

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



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Provider Compliance Tips for Home Health Services (Part A non DRG)

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Provider Types Affected:

- Physicians who refer beneficiaries to home health, order home health services, and/or certify beneficiary's eligibility for the Medicare home health benefit; home health agencies; and non-physician practitioners (NPPs)

Background

Based on the [Supplementary Appendices for the Medicare Fee-For-Service 2015 Improper Payments Report](#), the Medicare Fee-for-Service (FFS) improper payment rate for Home Health Agency (HHA) claims was 59 percent, representing approximately \$10.1 billion in improper payments and accounting for 22.6 percent of the overall Medicare FFS improper payment rate.

Reasons for Denials

Insufficient documentation accounted for a large proportion of improper payments for home health services. Face-to-face encounter narratives that did not meet guidelines were the most common reason for insufficient documentation errors. Other types of insufficient documentation errors included:

- Missing or deficient physician orders
- Missing or inadequate physician certification/re-certification
- OASIS not in repository/medical record
- Progress notes did not support therapy services rendered on billed dates of service

Note: As of January 1, 2015, CMS no longer requires the certifying physician to compose a brief narrative describing how the patient's clinical condition, as seen during the encounter, supports the patient's homebound status and need for skilled services.

To Prevent Denials

For home health services to be covered, a physician must certify (attest) that:

1. The beneficiary is confined to the home
2. The beneficiary is under the care of a physician
3. The beneficiary is receiving services under a plan of care established and periodically reviewed by a physician
4. The beneficiary is in need of skilled home health services
5. The beneficiary had a face-to-face encounter with an allowed provider type that:
 - 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 and
 - was related to the primary reason the beneficiary requires home health services

These requirements are shown in the [“Medicare Benefit Policy Manual,” Chapter 7](#), Section 30.5.1.

The beneficiary is confined to the home.

Based on the [“Medicare Benefit Policy Manual,” Chapter 7](#), Section 30.1.1, a beneficiary is considered “confined to the home” (homebound) if the following two criteria are met:

1. Criteria-One:
 - a. The beneficiary must either:
 - 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 in order to leave their place of residence OR
 - Have a condition such that leaving his or her home is medically contraindicated

If the beneficiary meets one of the Criteria-One conditions, then the beneficiary must ALSO meet the two additional requirements defined in Criteria-Two below.

2. Criteria-Two:
 - a. There must exist a normal inability to leave home and
 - b. Leaving home must require a considerable and taxing effort

The beneficiary is under the care of a physician and receiving services under a plan of care established and periodically reviewed by a physician.

The certifying physician’s medical record and/or the acute or post-acute care facility’s medical record (if the patient was directly admitted to home health from such setting) for the beneficiary must contain information that justifies the referral for Medicare home health services. This includes documentation that substantiates the beneficiary’s need for the skilled services and homebound status. (See the [“Medicare Benefit Policy Manual,” Chapter 7](#), Section 30.5.1.2.)

According to the [“Medicare Benefit Policy Manual,” Chapter 7](#), Section 30.2.1, if the plan of care includes a course of treatment for therapy services:

- The course of therapy treatment must be established by the physician after any needed consultation with the qualified therapist

- The plan must include measurable therapy treatment goals which pertain directly to the beneficiary's illness or injury, and the beneficiary's resultant impairments
- The plan must include the expected duration of therapy services
- The plan must describe a course of treatment which is consistent with the qualified therapist's assessment of the beneficiary's function.

The plan of care must be reviewed and signed by the physician every 60 days unless the beneficiary transfers to another HHA or gets discharged and returns to home health during the 60-day episode. (See the "[Medicare Benefit Policy Manual](#)," [Chapter 7](#), Section 30.2.6.)

The beneficiary is in need of skilled home health services.

According to the "[Medicare Benefit Policy Manual](#)," [Chapter 7](#), Section 30.4, the beneficiary must need one of the following:

1. Skilled nursing care that is
 - a. Reasonable and necessary
 - b. Needed on an "intermittent" basis and
 - c. Not solely needed for venipuncture for the purposes of obtaining blood samples.
2. Physical therapy
3. Speech-language pathology services
4. Have a continuing need for occupational therapy

The beneficiary had a face-to-face encounter with an allowed provider type.

Rather than composing a narrative to document that a face-to-face encounter occurred, the certifying physician must certify (attest) that a face-to-face encounter with the beneficiary was performed 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 performed by an allowed provider type, and was related to the primary reason that the beneficiary requires home health services. The certifying physician must also document the date of the encounter.

The certifying physician and/or the acute/post-acute care facility medical record (if the patient was directly admitted to home health) medical record for the beneficiary must contain the actual clinical note for the face-to-face encounter visit that demonstrates that the encounter:

- Occurred within the required timeframe
- Was related to the primary reason the beneficiary requires home health services
- Was performed by an allowed provider type (See the "[Medicare Benefit Policy Manual](#)," [Chapter 7](#), Section 30.5.1.2.)

Providers that are allowed to perform the encounter include:

- The certifying physician
- A physician (with privileges) that cared for the patient in the acute or post-acute care facility from which the patient was directly admitted to home health
- A nurse practitioner or a clinical nurse specialist working in accordance with State law and in collaboration with the certifying physician or in collaboration with an acute or post-acute care physician, with privileges, who cared for the beneficiary in the acute or post-acute care facility from which the beneficiary was directly admitted to home health

- A certified nurse midwife, as authorized by State law, under the supervision of the certifying physician or under the supervision of an acute or post-acute care physician with privileges who cared for the beneficiary in the acute or post-acute care facility from which the beneficiary was directly admitted to home health

A physician assistant under the supervision of the certifying physician or under the supervision of an acute or post-acute care physician with privileges who cared for the beneficiary in the acute or post-acute care facility from which the beneficiary was directly admitted to home health (See the “Medicare Benefit Policy Manual,” Chapter 7, Section 30.5.1.1.)

Resources

HHAs may find the following resources helpful in avoiding improper payments for their services:

For More Information About...	Resource
The Supplementary Appendices for the Medicare Fee-For-Service 2015 Improper Payments Report	https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT/CERT-Reports-Items/Downloads/AppendicesMedicareFee-for-Service2015ImproperPaymentsReport.pdf
“Medicare Benefit Policy Manual,” Chapter 7, Section 30	https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c07.pdf

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Supplementary Appendices for the Medicare Fee-For-Service 2015 Improper Payments Report	https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT/CERT-Reports-Items/Downloads/AppendicesMedicareFee-for-Service2015ImproperPaymentsReport.pdf
“Medicare Benefit Policy Manual,” Chapter 7	https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c07.pdf



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