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services



The Medicare Home Health Benefit



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This publication provides the following information about home health services:

- Qualifying for home health services;
- Consolidated billing (CB);
- Therapy services;
- Billing and payment; and
- Resources.

When “you” is used in this publication, we are referring to home health agencies (HHAs), physicians, and non-physician practitioners (NPPs).



QUALIFYING FOR HOME HEALTH SERVICES

What criteria must be met to qualify for home health services?

Medicare covers home health services when the following criteria are met:

- The beneficiary to whom services are furnished is eligible and enrolled in the Medicare Program and is not enrolled in a Medicare Advantage Plan;
- The beneficiary is eligible for coverage of home health services;
- The HHA furnishing the services has a valid agreement in effect to participate in the Medicare Program;
- The services for which payment is claimed are covered under the Medicare home health benefit;
- Medicare is the appropriate payer; and
- The services are not otherwise excluded from payment.

What criteria must a patient meet to be eligible for home health services?

For a patient to be eligible for Medicare home health services, he or she must meet the following criteria:

1. Be confined to the home;
2. Need skilled services;
3. Be under the care of a physician;
4. Receive services under a home health plan of care (HH POC) established and periodically reviewed by a physician; and
5. Had a face-to-face encounter related to the primary reason the patient requires home health services with a physician or an allowed NPP 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.

Who can perform the required face-to-face encounter?

The following health care providers can perform the required face-to-face encounter:

- The certifying physician;
- The physician who cared for the patient in an acute or post-acute care facility (from which the patient was directly admitted to home health);
- A nurse practitioner or clinical nurse specialist who is working in collaboration with the certifying physician or the acute/post-acute care physician; or
- A certified nurse midwife or physician assistant under the supervision of the certifying physician or the acute/post-acute care physician.

The face-to-face encounter cannot be performed by any physician or allowed NPP (listed above) who has a financial relationship with the HHA.



As a condition for payment, certain certification requirements must be met. What are these requirements?

- A physician must certify that a patient is eligible for Medicare home health services according to the “Code of Federal Regulations” at 42 CFR 424.22(a)(1)(i)-(v); and
- The physician who establishes the HH POC must sign and date the certification.

CMS does not require a specific form or format for the certification as long as a Medicare-enrolled physician certifies that the following five requirements, outlined in 42 CFR Section 424.22(a)(1), are met:

1. The patient needs intermittent skilled nursing (SN) care, physical therapy (PT), and/or speech-language pathology (SLP) services;
2. The patient is confined to the home (that is, homebound);
3. A HH POC 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; and
5. A face-to-face encounter:
 - a. 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;
 - b. Was related to the primary reason the patient requires home health services; and
 - c. Was performed by a physician or allowed NPP.

When should the physician complete the certification?

According to the regulations at 42 CFR 424.22(a)(2), the physician should complete the certification when the HH POC is established or as soon as possible thereafter. The certification must be complete prior to when an HHA bills Medicare for reimbursement.

When should the physician complete the recertification, and what must he or she include in the recertification?

At, or near, the end of the initial 60-day episode, you must make a decision on whether to recertify the patient for a subsequent 60-day episode. Recertification is required at least every 60 days when there is a need for continuous home health care after an initial 60-day episode and unless there is a:

- Patient-elected transfer; or
- Discharge with goals met and/or no expectation of a return to home health care. If a patient is discharged and then requires a new episode, the physician must complete a new certification (not a recertification).

Medicare does not limit the number of continuous episodes of recertification for patients who continue to be eligible for the home health benefit.

The recertification must:

1. Be signed and dated by the physician who reviews the HH POC;
2. Indicate the continuing need for skilled services (the need for occupational therapy [OT] may be the basis for continuing services initiated because the individual needed SN, PT, or SLP services); and
3. Estimate how much longer the skilled services will be required.

For more information about qualifying for home health services, the face-to-face encounter, and the required physician certification/recertification of patient eligibility, refer to the MLN Matters® article "[Certifying Patients for the Medicare Home Health Benefit](#)" on the Centers for Medicare & Medicaid Services (CMS) website.



CONSOLIDATED BILLING (CB)

What home health services are included in the CB governing Home Health Prospective Payment System (HH PPS)?

The home health services included in the CB governing HH PPS are:

- Part-time or intermittent SN services;
- Part-time or intermittent home health aide services;
- PT;
- OT;
- SLP services;
- Medical social services;
- Routine and non-routine medical supplies;
- Covered osteoporosis drugs as defined in Section 1861(kk) of the Social Security Act (the Act) (but excluding other drugs and biologicals);
- Medical services provided by an intern or resident-in-training of the program of the hospital (if you are affiliated or under common control with a hospital with an approved teaching program); and
- Home health services defined in Section 1861(m) of the Act provided under arrangement at hospitals, Skilled Nursing Facilities, or rehabilitation centers when they involve equipment too cumbersome to bring to the home or are furnished while the patient is at the facility to receive such services.

THERAPY SERVICES

What requirements and standards must be met for therapy services?

Skilled therapy services must be reasonable and necessary for the treatment of the patient's illness or injury or for the restoration or maintenance of function affected by the patient's illness or injury within the context of his or her unique medical condition. This means that the therapy services must be:

- Inherently complex, which means that they can be performed safely and/or effectively only by or under the general supervision of a skilled therapist;
- Consistent with the nature and severity of the illness or injury and the patient's particular medical needs, which include services that are reasonable in amount, frequency, and duration; and
- Considered specific, safe, and effective treatment for the patient's condition under accepted standards of medical practice.

The Medicare Learning Network® (MLN) publication titled "[Home Health Prospective Payment System](#)" on the CMS website provides information about the standards that must be met for skilled therapy services to be considered effective treatment for the patient's condition.

BILLING AND PAYMENT

How am I paid under the HH PPS for the Medicare home health services I furnish?

With the exception of certain covered osteoporosis drugs where the patient meets specific criteria and durable medical equipment (DME), payment for all services and supplies is included in the HH PPS episodic rate for individuals under a HH POC. You must provide the covered home health services (except DME) either directly or under arrangement (an outside supplier furnishes services under arrangement and looks to the HHA for payment). You must bill for such covered home health services, and payment must be made to you.

How am I paid for episodes of care?

The unit of payment under the HH PPS is a 60-day episode of care. A split percentage payment is made for most HH PPS episode periods. There are two payments – initial and final. The initial payment is made in response to a Request for Anticipated Payment (RAP), and the final payment is paid in response to a claim. Added together, the initial and final payments equal 100 percent of the permissible payment for the episode.

There is a difference in the percentage split of initial and final payments for initial and subsequent episodes for patients in continuous care. For all initial episodes, the percentage split for the two payments is 60 percent in response to the RAP and 40 percent in response to the claim. For all subsequent episodes in periods of continuous care, each of the two percentage payments is 50 percent of the estimated case-mix adjusted episode payment. The case-mix and wage-adjusted national 60-day episode payment is adjusted for case-mix based on the patient's condition and care needs or case-mix assignment. The payment is also adjusted to account for area wage differences.

What codes should I use on physician claims when certifying/recertifying eligibility for home health services?

The following Healthcare Common Procedure Coding System (HCPCS) codes are used on physician claims when certifying/recertifying eligibility for home health services:

- HCPCS code G0180 – Physician certification home health patient for Medicare-covered home health services under a home health plan of care (patient not present); and
- HCPCS code G0179 – Physician recertification home health patient for Medicare-covered home health services under a home health plan of care (patient not present).

If a HHA claim is not covered because the certification/recertification of eligibility was not complete or because there was insufficient documentation to support the patient's eligibility for the Medicare home health benefit, a physician's claim for certification/recertification of eligibility for home health services (HCPCS codes G0180 and G0179, respectively) is also not considered a Medicare-covered home health service.

For more information about home health billing and payment, refer to the MLN publication titled "[Home Health Prospective Payment System](#)" on the CMS website.

How should I code claims for home health episodes that span the October 1, 2015, International Classification of Diseases, 10th Edition (ICD-10) implementation date?

Home health claims that span the ICD-10 implementation date have International Classification of Diseases, 9th Edition, codes effective for the portion of services furnished on or before September 30, 2015, and ICD-10 codes effective for the portion of services furnished on or after October 1, 2015. For more information about home health episodes that span October 1, 2015, refer to the MLN Matters® article titled "[Special Instructions for the International Classification of Diseases, Clinical Modification 10th Edition \(ICD-10-CM\) Coding on Home Health Episodes that Span October 1, 2015](#)" on the CMS website.

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RESOURCES

The chart below provides home health resource information.

Home Health Resources

For More Information About...	Resource
Home Health Services	<p>Home Health Agency Center on the CMS website</p> <p>Chapter 7 of the “Medicare Benefit Policy Manual” (Publication 100-02) on the CMS website</p> <p>Chapter 10 of the “Medicare Claims Processing Manual” (Publication 100-04) on the CMS website</p> <p>Chapter 6 of the “Medicare Program Integrity Manual” (Publication 100-08) on the CMS website</p>
Code of Federal Regulations	<p>http://www.gpo.gov/fdsys/browse/collectionCfr.action?collectionCode=CFR on the United States (U.S.) Government Printing Office website</p>
Compilation of Social Security Laws	<p>http://www.ssa.gov/OP_Home/ssact/title18/1800.htm on the U.S. Social Security Administration website</p>
All Available MLN Products	<p>“MLN Catalog” on the CMS website</p>
Provider-Specific Medicare Information	<p>MLN publication titled “MLN Guided Pathways: Provider Specific Medicare Resources” on the CMS website</p>
Medicare Information for Patients	<p>https://www.medicare.gov on the CMS website</p>



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