

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-08 Medicare Program Integrity	Centers for Medicare & Medicaid Services (CMS)
Transmittal 704	Date: March 17, 2017
	Change Request 10006

SUBJECT: Home Health (HH) Language in Pub. 100-8

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to provide clarification to the existing HH language in chapter 6 of Pub 100-8.

EFFECTIVE DATE: April 17, 2017

**Unless otherwise specified, the effective date is the date of service.*

IMPLEMENTATION DATE: April 17, 2017

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)

R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	6/6.2/6.2.1.1/Certification Requirements
R	6/6.2/6.2.3/The Use of the Patient's Medical Record Documentation to Support Home Health Certification

III. FUNDING:

For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

**Business Requirements
Manual Instruction**

Attachment - Business Requirements

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I. GENERAL INFORMATION

A. Background: The Centers for Medicare & Medicaid Services (CMS) is providing additional clarifying language to the existing HH language in chapter 6 of Pub. 100-08. On November 6, 2014, CMS issued CMS-1611-F, Calendar Year 2015 Home Health Prospective Payment System (HH PPS) Final Rule. The final rule eliminates the requirement of a face-to-face encounter narrative as part of the certification of patient eligibility for HH services. In determining whether a patient is eligible to receive services under the Medicare HH benefit at the start of care, documentation in 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) is to be used as the basis for certification of HH eligibility. The certifying physician can incorporate information obtained from or generated by the HH agency (HHA) into his or her medical record, to support the patient's homebound status and need for skilled care, by including it in his or her documentation and signing and dating to demonstrate review and concurrence. The physician's/acute/post-acute care facility's record, in conjunction with appropriately incorporated HHA documentation should substantiate the certification of eligibility for home health services.

B. Policy: This CR does not contain any legislative or regulatory policies.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
10006.1	The Medicare Administrative Contractor (MAC) shall determine whether home health certification requirements are met in accordance with the clarified language provided.			X						
10006.2	The MAC shall use the patient's medical record documentation to support the home health certification in accordance with the clarified language provided.			X						

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	None					

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information:

V. CONTACTS

Pre-Implementation Contact(s): Heather Wetherson, heather.wetherson@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 0

6.2.1.1 – Certification Requirements

(Rev. 704, Issued: 03-17-17, Effective: 04-17-17, Implementation: 04-17-17)

When conducting a medical necessity review, the review contractor shall determine whether the supporting documentation addresses each of the following criteria for which a physician certified (attested to):

1. **Homebound.** Home health services are or were required because the individual is or was confined to the home *per the criteria below* (as defined in sections 1835(a) and 1814(a) of the Social Security Act).

a. Criteria-One:

The patient must--

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

b. Criteria-Two:

- *There must exist a normal inability to leave home;*

AND

- *Leaving home must require a considerable and taxing effort.*

In determining whether the patient meets criterion two of the homebound definition, the clinician needs to take into account the illness or injury for which the patient met criterion one and consider the illness or injury in the context of the patient's overall condition. The clinician is not required to include standardized phrases reflecting the patient's condition (e.g., repeating the words "taxing effort to leave the home") in the patient's chart, nor are such phrases sufficient, by themselves, to demonstrate that criterion two has been met. For example, longitudinal clinical information about the patient's health status is typically needed to sufficiently demonstrate a normal inability to leave the home and that leaving home requires a considerable and taxing effort. Such clinical information about the patient's overall health status may include, but is not limited to, such factors as the patient's diagnosis, duration of the patient's condition, clinical course (worsening or improvement), prognosis, nature and extent of functional limitations, other therapeutic interventions and results, etc.

2. **Skilled Care.** The patient needs or needed intermittent **skilled** nursing care (other than solely venipuncture for the purposes of obtaining a blood sample), physical therapy, and/or speech language pathology services as defined in 42 CFR 409.42(c).

NOTE: Where a patient's sole skilled service need is for skilled oversight of unskilled services (management and evaluation of the care plan as defined in 42 CFR 409.42(c)), the physician must include a brief narrative describing the clinical justification of this need as part of the certification, or as a signed addendum to the certification. The physician must sign immediately following the narrative.

3. **Plan of Care.** A plan for furnishing the services has been established and is, or will be, periodically reviewed by a physician who is a doctor of medicine, osteopathy, or podiatric medicine (a doctor of podiatric medicine may perform only plan of treatment functions that are consistent with the functions he or she is authorized to perform under state law). If the physician's orders for home health services meet the requirements specified in 42 CFR 409.43 Plan of Care Requirements, this meets the requirement for establishing a plan of care as part of the certification of patient eligibility for the Medicare home health benefit.
4. **Under Physician Care.** Home health services will be or were furnished while the individual is or was under the care of a physician who is a doctor of medicine, osteopathy, or podiatric medicine.
5. **Face-to-Face Encounter.** A face-to-face patient encounter occurred no more than 90 days prior to the home health start of care date or within 30 days after the start of the home health care, was related to the primary reason the patient requires home health services, and was performed by an allowed provider type defined in 42 CFR 424.22(a)(1)(v). The certifying physician must also document the date of the encounter as part of the certification.

While the face-to-face encounter must be related to the primary reason for home health services, the patient's skilled need and homebound status can be substantiated through an examination of all submitted medical record documentation from the certifying physician, acute/post-acute care facility, and/or HHA (see below). The synthesis of progress notes, diagnostic findings, medications, nursing notes, etc., help to create a longitudinal clinical picture of the patient's health status.

6.2.3 – The Use of the Patient's Medical Record Documentation to Support the Home Health Certification

(Rev. 704, Issued: 03-17-17, Effective: 04-17-17, Implementation: 04-17-17)

As mentioned in section 6.2.1.1 – Certification Requirements, for home health services to be covered by Medicare, the certifying physician's and/or the acute/post-acute care facility's medical record for the patient must contain sufficient documentation of the patient's medical condition(s) to substantiate eligibility for home health services. The information may include, but is not limited to, such factors as the patient's diagnosis, duration of the patient's condition, clinical course (worsening or improvement), prognosis, nature and extent of functional limitations, other therapeutic interventions and results, etc.

The physicians'/acute/post-acute care facility's medical records can always stand alone in substantiating eligibility for home health services. The physician's/acute/post-acute care facility's record, in conjunction with appropriately incorporated HHA documentation (e.g., Form 485/Plan of Care, OASIS, etc.), may also substantiate the certification of eligibility for home health services. The HHA's generated medical record documentation for the patient, by itself, is not sufficient in demonstrating the patient's eligibility for Medicare home health services.

As noted earlier, per 42CFR424.22 (a) and (c) it is the patient's medical record held by the certifying physician and/or the acute/post-acute care facility that must support the patient's eligibility for home health services. Therefore, any documentation used to support certification that was generated by the home health agency must be signed off by the certifying physician and incorporated into the medical record held by the physician or the acute/post-acute care facility's medical record. **Any information provided to the certifying physician by the HHA and incorporated into the patient's medical record held by the physician or the acute/post-acute care facility's medical record (if the patient was directly admitted to home health) must corroborate the rest of the patient's medical record.** *This means that the HHA information, along with the certifying physician's and/or the acute/post-acute care facility's medical record, creates a clinically consistent picture that the patient is eligible for Medicare home health services.* This could include, but is not limited to, *the plan of care required per 42 CFR 409.43, the initial and/or the comprehensive assessment of the patient required per 42 CFR 484.55, the inpatient discharge summary or*

multi-disciplinary clinical notes, etc., which must correspond to the dates of service being billed and not contradict the certifying physician's and/or the acute/post-acute care facility's own documentation or medical record entries. *Once incorporated into the certifying physician's medical record for the patient, the HHA information can be used to support the patient's homebound status and need for skilled care*, the reviewer shall consider all documentation from the HHA that has been signed off in a timely manner and incorporated into the physician/hospital record when making its coverage determination. HHA documentation that is used to support the home health certification is considered to be incorporated timely when it is signed off prior to or at the time of claim submission. **See section 6.2.6 Examples of Sufficient Documentation Incorporated into a Physician's Medical Record.**

It is important to apply the review process to the entire patient's medical record that is received by the reviewer. Doing so assures that the reviewer is establishing that the HHA generated medical record documentation corroborates other patient medical records received and used to support the patient's eligibility for home health services. Therefore, the HHA generated documentation does not necessarily need to restate pertinent facts or conditions, but instead the HHA generated medical records for the patient should be in alignment with *and not contradict* other patient records. The HHA generated medical record for the patient together with other medical records received must lead the reviewer to confirm that the patient is eligible for home health services as established in 42 CFR 424.22(a)(1).