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National Provider Call Transcript

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Centers for Medicare & Medicaid Services
Certifying Patients for the Medicare Home Health Benefit
MLN Connects National Provider Call
Moderator: Charlie Eleftheriou
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Contents

Operator: At this time, I would like to welcome everyone to today's MLN Connects National Provider Call. All lines will remain in a listen-only mode until the question-and-answer session. This call is being recorded and transcribed. If anyone has any objections, you may disconnect at this time.

I will now turn the call over to Charlie. Thank you, you may begin.

Announcements and Introduction

Charlie Eleftheriou: Good afternoon, this is Charlie Eleftheriou from the Provider Communications Group here at CMS, and as today's moderator, I'd like to welcome everyone to this MLN Connects National Provider Call on "Certifying Patients for the Medicare Home Health Benefit." MLN Connects Calls are part of the Medicare Learning Network.

The calendar year 2015 Home Health Prospective Payment System final rule finalized the new patient certification requirement for home health agencies beginning January 1st, 2015. During this MLN Connects Call, CMS subject matter experts will discuss the changes to the Medicare home health benefit, followed by a question-and-answer session.

Before we get started, there are few items I'd like to quickly cover. You should have received an email earlier this afternoon with the link to today's slide presentation, information about several example documents that subject matter experts will be referring to, and an email address for additional questions you might have following this call.

If you have not received that email, the call materials can be found on today's Call Details web page. To access the Call Details page, visit www.cms.gov/npc, as in National Provider Call. That's cms.gov/npc. On the left side, select National Provider Calls and Events, and then select today's call by date from the list.

In the Call Materials section, you'll see a link to the presentation and a link to download the example documents that we will be referencing. The email address for additional questions following the call is "homehealth," which is one word, _hospice_dmeodf-l. Again, that's homehealth_hospice_dmeodf-l@cms.hhs.gov.

Lastly, I'll just note that this call is being recorded and transcribed. An audio recording and written transcript will be posted to the Call Details page when available. And we'll also be announcing in the MLN Connects Provider eNews.

At this time, I'd like to begin our presentation by turning the call over to Randy Throndset.

Presentation

Randy Throndset: Thanks Charlie. Good morning, or good afternoon for those of you that are joining us from the western part of the country. My name is Randy Throndset, and I am the Director of the Division of Home Health and Hospice. My division is responsible for Medicare home health and hospice payment policy here at the Centers for Medicare & Medicaid Services. I want to first thank everyone for taking time out of their busy schedules to join us on this call today for a presentation on home health program requirements, specifically, the certification of patient eligibility for the Medicare home health benefit.

Current law requires that the certifying physician be responsible for determining whether a patient meets eligibility criteria. That is, homebound status and the need for skilled services and for understanding the current clinical needs of the patient such that the physician can establish an effective plan of care.

The goal of the Affordable Care Act's face-to-face provision is to achieve greater physician accountability in certifying a patient's eligibility in establishing that patient's plan of care. Recently, CMS went through its calendar year 2015, home health PPS rulemaking in which we proposed and finalized changes to the existing home health face-to-face requirements. I want to thank the public for the very thoughtful comments that we received on the proposed face-to-face policies in that rule.

As noted in our response to comments in that final rule, we agree with commenters that there should be sufficient evidence in the patient's medical record to demonstrate that the patient meets the Medicare home health eligibility criteria. To that end, for episodes beginning January 1st, 2015, and beyond, we have eliminated the home health face-to-face narrative requirement.

Today we're fortunate to have with us CMS's home health policy expert and technical adviser, Hillary Loeffler, and our Chronic Care Policy Group's Medical Director, Dr. Crystal Simpson, to walk us through three important topics. First, patient eligibility for the Medicare home health benefit; second, certification requirements, including that of the required face-to-face encounter; and lastly, recertification requirements.

At the conclusion of their presentation, Jill Nicolaisen, the Director of CMS's Division of Medical Review, is going to walk us all through some of the more frequent questions that we have received along with your registrations for this call. After which, we'll open it up for callers with any other questions that they might have.

One of the goals of this call is that the material that Hillary and Dr. Simmons — Dr. Simpson are going to present on today will answer many of the questions that you may have on your minds. And with that, I'd like to turn it over to Hillary and Dr. Simpson, who are going to walk you through their presentation.

Hillary Loeffler: Thank you Randy. As Randy mentioned, I am Hillary Loeffler. I'm a technical adviser in the Division of Home Health and Hospice, and I'd like to begin just with running through slide 3, which is our disclaimers. I just want to note this presentation was current at the time it was published or uploaded onto the web. Medicare policy changes frequently, so links to the source documents have been provided within the document for your reference.

This presentation was prepared as a service to the public and is not intended to grant rights or impose obligations. This presentation may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents.

With that, I'm turning to slide 4, which is our agenda for today's call. I'm going to begin with a brief overview of the Medicare home health benefits and then, as Randy mentioned, I'll discuss the criteria that must be met for a patient to be considered eligible for Medicare home health services and then the requirements for certifying patient eligibility, of which the face-to-face encounter is a component. I will wrap up the presentation with the recertification requirements and available resources before we move to the question-and-answer portion of today's call.

Overview of Medicare Home Health Benefits

OK, so starting with a brief overview of the Medicare home health benefits. On slide 6 per the Social Security Act. The Act itself defines the services covered under the Medicare home health benefit. They include skilled nursing care on a part-time or intermittent basis, home health aides on a part-time or intermittent basis, physical therapy, occupational therapy, speech-language pathology, medical social services.

And then turning to slide 7. Medicare home health services include routine and nonroutine medical supplies; durable medical equipment—although, DME is paid separate from the home health payment rates; and an osteoporosis drug, which is defined in the Act and is reimbursed on a reasonable cost basis as long as the patient meets certain criteria.

OK, moving to slide 8. Excluded from coverage — coverage under the home health benefit are drugs and biologicals, transportation, housekeeping services, and services that are otherwise covered under the End Stage Renal Disease program.

Patient Eligibility

OK, so moving on to the criteria that must be met for a patient to be considered eligible for Medicare home health services, we're on slide 10. So to be eligible for Medicare home health services, a patient must have Medicare Part A and/or Part B and be:

1. Confined to the home,
2. Need skilled services,
3. Be under the care of a physician,
4. Receive services under a plan of care established and reviewed by a physician, and
5. Have had a face-to-face encounter with a physician or allowed nonphysician practitioner, and

Care must be furnished by or under arrangements made by a Medicare participating home health agency.

So I just want to remind folks on the call that for item number 3, under the care of a physician, so this means that the physician doesn't just hand off the patient to the home health agency, but that the physician is actually acting as a supervisor of the patient's care, and is, therefore, ultimately responsible for the patient.

OK, so slide 11, confined to the home. That's the first item that I mentioned on slide 10, first of five criteria that must be met for patients to be considered eligible. Per the Social Security Act, an individual shall be considered confined to the home or homebound, which we use those terms interchangeably in this presentation, if the following two criteria are met:

- Criteria one, because of illness or injury, the patient must 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 the patient must have a condition such that leaving his or her home is medically contraindicated.

- Criteria two, both of the following conditions must be met. There must exist a normal inability for the patient to leave the home, and when the patient does leave the home, it must require a considerable and taxing effort.

OK, moving to slide 12. The patient may be considered homebound, that is confined to the home, if:

- absences from home are infrequent,
- for periods of relatively short duration,
- for the need to receive health care treatment,

- for religious services,
- to attend adult day care programs, or
- for other unique or infrequent events, such as a funeral, graduation, or trip to the barber

Slide 13 contains three examples of confined to the home:

- Example number one — a patient who is blind or senile and requires the assistance of another person in leaving their place of residence.

- Number two — a patient who has just returned from a hospital stay involving surgery who may be suffering from resultant weakness and pain and, therefore, their actions may be restricted by their physician to certain specified and limited activities, such as getting out of bed only for a specified period of time or walking stairs only once a day.

- Example number three — a patient with a psychiatric illness that is manifested in part by a refusal to leave home or is of such a nature that it would be — would not be considered safe for the patient to leave home unattended, even if they have no physical limitations.

Moving to slide 14 for the second criteria, the skilled service need. Once again, per the Social Security Act, the patient must be in need of one of the following: skilled nursing care on an intermittent basis, and intermittent is defined as furnished or needed on fewer than 7 days each week or less than 8 hours each day for periods of 21 days or less, with extensions in exceptional circumstances when the need for additional care is finite and predictable; or the patient needs physical therapy, speech-language pathology services; or continuing need for occupational therapy once they've received skilled nursing, PT, or speech-language pathology.

Moving to slide 15 for our third criteria to establish patient eligibility for the home health benefits, under the care of a physician. Once again per the Act, the patient must be under the care of a physician. For the Social Security Act and the Federal regulations, a physician is defined as a doctor of medicine, doctor of osteopathy, or doctor of podiatric medicine who may perform only plan-of-treatment functions that are consistent with the functions he or she is authorized to perform under State law. In addition, the physician must be enrolled as a Medicare provider.

Slide 16. Eligibility criteria number four, receiving services under a plan of care. Once again per the Social Security Act, the patient must receive home health services under a plan of care established and periodically reviewed by a physician. Per the regulations, a plan of care may not be established and reviewed by any physician who has a financial relationship with the home health agency. The physician cannot have a financial

relationship as defined in regulation unless the relation — physician's relationship meets one of the exceptions noted in the Social Security Act.

Certification Requirements

OK. So the next few slides will describe the requirements for certifying patient eligibility for Medicare home health services. This includes the recent changes finalized in the calendar year 2015 Home Health Prospective Payment System final rule and effective for episodes beginning on or after January 1, 2015.

Slide 18. As a condition for payment, the regulations require a physician to certify that a patient is eligible for Medicare home health services. The physician who establishes the home health plan of care must sign and date the certification. The Centers for Medicare & Medicaid Services, CMS, does not require a specific form or format for the certification as long as the five certification requirements, which are outlined in regulation and on slide 10, are met.

Slide 19. Per the regulations, physicians should complete the certification when the plan of care is established or as soon as possible thereafter. The certification must be complete prior to when the home health agency bills Medicare for reimbursement. And we noted in the final rule, it is not acceptable for home health agencies to wait until the end of a 60-day episode of care to obtain this completed certification.

Slide 20. In order for a certification of patient eligibility to be considered complete, the physician must certify that:

1. The patient needs intermittent skilled nursing care, physical therapy, and/or speech language pathology services;
2. The patient is confined to the home or homebound;
3. A plan of care has been established and will be periodically reviewed by a physician; and
4. Services will be furnished while the individual is under the care of a physician.

A physician was required to attest to these four requirements even prior to the inception of the face-to-face encounter requirements in January of 2011.

Slide 21 contains the fifth requirement, the certifying physician must certify that a face-to-face encounter occurred no more than 90 days prior to the home health start of care date, or within 30 days of the start of care date, was related to the primary reason the patient requires home health services, and was performed by a physician or allowed nonphysician practitioner.

The certifying physician must also document the date of the face-to-face encounter. A narrative describing the patient's homebound status and need for skilled care is no longer required for episodes beginning on or after January 1, 2015.

Slide 22. A face-to-face encounter can be performed by:

- The certifying physician,
- The physician who cares 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 a certifying physician or the acute/post-acute care physician.

Per the regulations, the face-to-face encounter cannot be performed by any physician or allowed NPP listed above who has a financial relationship with the home health agency.

Slide 23. Although CMS finalized the elimination of the face-to-face encounter narrative, effective January 1, 2015, a narrative is still required when the physician orders skilled nursing for management and evaluation of nonskilled care. If the narrative is part of a certification form, then the narrative must be located immediately prior to the physician's signature. If the narrative exists as an addendum to the certification form, in addition to the physician's signature on the new — on the certification form, the physician must sign immediately following the narrative in the addendum.

On slide 24 we just want to reiterate that for skilled nursing care to be considered reasonable and necessary for management and evaluation of the patient's plan of care, the complexity of the necessary unskilled services that are a necessary part of the medical treatment must require the involvement of a registered nurse to promote the patient's recovery and medical safety in view of the patient's overall condition. There is more information on skilled nursing for management and evaluation in Section 40.1.2.2 in Chapter 7, which is the home health chapter of the "Medicare Benefit Policy Manual."

And I am going to turn the call over, just for a moment, to Dr. Simpson, who is going to walk us through an example of management and evaluation.

Examples of Management and Evaluation

Dr. Crystal Simpson: On slide 25, here we have a skilled nursing for management and evaluation example. This example states that you have an aided patient with a history of diabetes mellitus and angina pectoris who is recovering from an open reduction of the neck of the femur. He requires, among other services, careful skin care, appropriate oral medications, a diabetic diet, a therapeutic exercise program to preserve muscle tone and body condition, and observation to notice signs of deterioration in his condition or complications resulting from his restricted, but increasing, mobility.

From a clinical perspective, one can say that this patient requires:

- Careful skin care — This can be taught to a nonskilled person. As you know, sometimes we tell our diabetics what to do when they are examining their feet.
- Appropriate oral medications — People take their medications every day, the oral ones, as you all are well aware.
- A diabetic diet — Many people follow a diabetic diet daily.
- Therapeutic exercise program to preserve muscle tone — A nonskilled person could be taught to perform this exercise program on his own. For example, after a person finishes a physical therapy program, the therapist can teach them what exercises to do to continue at home on their own.
- Observations for signs of deterioration — A nonskilled person can be taught to look for changes in his or her condition. We have seen where you can say to the patient, or it's written on a discharge summary, call if the temperature is greater than, we'll just use this example, 100.4.

Each of these can be a nonskilled service. However, it is the combination of all of these issues put together which can require the management of a skilled nurse. The key here is to remember, because each of these services are nonskilled services, the narrative is essential to describing why you require skilled personnel to aid in — aid the patient with these services.

And now, I will turn it back to you, Hillary, for slide 26.

Supporting Documentation for Certification Requirements

Hillary Loeffler: Thank you Dr. Simpson. As Randy mentioned in the beginning of the phone call today, we received correspondence and comments from the home health industry indicating that sufficient documentation that demonstrates the patient's eligibility for Medicare home health services can be found in the patient's medical record, and that a narrative is redundant.

While we finalize the elimination of the face-to-face encounter narrative in the calendar year 2015 Home Health Prospective Payment System final rule, we note that physician involvement is critical from both a patient quality of care and a program integrity perspective. Therefore, effective for episodes beginning on or after January 1, 2015, documentation and the certifying physician's medical records and/or the acute/post-acute care facility's medical records if the patient was directly admitted to home health, must demonstrate that the patient for whom eligibility has been certified is truly eligible for the Medicare home health services.

If the documentation used as the basis for the certification of eligibility is not sufficient to demonstrate that the patient is or was eligible to receive services under the Medicare home health benefit, payment will not be rendered for home health services provided.

Twenty-seven. Per the new regulations, and I'm just going to read this right here since it's new, it's 42 CFR 424.22(c), "Certifying physicians and acute/post-acute care facilities must provide, upon request, the medical record documentation that supports the certification of patient eligibility for the Medicare home health benefit to the home health agency, review entities, and/or CMS.

"Certifying physicians who show patterns of noncompliance with this requirement, including those physicians whose records are inadequate or incomplete for this purpose, may be subject to increased reviews, such as provider-specific probe reviews."

Slide 28. We note that information from the HHA can be incorporated into the certifying physician's and/or the acute/post-acute care facility's medical record for the patient. However, information from the HHA must be corroborated by other medical record entries and align with the time period in which services were rendered.

The certifying physician must review and sign off on anything incorporated into the patient's medical record that is used to support the certification of patient eligibility, that is, agree with the material by signing and dating the entry.

Slide 29. This slide contains five elements that will be looked — that we will look for in the supporting documentation. The certifying physicians and/or the acute/post-acute care facility's medical record for the patient must contain information that justifies the referral for Medicare home health services. This includes documentation that substantiates the patient's need for skilled services and homebound status.

The certifying physicians and/or the acute/post-acute care facility's medical record for the patient must contain the actual clinical note for the face-to-face encounter visit. And the actual clinical note must demonstrate that the encounter occurred within the required timeframe, was related to the primary reason the patient requires home health services, and was performed by an allowed provider type. This information can be found most often, but is not limited to, clinical and progress notes and discharge summaries.

So keeping these five elements in mind, I'm going to turn it over once again to Dr. Simpson, and she is going to walk us through four separate examples of what we would look for in supporting documentation.

Examples of Certification Supporting Documentation

Dr. Crystal Simpson: Yes, thank you Hillary. You should have received these four examples when you also received the presentation. And so now we're going to go through each of these examples. But the key as we're going through each of these examples is to remember the five things that the supporting documentation for certification — what you must have.

Number 1, the need for skilled services. Number 2, documentation that substantiates the patient's homebound status, a clinical note of the face-to-face encounter that demonstrates that the encounter, 3, occurred in the required timeframe. And when we say that, we mean that the date of the encounter occurred no more than 90 days before the start of home health care or within 30 days of the start of home health care.

Number 4, the note is related to the primary reason that the patient requires home health services. For example, if a patient requires home health services for physical therapy for left knee arthroplasty, but the note only talks about the patient's hypertension and congestive heart failure, then that would not be supportive of the patient requiring home health services.

Number 5, performed by an allowed provider type, that is a physician or allowed nonphysician practitioner, as was referenced previously on slide 22. And when we say that, we mean an NP or clinical nurse specialist working in collaboration with a certifying physician or a certified nurse midwife or physician's assistant under the supervision of the certifying physician or acute/post-acute care physician.

And now we will start with example 1, a discharge summary from the hospital. This summary meets the five criteria needed for supporting documentation for certification.

Number 1, skilled need. If you look at the section called Discharge Condition, and that is towards the bottom of the example 1 page of the AAA hospital discharge summary, and it's also circled by the large oval, you will see that the last two sentences of that section state, "PT is needed to restore the ability to walk without support. And short-term skilled nursing is needed to monitor for signs of decomposition or adverse events from the new Coumadin medical regimen."

Number 2, homebound status, within that same section, entitled Discharge Condition, the third sentence of that paragraph states, "The patient is temporarily homebound, secondary to status post, total knee replacement and currently walker dependent with painful ambulation."

Number 3, timeframe. At the top of the page on the right-hand side is the discharge date. In this case, we also have a box that states, "Date of the encounter," and it is 02/17/2014. As you are aware, the patient is seen on the date that he or she leaves the hospital by the clinician responsible for his or her care.

Number 4, the note is related to the primary reason for home care. The note, back if you look at the discharge condition section with the oval, states that the patient is receiving home care due to the knee replacement and the need to restore the ability to walk without support.

And lastly, number 5, performed by an allowed provider type. At the bottom of this page of this note on example 1, you can see on the left, lower hand side, you can see that the note was signed and dated by an allowed provider type, in this case, John Doe, M.D. Please note that sometimes a note is dictated but not signed yet by the provider type. We realize that sometimes the provider must correct the note after transcription and prior to signing. So to qualify as supporting documentation, the note must be signed and dated by the allowed provider type.

And now, we will move on to example number 2. This example is a progress or outpatient clinic note. Just to review, the supporting documentation requires five things.

- Number 1 — The need for skilled services,
- Number 2 — Documentation that substantiates the patient's homebound status,
- Number 3 — That the visit, the face-to-face encounter occurred in the required timeframe,
- Number 4 — The note is related to the primary reason that the patient requires home health services, and
- Number 5 — The note was performed by an allowed provider type, that is a physician or allowed nonphysician practitioner, as was referenced previously.

Number 1, skilled services. In the plan section of the note, which you could see at the bottom of example 2, it also is circled by an oval, you can see that the last sentence states short-term nursing is needed for wound care, monitor for signs of infection, and education on wound care for family to perform dressing changes.

Number 2, homebound status. Once again, in the plan section, the fourth sentence, it states, "The patient is now homebound due to minimal weight-bearing on left foot and restrictions on walking to promote wound healing. She is currently using a wheelchair." We would consider the wheelchair to be an assisted device.

Number 4 — number 3, timeframe. If you look at the upper right-hand corner, the date of the face-to-face encounter is 05/03/2013, and we have that by a smaller – circled by a smaller oval with the arrow pointing to the box, which states date of encounter.

Number 4, the note is related to the primary reason for home care. So now let's look back again at the plan section. The plan section of the note shows that the patient is to receive home care for her current wound care.

And number 5, lastly, allowed provider type. At the bottom of the note, on the left-hand side of the page, you can see that it is signed and dated by the allowed provider type, John Doe, M.D. You can see Dr. John Doe has a very busy practice.

Now we will move on to Example number 3, and this is a progress note and problem list. This example depicts how other parts of the physician record can be utilized as a part of the supporting documentation for certification.

Let's recap what is necessary to find in the supporting documentation to support certification. Please remember, we need to show five things.

- Number 1 — The need for skilled services,
- Number 2 — Documentation that substantiates the patient's homebound status,
- Number 3 — That the face-to-face encounter occurred in the required timeframe,
- Number 4 — The note is related to the primary reason that the patient requires home health services, and lastly
- Number 5 — That the face-to-face encounter was performed by an allowed provider type, that is a physician or allowed nonphysician practitioner, as was referenced previously.

This patient is one of my — is from one of my favorite TV shows, Buck Rogers. So let's see if Mr. Rogers' note contains the necessary supporting documentation.

Number 1, skilled need. If you look at the Plan section of Mr. Rogers's note, which is toward the bottom of the Example 3, Part 1 of 2, that's what it's titled at the top of the page. If you look to the bottom of that page, you'll see a large oval, and within that, you'll see Plan. And if you look at the Plan section of Mr. Rogers' note, once again, on the page titled, Example 3, Part 1 of 2, you can see that the last sentence states, "The patient requires a home health PT program for gait training and increasing muscle strength to restore the patient's ability to walk in his residence."

Number 2, homebound. In the HPI, History of Present Illness, the third sentence states, and that's at the top of the page underneath the chief complaint, the third sentence states that his caregiver is present with him for the visit. The seventh sentence within that same HPI, History of Present Illness, states that he used a wheelchair to move from the front of the office building to the exam room. However, we know from the Plan section that's at the bottom of this example that the patient's baseline is that he walks in his residence, so he is not wheelchair dependent.

It seems as if there does not appear to be anything in the note that definitively supports the fact that the patient is homebound based on the definition as defined by statute on slide 11 that was shared with you at the beginning of the presentation. Before we become too excited that the claim will be denied, let's see if the other requirements have been met.

Number 3, timeframe. The date of the encounter is in the upper right-hand corner of the note, we see that it is 09/01/2014. You can see it's circled by the smaller oval and it's connected by an arrow to the box entitled Date of the Encounter.

Number 4, the note is related to the primary reason for home care. The assessment and plan section at the bottom of this note, on the first page of Example 3, Part 1 of 2 shows that the patient has muscle weakness secondary to deconditioning due to pneumonia. And the home care would be for PT for gait training and increasing muscle strength.

Number 5, lastly, allowed provider type. In the lower left-hand corner of the note you can see that the note has been signed and dated by an allowed provider type, Jane Doe, M.D. It appears that everything except for homebound status was in the note. So everything except for homebound status was in the note. Please note except.

So are there other parts of the physician's records that could be utilized to support homebound status? Let's turn to, in this example we have a Part 2 of 2. This is a Problem List. On that Problem List, it states that the patient had blindness since 2002, and because of his blindness, he requires caregiver assistance in order to leave the home.

The key here is that the Problem List gives you an idea as to why the patient is homebound. It goes beyond stating the patient is blind but provides an idea of the extent of his blindness, because we know there are some people who are blind but are able to function independently, because he requires a caregiver for assistance in order to leave the home.

This is consistent with the definition of homebound on slide 11 and the example of homebound on slide 13. The two together — the Problem List as well as the doctor's note —meet all five criteria. The two had to come together to support — to act as supporting documentation for certification.

And now let's move on to our last example, which is number 4, Discharge Summary and Comprehensive Assessment. This example provides an idea as to how to bring together information from the physician's record with information from the home health agency's record. In this instance, it is two pages from the comprehensive assessment. We chose two paces — two pages from OASIS, which is part of the comprehensive assessment, as most, if not all of you from home health agencies, should be familiar with the OASIS.

We also did not want to make the file so large that you would still be downloading it throughout the presentation. So we limited it to these two pages from the OASIS, which is a component of the home health agency's comprehensive assessment.

However, before we go into the example, let's review the five things that we are looking for in the supporting documentation. Even though we are not in the same room, please feel free to say it with me, because I'm sure you've heard it from me a lot of times:

- Number 1 — The need for skilled services,
- Number 2 — Documentation that substantiates the patient's homebound status,
- Number 3 — The face-to-face encounter occurred in the required timeframe,
- Number 4 — The note is related to the primary reason that the patient requires home health services, and
- Number 5 — The note, the face-to-face encounter, has been performed by an allowed provider type.

For Example 4 — now we're going to come back to Example 4. You're looking at the one that's entitled Example 4, Part 1 of 2. We're moving down to the section entitled Discharge Condition. In the Discharge Condition section, the last two sentences state, "PT is needed to restore the ability to walk without support. Short-term skilled nursing is needed to monitor for sign of decomposition and teaching of Lovenox injection." We can see that this patient has a skilled need.

Number 2, homebound. In this example, you can see that under Procedures, the patient had a total left knee arthroplasty, and you know that the patient requires PT. Even though you could probably guess why the patient is homebound, it does not appear to be stated in this discharge summary. Before you become concerned that your claim will be denied, let's see if the other criteria for supporting documentation have been met.

Number 3, timeframe. We see the discharge date in the upper right-hand corner of 04/18/2014. You can see it, we've placed a circle — we changed from the oval, we made it a circle. And it's attached by arrow to the box that says, "Date of the Encounter."

Number 4, the note is related to the primary reason for home care. This note shows that the patient underwent, when you look at the section entitled Procedures, which is about a third of the way down the page, that the patient underwent left total knee arthroplasty. And we know from the note that we've talked about so far that he's supposed to receive PT to restore his ability to walk.

Number 5, lastly, an Allowed Provider Type. In the lower left-hand corner, we see that the note has been signed and dated be an allowed provider type. In this case, it is Sam Bone, M.D. It seems as if the note has everything except documentation of why the patient is homebound. It's hints at it, but it does not state it. As many of you in the health profession know, if you did not document it, then you did not do it. And the reviewer may be left with the question as to why doesn't this patient go to the outpatient therapy?

So let's turn to the home health agency excerpts from the comprehensive assessment. It is titled Example 4, Part 2 of 2. In this excerpt, you can see that it is part of the section of ADLs/IADLs, so activity to daily living and independent activities of daily living. And even though the patient has scored ones and twos on the check boxes, the most important part is the home health agency's clinician's written assessment. We really value what you as clinicians working for the home health agencies do every day. And we really do appreciate when you document what you are doing. That is quite helpful to us.

If you turn to the last comment on page 14, so the Example 4 Part 2 of 2 has two pages. The second page, we even put a number, page 14 on there for you. And you can see in the Comment section, the written comments, the second sentence of the written comment states, "The patient requires a wheeled walker and requires weekly queuing to remind him to not shuffle when he walks."

And what we really appreciate is how much more information we see from the comments. We can visualize this patient thanks to the wonderful comments written by this home health agency clinician.

This section from the home health agency, which has been incorporated into the physician's record, has been signed and dated by the patient's physician, Sam Bone, M.D. You see underneath the number, underneath page 14, you see that it's been signed and dated by certifying physician indicating review and incorporation into the patient's medical record.

The two together, the section from a comprehensive assessment done by the home health agency and the physician's discharge summary, corroborate each other. The two fit together.

The discharge summary states that PT is needed to restore the ability to walk without support. And the section from the home health agency's comprehensive assessment describes the supportive device, a wheeled walker. They both corroborate the patient's clinical needs and why the patient is homebound.

Hillary, I will now turn it back over to you.

Recertification Requirements

Hillary Loeffler: Thank you Dr. Simpson. So I am now on slide 32, recertification. At the end of the initial 60-day episode, a decision must be made as to whether or not to recertify the patient for a subsequent 60-day episode. Per the regulations, recertification is required at least every 60 days when there is a continuous home health care — need for continuous home health care after an initial 60-day episode and unless there is a patient-elected transfer, or a discharge with goals met and/or no expectation of a return to home health care.

So when the patient transfers or is discharged and readmitted, these situations trigger a new certification rather than a recert. A recertification is only appropriate for continuous home health care. Medicare does not limit the number of continuous episode recertifications for patients who continue to be eligible for the home health benefit.

Slide 33. Per the regulations, the recertification must be signed and dated by the physician who reviews the plan of care. It must indicate the continuing need for skilled services, and at this point, the need for occupational therapy may be the basis for continuing services that were initiated because the individual needed skilled nursing, physical therapy, or speech-language pathology services. The recertification must also estimate how much longer the skilled services will be required. And, of course, the patient must still be considered confined to the home. I want to point out that for recertification, a face-to-face encounter and documentation of that encounter is not required.

OK, slide 34. Just reiterates that for recertifications, just like certifications, if the physician is still ordering services for management and evaluation of unskilled care, a narrative is also required for recertifications. And very — the same requirements for certification apply here for recerts. The narrative must be located immediately prior to the physician's signature. If the narrative that exists as an addendum to the recertification form, in addition to the physician's signature on the recertification form, the physician must sign immediately following the narrative in the addendum.

OK, moving to slide 35. Physicians can bill for certifying and recertifying patient eligibility for Medicare home health services. These are G-codes that can be billed for works done when the patient is not present. G-code 0180 is for physician certification of a home health patient for Medicare-covered home health services. And G0179 is for recertifications.

OK, slide 36. Certifying and recertifying patient eligibility can include contacting the home health agency, reviewing reports of patient status required by physicians to affirm the implementation, and any adjustments to the plan of care that meets the patient's needs. And then I want to reiterate what we finalized in the calendar year 2015 Home Health Prospective Payment System final rule.

Physician claims for certification or recertification of eligibility are not considered to be for Medicare covered home health services if the home health agency claim itself was noncovered because cert or recert of eligibility was not complete or because there was insufficient documentation to support that the patient was eligible for the Medicare home health benefit.

So that means if a home health claim is denied, the physician claim as well is considered noncovered and subject to recoupment.

OK, and that brings us to our resources.

Resources

On slide 38, we list the website address for our Medicare Home Health Agency website. This is where you can find a lot of pertinent information about the home health benefit, and on that website is the link to that calendar year 2015 Home Health Prospective Payment System final rule. And then, below that is a link to the Home Health Prospective Payment System web page that just provides basic information about the prospective payment system itself.

On slide 39, we include a link to a publication that provides a brief overview of the Prospective Payment System and then below that, I note a link to chapter 6 of the "Medicare Program Integrity Manual."

And then on the next page, on slide 40 also contains a link to chapter 7 of the "Medicare Benefit Policy Manual." Both of those chapters, chapter 6 of the Program Integrity Manual and chapter 7 of the Benefit Policy Manual are currently being revised to reflect the changes in that calendar year 2015 Home Health Prospective Payment System final rule and should be out shortly.

Slide 40 also contains a link to chapter 10 of the Claims Processing Manual, and that's the home health chapter of the Claims Processing Manual. That will provide a lot more details that highlight how you submit a claim for reimbursement.

And then with that, I'm going to turn it over to Jill Nicolaisen. As Randy mentioned, she's the Director in our Office of Financial Management, responsible for medical review, and she's going to walk through about a dozen or so questions that we received from those that registered for the call.

Questions Submitted in Advance

Jill Nicolaisen: Thank you Hillary. Thanks everyone. The first question I'm going to go over is, Please clarify how the physician's records will be accessed by the MAC? Will the MAC request that the home health agency obtain the record or will it request information directly from the physician?

And the response is, as we stated in the calendar year 2015, Home Health PPS final rule, certifying physicians and/or acute/post-acute care facility should provide the documentation that substantiates the patient's eligibility to the home health agency upon request.

In turn, the home health agency must provide the documentation from the certifying physician and/or acute/post-acute care facility that substantiates the patient's eligibility for the Medicare home health benefit to CMS and/or its contractors upon request.

The next question, As of January 1st, 2015, will home health agencies have the option to either use the narrative in the certification of eligibility or must they rely solely on the physician's and/or acute/post-acute care facility's medical record?

And the response is, as we stated in the final rule, we are eliminating the face-to-face encounter narrative and regulation and it is no longer required as a condition for Medicare payments. It would be permissible for the home health agency to communicate with and provide information to the certifying physician about the patient's homebound status and need for skilled care. However, the certifying physician must review and sign off on anything incorporated into his or her medical record for the patient that is used to support his or her certification or recertification of patient eligibility for the home health benefit.

In addition, any information from the home health agency that is incorporated into a certifying physician's and/or the acute/post-acute care facility's medical record for the patient if the patient was directly admitted to home health and used to support to certification of patient's eligibility for the home health benefit must corroborate the certifying physician's and/or the acute/post-acute care facility's own documentation or medical record entry.

The next question received: The regulations state that the physicians' documentation and their own medical record must support the need for skilled home care and a homebound status. Is the home health agency required to have a copy of the physician's documentation prior to submitting a claim for reimbursement?

The response is that the home health agency is not required to have a copy or the physician's documentation prior to submitting a claim for reimbursement. However, because eligibility for home health services is established by the physicians in the patient's medical record, the home health agency may want to consider obtaining this documentation as early in the home health episode as possible to assure themselves that the Medicare home health patient eligibility criteria has been met.

While not a Medicare requirement, the home health agency may implement such a procedure as a sound business practice. As a reminder, the home health agency is required to provide documentation from the certifying physicians and/or acute or post-acute care facility that substantiates the patient's eligibility for the Medicare home health benefit to CMS and/or its contractors upon request.

The next question: If the home health agency provides information for the physician to consider, sign, and incorporate into their medical records, what corroborating documentation, would agencies need to submit with medical review?

We stated in the Final Rule that the corroborating information can be found most often in clinical and progress note and discharge summaries. We also said that the certifying

physician's and/or acute or post-acute care facility's medical record to the patient must contain the actual clinical note for the face-to-face encounter visit that demonstrates that the visit occurred within the required timeframe, was related to the primary reason the patient requires home health services, and was performed by an allowed provider type, as you've heard several times today.

We intend to provide additional guidance in our manuals about the corroborating documentation we would expect to see in the record in order to support patient eligibility. However, it is important to note that the information required in the certifying physician's medical record to support and corroborate documentation supplied by the HHA will be determined on an individual basis depending on the clinical scenario at hand for each case.

So our next question: How can the home health agency be expected to control what the physician puts in the record regarding the patient's need for home health?

As we previously stated, because eligibility for home health services is established by the physician in the patient's medical record, the home health agency may want to consider obtaining this documentation as early in the home health episode as possible. We understand that some challenges arise when the physician's documentation is relied upon to make coverage determinations of home health and other services and supplies. We plan on conducting outreach activities to physicians to educate them on the new home health certification requirements.

Certifying physicians who show patterns of noncompliance with providing sufficient documentation, including those physicians whose records are inadequate or incomplete for this purpose, may be subject to increased reviews such as provider-specific probe reviews.

We believe that these are important first steps to remind physicians that coordination and corroboration between the physician and the home health agency is essential in providing quality patient care.

Next question: How much detail will the home health agency be required to obtain from the physician to support medical necessity in homebound status?

The health agency should obtain as much documentation from the certifying physician's medical record and/or the acute/post-acute care facility's medical record if the patient was directly admitted to home health as they deem necessary to assure themselves that the Medicare home health patient eligibility requirements have been met.

The next question, I am not sure from the information issued so far whether or not a face-to-face encounter needs to be done with a recertification or just a certification.

As we stated in the final rule, the face-to-face encounter requirement is applicable for certifications, not recertifications, rather than initial episodes. A certification versus recertification is considered to be at any time that a start of care OASIS is completed to initiate care.

Our next question: If the brief face-to-face encounter narrative is no longer required and in parens (note that we are not talking about the narrative still required for the evaluation and management of unskilled complex care), how then should the medical necessity of the home health service be established?

The Medicare statute prohibits payment for any service that is not reasonable and necessary for the diagnosis or treatment of illness or injury. As such, it's always been a requirement that the home health services be medically necessary for treatment of the patient based on their clinical situation and the need for such services. Medicare medical reviewers will look at the entirety of the medical record, including the information created by the home health agency and the physicians to make a determination that the home health services rendered were reasonable and necessary for that particular patient.

The next question: If a physician is required to document the patient's homebound status, then why does the home health agency need to do this also? It seems very redundant, and if one contradicts the other, a problem is created as to who is right. Which homebound status are you going to use?

The answer is, per the Medicare conditions of participation in 42 CFR, 44.55, a registered nurse must conduct an initial assessment visit to determine the immediate care and support needs of the patient and for Medicare payment —patients, to determine eligibility for the Medicare home health benefit, including homebound status. The initial assessment visit must be held either within 48 hours of referral or within 48 hours of the patient's return to home or on a physician's ordered start of care date.

In addition, a comprehensive assessment must be completed no later than 5 calendar days after the start of care and include the determination of eligibility for the Medicare home health benefit, including the homebound status. If the two sources of information on homebound status do not agree with each other, if there's a conflict, then payment will not be rendered.

And the next question: It is — is it necessary to have a separate certification form signed by a physician or can the certification requirement be built into the plan of care or physician orders?

So as Hillary stated on slide 18 of the presentation, CMS does not require a specific form or format for the certification and/or the plan of care as long as the certification requirements and the plan of care requirements are otherwise met.

The next question, Is it required to have the face-to-face encounter physician visit note in the patient's chart of January 1, 2015, if the patient has been seen in the last 90 days for the primary reason for home care and that visit note does not contain a statement of homebound status? Does the patient have to be seen again or can this be documented in the physician's visit note?

So, as we stated in the final rule, the certifying physician's and/or acute/post-acute care facility's medical record for the patient must contain the actual clinical note for the face-to-face encounter visit. The documentation must demonstrate three things. That the visit:

1. Occurred within the required timeframe,
2. Was related to the primary reason the patient required home health services, and
3. Was performed by an allowed physician provider type.

A statement of homebound status is not a requirement for the face-to-face encounter clinical note, and as such, the patient does not need to be seen again. However, the certifying physician's and/or acute or post-acute care facility's medical record for the patient, including the information from the home health agency that is incorporated into the certifying physician's and/or acute or post-acute care facility's medical record to support the certification of patient eligibility for the health benefit must support eligibility for home health services. And again, this includes information supporting that a patient is homebound.

The next question: Many face-to-face encounters occur between the allowed nonphysician practitioner and the patient. These encounters are typically entered into the physician office documentation by the nurse practitioner or physician assistant. Will a cosignature of the certifying physician adequately meet the criteria for certification if the nurse practitioner or physician assistant has documented medical necessity and homebound status?

And the response is, the certifying physician does not need to cosign the clinical note from a face-to-face encounter performed by an allowed nonphysician practitioner. In order for the certification of eligibility to be considered complete, the certification requirement detailed in the presentation today must be complete, and the certification must be signed and dated by the certifying physician.

And then one final question: Why can't medical reviewers rely solely on the home health agency's medical record for the patient to substantiate eligibility as they have in the past?

So home health services have been under scrutiny by the Department of Health and Human Services, Office of the Inspector General, or OIG, and the Government Accountability Office, or GAO, recently and improper payments have increased in recent years. Concerns about home health services were discussed in a report issued by the GAO entitled, "Improvements Needed to Address Improper Payments in Home Health," which was GAO's report number 09-185. This report concluded, in part, that in the absence of greater prevention, detection, and enforcement effort, the Medicare home health benefits will continue to be a ready target for fraud and abuse.

Given the GAO report, recent reports of fraud and scrutiny of home health services by the OIG, and the ACA provision that mandates that — mandates that a face-to-face encounter must occur with the patient before the physician certifies the patient's eligibility for the home health benefit, we believe that relying on solely — solely on the home health agency's record to substantiate eligibility is no longer appropriate. And I will just add that the 2014, home health improper payment rate was 51.4 percent, which accounted for 19.1 percent of the overall Medicare fee-for-service improper payment rate. The projected improper payment amount for home health services during the 2014 report period was $9.4 billion dollars.

Also I will add that home health services are one of a number of Medicare benefits that rely on documentation from an ordering provider to support medical necessity without the entity who provides the service. I mean — I'm sorry, let me state that again. So home health services are one of a number of benefits that rely on documentation from an ordering facility — from an ordering provider to support medical necessity. And some other examples are laboratory services and durable medical equipment, prosthetics, orthotics, and supplies. In these cases, it's been our longstanding policy that records from providers with a financial interest in the claim outcome are not considered sufficient by themselves for the purpose of determining that the item or service is reasonable and necessary.

Section 1814A, 1835A, and 1877 of the Social Security Act require a physician who does not have a financial relationship with the home health agency to certify that the patient's eligibility for home health services agreement. And with that, that's the conclusion of the prepared Qs&As, and I will turn this back to Charlie.

Keypad Polling

Charlie Eleftheriou: Thank you. We did go a little bit overtime. But before we jump into live Q&A, we're going to have to pause for a moment to complete keypad polling so that CMS has an accurate count of the number of participants on the line with us today.

Please note that there will be a moment of silence on the line while we tabulate the results. And we're now ready to start polling.

Operator: CMS appreciates that you minimize the Government's teleconference expense by listening to these calls together using one phone line. At this time, please use your telephone keypad and enter the number of participants that are currently listening in. If you are the only person in the room, enter 1. If there are between two and eight of you listening in, enter the corresponding number. If there are nine or more of you in the room, enter 9.

Once again, if you are the only person in the room, enter 1. If there are between two and eight of you listening in, enter the corresponding number. If there are nine or more of you in the room, enter 9. Please hold while we complete the polling. Please hold while we complete the polling. Please continue to hold while we complete the polling.

Thank you for your participation. I'd now like to turn the call back over to Charlie.

Question-and-Answer Session

Charlie Eleftheriou: Thank you. And now our subject matter experts here will take as many questions as we can in the remaining time. Because the call is being recorded and transcribed, please state your name and the name of your organization before asking your question. And in an effort to hear from as many callers as possible and time, we do have — we ask that you limit yourself to one question at a time. If you have more than one question, please press star 1 after your first question was answered to get back in the queue, and we'll address additional questions if time permits. And now we're ready to take our first question.

Operator: To ask a question, press star followed by the number 1 on your touchtone phone. To remove yourself from the queue, please press the pound key. Remember to pick up your handset before asking your question to assure clarity. Please note your line will remain open during the time that you are asking your question so anything that you say or any background noise will be heard in the conference. Please hold while we compile the Q&A roster.

The first question comes from Pamela Hall. Pamela, your line is open.

Pamela Hall: Can you hear me?

Charlie Eleftheriou: We certainly can.

Pamela Hall: Keeping with the thought of including the homebound status and the descriptors of medical necessity that corroborates what the clinician has seen on the admission assessment in a summary, and including that on the plan of care, would that

be acceptable? And would it require the physician to actually sign right below that summary, or would one signature on the entire plan of care be adequate?

Randy Throndset: This is Randy Throndset, I'll address the signature requirements. I mean, again, Hillary — as Hillary pointed out several times during the presentation, we don't have any format requirements. So whether or not the plan of care is combined with the certification or not, we're not — we're not really pinning anybody into a specific format for that. So whatever — whatever works for your business in so far as whether it's a combined document or whether you have separate documents and, therefore, need a signature for each of the plan of care and the certification, it all depends on how you have that set up.

In so far as wanting to know if the plan of care can be used to — if I understood the question right, the question is whether or not the plan of care can be used to corroborate with what the physician has in his or her medical record, if that's going to be enough. Again, this really goes to the content. So — if the — if the documentation from the physician or from the facility is lacking, like Dr. Simpson gave some examples to where there were some gaps, if you will, in what was there. But when you looked at the information that came from the home health agency, if that fit with what the physician or facility was providing and it provided that additional documentation that was necessary to substantiate the eligibility, then, yes.

I won't say as a matter of fact that just by attaching or getting the physician to incorporate the plan of care into his or her medical records, that that's necessarily going to have the information that's going to be needed to substantiate that. Again, it all goes to the content and whether the two together are going to substantiate the eligibility.

Charlie Eleftheriou: And we'll take our next question.

Operator: Your next question comes from Carolyn Buffington. Carolyn, your line is open.

Carolyn Buffington: Yes, I was wondering, currently, we have a form that is a face-to-face form that's required to come back with a narrative from the physician and a plan of care certification that's required to come back signed by the physician. Can — do you totally do away with the face-to-face document as long as the collaborating documentation is either on a plan of care or some other document?

Hillary Loeffler: Hi, this is Hillary Loeffler. So the data — the encounter still has to be documented as part of the cert. So as long as the certification contains all of the elements that I went through in my presentation and also indicates the date that the encounter occurred, there doesn't need to be a narrative anymore. So if you can include that all on one plan of care form or one certification form, we don't necessarily need a separate face-to-face document.

Carolyn Buffington: All right, great. So you could act — the home health agency could actually document the encounter date by the physician and anything that – whether it's homebound, any of that, and have him just sign the plan of care certification, and that would meet the requirement.

Hillary Loeffler: That wouldn't meet the requirements for medical review — review of whether the patient was truly eligible for the benefit. Now remember, there still needs to be medical record entries that are reviewed that are done by the physician or the acute/post-acute care facility that substantiate that his attestation of the patient's eligibility for the benefit is really justified based on his medical record entries.

Carolyn Buffington: All right, great.

Hillary Loeffler: Yes, so nothing from the home health agency can stand by itself. It still has to be collaborated.

Dr. Crystal Simpson: Yes, it has to collaborate with the physician's documentation.

Carolyn Buffington: Thank you so much.

Hillary Loeffler: Um-hum.

Operator: Your next question comes from Tanya Anderson. Tanya, your line is open.

Tanya Anderson: Hi, I have a question in reference to Example 3, Part 1 of 1.

Dr. Crystal Simpson: Yes.

Tanya Anderson: She said that the progress note would not stand on its own as meeting all five requirements because there — because there was no homebound status in there. In the H&P section, the first section, it indicates the patient is using a wheelchair now. The plan section that she referenced, she said it says he could ambulate at home, but that says that that was prior to his hospitalization, and this visit was 2 weeks after his hospitalization. So I'm wondering, it does show that he is now wheelchair bound where before he was not. So why does that not qualify?

Dr. Crystal Simpson: OK, great question. And I think in the history of present illness we made a point of saying he used a wheelchair to move from the front of the office building to the exam room. What we did not say was how he made it from the car to the doctor's office building itself. And so, it's just indicating that he basically made it to the front door, but then needed assistance in a wheelchair to the exam room. And so that means that he is able to move — or he was able to move around just a little bit, enough to make it there.

And so, I think that you make a great point, but you also are showing the ambiguity from it because the note only states that he needed it to move from the front of the office to the exam room. And so you're pointing out what a medical reviewer may actually see, and so that's why that note hoped to collaborate why the patient was truly homebound.

Next question.

Operator: Your next question comes from Sarina Nicola. Sarina, your line is open.

Charlie Eleftheriou: Can we move on to the next caller, please?

Operator: Your next question comes from Kim Hall.

Kim Hall: Yes, hello. I'm calling from Advanced Home Care in High Point, North Carolina. My question is this, I understand that the National Association of Home and Hospice Care and the VNAA have requested a delay on the implementation of the new face-to-face requirements because of all the operational difficulties this is going to be posing to the home health agency. I just wondered if there would be a delay.

Randy Throndset: This is Randy Throndset. We've received that letter from NAHHC and one from the VNAA, and senior management is looking at it and we're formulating a response. I can't tell you today that a delay has been approved because one has not. But we have received the letter and we received similar sorts of questions and so forth, and officials are looking at that and will be communicating on that aspect in the near future.

Kim Hall: Thank you.

Randy Throndset: Yes.

Operator: Your next question comes from Terry Sweeny.

Terry Sweeny: Yes, can you hear me?

Charlie Eleftheriou: We can.

Terry Sweeny: OK, great. I've got a question regarding face-to-face and a possible cosignatory needed, because I've got some — there's been some discrepancy on your — the July MLN Network education and what you said today. So in a situation where a face-to-face is completed by a hospital, the hospitalist, an acute care facility, provided to the home health agency, it meets all the criteria, we are under the impression, based on the July education, that the certifying physician must cosign that document in order for it to be valid, is that correct or not?

Hillary Loeffler: So the hospitalist did the face-to-face encounter, but is not certifying, they're handed off to the community doc, who will be the certifying physician?

Terry Sweeny: Correct.

Hillary Loeffler: OK. Yes, so the July MLN was prior to the final rule being issued, so that is currently accurate for periods of care where the episode was initiated before January 1, 2015. So after January 1, 2015, that issue kind of goes away. So the certifying physician is basically just going to attest to the things that we have in our presentation and that we'll be looking for the actual clinical note instead. And that does not need to be cosigned, it stands on its own.

Terry Sweeny: So, that's great news. Thank you. So if our record has the face-to-face valid from the hospitalist, we share that with the certifying physician, it's their responsibility to keep it in their records, and we would be good.

Hillary Loeffler: Yes, absolutely, as long as they made all the certification requirements.

Terry Sweeney: Right, thank you.

Hillary Loeffler: Um-hum.

Operator: Your next question comes from Shelly Bernardini.

Shelly Bernardini: Hi, this is Shelly Bernardini with National Government Services. I have a question about the CMS Form 485, and I have continued to see it used out in the communities. And I'm wondering going forward if you're anticipating the continued use of the Form 485 and the home health agencies filling that out and having the referring physician or the community physician sign off on it. This is the way that it's been done and continues to be done, and I'm just wondering what's your take is on that form being used continually.

Randy Throndset: This is Randy Throndset. As you pointed out, it's not an official CMS form.

Shelly Bernardini: Thank you.

Randy Throndset: We don't — we do not have any immediate plans to resurrect the form. As you see in our regulations, we concentrate on the content requirements of the plan of care. So we're more concerned with it meeting all the content requirements in the regulation. So as long as it — as long as a plan of care has all those content requirements, we're fine with it be on a 485 or another form or form that combines the cert and the plan of care. It just — we have certification requirements, we have plan of care requirements, and that's where our focus is.

Shelly Bernardini: And that' what — that's what my question was because that Form 485 doesn't have all — does not meet all of those requirements. So, thank you.

Randy Throndset: You're welcome.

Charlie Eleftheriou: And I think we'll have time for one more question.

Operator: And the final question comes from Lori Ellison. Lori, your line is open.

Lori Ellison: Hi, just to clarify, when you just said that — or the caller calling — that was just calling in said that the 485 does not meet both the plan of care and the certification requirements. Are we still talking about two specific documents or can the 485 be modified to meet the certification requirements?

Randy Throndset: This is Randy Throndset. Again, we do not have, we as in CMS, we do not have a CMS 485. That requirement ended some time ago. So if agencies are using an older version of the 485 and they have made whatever changes they needed to make to it to meet the current content requirements, that's fine.

I'm not going to attest to whether or not a version of the 485 that a provider might be using meets all the requirements. I mean providers are responsible for knowing what the content requirements are. And if they're using an old – a version of the 485 that they've updated that has all the content requirements, they're good to go. Otherwise the obvious would be is that, if they're using a version that, for whatever reason, doesn't have all the content requirements, they would — they would not be meeting the content requirement that we've outlined in regulation.

Lori Ellison: Right. And in followup to that, if you do have the corroborating information from the physician included in the plan of care, can you obtain this information via the phone, or do you have to have actual copies of the physician's corroborating information in the home health agency record?

Jill Nicolaisen: So the answer is that you would have to have the actual copies of the physician's medical records to corroborate with the information that was on the form.

Hillary Loeffler: Yes, and this is Hillary and I'll note that the final regulations specified that the actual encounter note is needed as well and will be reviewed.

Lori Ellison: OK, thank you.

Hillary Loeffler: Um-hum.

Additional Information

Charlie Eleftheriou: You're welcome. And unfortunately, that's all the time we have for questions today. If we did not — I'm sorry, if you do have additional questions, I'm going to repeat that email address where you can send your question, and it's homehealth— which is again one word—homehealth_hospice_dmeodf-l@cms.hhs.gov.

On slide 42 of the presentation today, you'll find information on how to evaluate your experience with today's call. Evaluations are anonymous, confidential, and voluntary. And we hope you'll take a few moments to evaluate your experience. And again, my name is Charlie Eleftheriou. I'd like to thank the subject matter experts and the participants who joined us today. And have happy holidays.

Operator: This concludes today's call. Presenters please hold.

-END-