

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-02 Medicare Benefit Policy	Centers for Medicare & Medicaid Services (CMS)
Transmittal 208	Date: April 22, 2015
	Change Request 9119

Transmittal 207, dated April 10, 2015, is being rescinded and replaced by Transmittal 208 to revise the effective date of the change. All other information remains the same.

SUBJECT: Manual Updates to Clarify Requirements for Physician Certification and Recertification of Patient Eligibility for Home Health Services

I. SUMMARY OF CHANGES: This Change Request manualizes policies discussed in the CY 2015 HH PPS Final Rule published on November 6, 2014. These policies relate to the requirements for physician certification and recertification of patient eligibility for Medicare home health services. This Change Request also updates the timeframe required for therapy functional reassessments and makes various editorial changes throughout chapter 7.

EFFECTIVE DATE: January 1, 2015

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

IMPLEMENTATION DATE: May 11, 2015

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

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	7/Table of Contents
R	7/10/Home Health Prospective Payment System (HH PPS)
R	7/10.1/National 60-Day Episode Rate
R	7/10.2/Adjustments to the 60-Day Episode Rates
R	7/10.4/Counting 60-Day Episodes
R	7/10.5/Split Percentage Payment Approach to the 60-Day Episode
R	7/10.7/Low Utilization Payment Adjustment (LUPA)
R	7/10.8/Partial Episode Payment (PEP) Adjustment
R	7/10.10/Discharge Issues
R	7/10.11/Consolidated Billing

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	7/20.1.2/Determination of Coverage
R	7/20.2/Impact of Other Available Caregivers and Other Available Coverage on Medicare Coverage of Home Health Services
R	7/30.1.1/Patient Confined to the Home
R	7/30.1.2/Patient's Place of Residence
R	7/30.2.1/Content of the Plan of Care
R	7/30.2.5/Use of Oral (Verbal) Orders
R	7/30.3/Under the Care of a Physician
R	7/30.5/Physician Certification and Recertification of Patient Eligibility for Medicare Home Health Services
R	7/30.5.1/Physician Certification
R	7/30.5.1.1/Face-to-Face Encounter
N	7/30.5.1.2/Supporting Documentation Requirements
R	7/30.5.2/Physician Recertification
R	7/30.5.3/Who May Sign the Certification or Recertification
N	7/30.5.4/Physician Billing for Certification and Recertification
R	7/40.1.2.15/Psychiatric Evaluation, Therapy, and Teaching
R	7/40.1.3/Intermittent Skilled Nursing Care
R	7/40.2.1/General Principles Governing Reasonable and Necessary Physical Therapy, Speech-Language Pathology Services, and Occupational Therapy
R	7/50.7.1/Impact on Care Provided in Excess of "Intermittent" or "Part-Time" Care
R	7/70.2/Counting Visits Under the Hospital and Medical Plans
R	7/80.5/Services Covered Under the End Stage Renal Disease (ESRD) Program
R	7/90/Medical and Other Health Services Furnished by Home Health Agencies
R	7/100/Physician Certification for Medical and Other Health Services Furnished by Home Health Agency (HHA)

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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EFFECTIVE DATE: January 1, 2015

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IMPLEMENTATION DATE: May 11, 2015

I. GENERAL INFORMATION

A. Background: In the calendar year (CY) 2015 Home Health Prospective Payment System (HH PPS) final rule, CMS finalized clarifications and revisions to policies regarding physician certification and recertification of patient eligibility for Medicare home health services. In the final rule, CMS also finalized revisions to the timeframe required for therapy functional reassessments.

B. Policy: Face-to-face Encounter Requirements

The Affordable Care Act requires that the certifying physician or allowed non-physician provider (NPP) must have a face-to-face encounter with the beneficiary before they certify the beneficiary's eligibility for the home health benefit. Regulations require that the encounter occur within 90 days before care begins or up to 30 days after care began. Previous regulations required that documentation of the encounter must include a narrative to explain why the clinical findings of the encounter support that the patient is homebound and in need of skilled services.

CMS has implemented three changes to the face-to-face encounter requirements for episodes beginning on or after January 1, 2015. These changes reduce administrative burden and provide home health agencies with additional flexibilities in developing individual agency procedures for obtaining documentation supporting patient eligibility for Medicare home health care.

First, CMS has eliminated the narrative requirement. The certifying physician is still required to certify that a face-to-face patient encounter occurred and document the date of the encounter as part of the certification of eligibility. For medical review purposes, CMS requires 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) to be used as the basis for certification of patient eligibility.

Second, if an HHA claim is denied, the corresponding physician claim for certifying/re-certifying patient eligibility for Medicare-covered home health services is considered non-covered as well because there is no longer a corresponding claim for Medicare-covered home health services.

Lastly, CMS clarified that a face-to-face encounter is required for certifications, rather than initial episodes; and that a certification (versus a re-certification) is generally considered to be any time a new start of care assessment is completed to initiate care.

Therapy reassessments

CMS has eliminated the 13th and 19th visit therapy reassessment requirements. For episodes beginning on or after January 1, 2015; at least every 30 calendar days a qualified therapist (instead of an assistant) must provide the needed therapy service and functionally reassess the patient. This policy change lessens home health agencies' burden of counting visits. This change also reduces the risk of non-covered visits so that therapists can focus more on providing quality care for their patients, while still promoting therapist involvement and quality treatment for all beneficiaries regardless of the level of therapy provided.

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility									
		A/B MAC			D M E M A C	Shared- System Maintainers				Other	
		A	B	H H H		F I S S	M C S	V M S	C W F		
9119 - 02.1	Medicare contractors shall be aware of the revisions to the requirements for physician certification and recertification of patient eligibility for Medicare home health services. Medicare contractors shall also be aware of the revised timeframe for therapy functional reassessments.	X	X	X							

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility					
		A/B MAC			D M E M A C	C E D I	
		A	B	H H H			
9119 - 02.2	MLN Article: A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web sites and include information about it in a listserv message within 5 business days after receipt of the notification from CMS announcing the availability of the article. In addition, the provider education article shall be included in the contractor's next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X	X	X			

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:
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Section B: All other recommendations and supporting information:

V. CONTACTS

Pre-Implementation Contact(s): Hillary Loeffler, 410-786-0456 or hillary.loeffler@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

Medicare Benefit Policy Manual

Chapter 7 - Home Health Services

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10 - Home Health Prospective Payment System (*HH PPS*)

(Rev. 208, Issued: 04-22-15, Effective: 01-01-15, Implementation: 05-11-15)

The unit of payment under *the HH PPS* is a national 60-day episode rate with applicable adjustments. The episodes, rate, and adjustments to the rates are detailed in the following sections.

10.1 - National 60-Day Episode Rate

(Rev. 208, Issued: 04-22-15, Effective: 01-01-15, Implementation: 05-11-15)

A. Services Included

The law requires the 60-day episode to include all covered home health services, including medical supplies, paid on a reasonable cost basis. That means the 60-day episode rate includes costs for the six home health disciplines and the costs for routine and nonroutine medical supplies. The six home health disciplines included in the 60-day episode rate are:

1. Skilled nursing services
2. Home health aide services;
3. Physical therapy;
4. Speech-language pathology services;
5. Occupational therapy services; and
6. Medical social services.

The 60-day episode rate also includes amounts for nonroutine medical supplies and therapies that could have been unbundled to Part B prior to *HH PPS*. (See [§10.11.C](#) for those services.)

B. Excluded Services

The law specifically excludes durable medical equipment (*DME*) from the 60-day episode rate and consolidated billing requirements. *DME* continues to be paid on the fee schedule outside of the *HH PPS* rate.

The osteoporosis drug (injectable calcitonin), which is covered where a woman is postmenopausal and has a bone fracture. This drug is also excluded from the 60-day episode rate but must be billed by the home health agency (HHA) while a patient is under a home health plan of care since the law requires consolidated billing of osteoporosis drugs. The osteoporosis drug continues to be paid on a reasonable cost basis.

10.2 - Adjustments to the 60-Day Episode Rates

(Rev. 208, Issued: 04-22-15, Effective: 01-01-15, Implementation: 05-11-15)

A. Case-Mix Adjustment

A case-mix methodology adjusts payment rates based on characteristics of the patient and his/her corresponding resource needs (e.g., diagnosis, clinical factors, functional factors, service needs). The 60-day episode rates are adjusted by case-mix methodology based on data elements from the *Outcome and Assessment Information Set (OASIS)*. The data elements of the case-mix adjustment methodology are organized into three dimensions to capture clinical severity factors, functional severity factors, and service utilization factors influencing case mix.

In the clinical, functional, and service utilization dimensions, each data element is assigned a score value. The scores are summed to determine the patient's case-mix group.

B. Labor Adjustments

The labor portion of the 60-day episode rates is adjusted to reflect the wage index based on the site of service of the beneficiary. The beneficiary's location is the determining factor for the labor adjustment. The *HH* PPS rates are adjusted by the pre-floor and pre-reclassified hospital wage index. The hospital wage index is adjusted to account for the geographic reclassification of hospitals in accordance with §§1886(d)(8)(B) and 1886(d)(10) of the Social Security Act (the Act.) According to the law, geographic reclassification only applies to hospitals. Additionally, the hospital wage index has specific floors that are required by law. Because these reclassifications and floors do not apply to HHAs, the home health rates are adjusted by the pre-floor and pre-reclassified hospital wage index.

NOTE: The pre-floor and pre-reclassified hospital wage index varies slightly from the numbers published in the Medicare inpatient hospital PPS regulation that reflects the floor and reclassification adjustments. The wage indices published in the home health final rule and subsequent annual updates reflect the most recent available pre-floor and pre-reclassified hospital wage index available at the time of publication.

10.4 - Counting 60-Day Episodes

(Rev. 208, Issued: 04-22-15, Effective: 01-01-15, Implementation: 05-11-15)

A. Initial Episodes

The "From" date for the initial certification must match the start of care (SOC) date, which is the first billable visit date for the 60-day episode. The "To" date is up to and including the last day of the episode which is not the first day of the subsequent episode. The "To" date can be up to, but never exceed a total of 60 days that includes the SOC date plus 59 days.

B. Subsequent Episodes

If a patient continues to be eligible for the home health benefit, the *HH* PPS permits continuous episode recertifications. At the end of the 60-day episode, a decision must be made whether or not to recertify the patient for a subsequent 60-day episode. An eligible beneficiary who qualifies for a subsequent 60-day episode would start the subsequent 60-day episode on day 61. The "From" date for the first subsequent episode is day 61 up to including day 120. The "To" date for the subsequent episode in this example can be up to, but never exceed a total of 60 days that includes day 61 plus 59 days.

NOTE: The certification or recertification visit can be done during a prior episode. *The Medicare Conditions of Participation, at 42 CFR 484.55(d)(1), require that the recertification assessment be done during the last 5 days of the previous episode (days 56-60).*

10.5 - Split Percentage Payment Approach to the 60-Day Episode

(Rev. 208, Issued: 04-22-15, Effective: 01-01-15, Implementation: 05-11-15)

In order to ensure adequate cash flow to HHAs, the *HH* PPS has set forth a split percentage payment approach to the 60-day episode. The split percentage occurs through the request for anticipated payment (RAP) at the start of the episode and the final claim at the end of the episode. For initial episodes, there will be a 60/40 split percentage payment. An initial percentage payment of 60 percent of the episode will be paid at the beginning of the episode and a final percentage payment of 40 percent will be paid at the end of the episode, unless there is

an applicable adjustment. For all subsequent episodes for beneficiaries who receive continuous home health care, the episodes will be paid at a 50/50-percentage payment split.

10.7 - Low Utilization Payment Adjustment (LUPA)

(Rev. 208, Issued: 04-22-15, Effective: 01-01-15, Implementation: 05-11-15)

An episode with four or fewer visits is paid the national per visit amount by discipline adjusted by the appropriate wage index based on the site of service of the beneficiary. Such episodes of four or fewer visits are paid the wage-adjusted per visit amount for each of the visits rendered instead of the full episode amount. The national per visit amounts by discipline (skilled nursing, home health aide, physical therapy, speech-language pathology, occupational therapy, and medical social services) are updated and published annually by the applicable market basket for each visit type.

Beginning in CY 2008, to offset the full cost of longer, initial visits in some LUPA episodes, CMS has modified the LUPA by increasing the payment by an add-on amount for LUPAs that occur as the only episode or the initial episode during a sequence of adjacent episodes.

10.8 - Partial Episode Payment (PEP) Adjustment

(Rev. 208, Issued: 04-22-15, Effective: 01-01-15, Implementation: 05-11-15)

A. PEP Adjustment Criteria

The PEP adjustment accounts for key intervening events in a patient's care defined as:

- A beneficiary elected transfer; or
- A discharge *and return to home health* during the 60-day episode.

The intervening event defined as the beneficiary elected transfer or discharge and return to *home health* during the 60-day episode warrants a new 60-day episode for purposes of payment. A start of care OASIS assessment and physician certification of the new plan of care are required. When a new 60-day episode begins due to the intervening event of the *beneficiary elected* transfer or discharge and return to *home health* during the 60-day episode, the original 60-day episode is proportionally adjusted to reflect the length of time the beneficiary remained under the agency's care prior to the intervening event.

Home health agencies have the option to discharge the patient within the scope of their own operating policies. However, an HHA discharging a patient as a result of hospital (*skilled nursing facility (SNF)* or rehab facility) admission with the patient returning to home health services at the same HHA during the 60-day episode will not be recognized by Medicare as a discharge for billing and payment purposes, and thus a Partial Episode Payment (PEP) adjustment would not apply. An intervening hospital (SNF or rehab facility) stay will result in a full 60-day episode spanning the start of care date prior to the hospital (SNF or rehab facility) admission, through and including the days of the hospital admission, and ending 59 days after the original start of care date.

B. Methodology Used to Calculate PEP Adjustment

The PEP adjustment for the original 60-day episode is calculated to reflect the length of time the beneficiary remained under the care of the original HHA based on the first billable visit date through and including the last billable visit date. The PEP adjustment is calculated by determining the actual days served by the original HHA (first billable visit date through and including last billable visit date as a proportion of 60 multiplied by the original 60-day episode payment).

C. Application of Therapy Threshold to PEP Adjusted Episode

The therapy threshold item included in the case-mix methodology used in *the HH PPS* is not combined or prorated across episodes. Each episode whether full or proportionately adjusted is subject to the therapy threshold for purposes of case-mix adjusting the payment for that individual patient's resource needs.

D. Common Ownership Exception to PEP Adjustment

If an HHA has a significant ownership as defined in [42 CFR 424.22](#), then the PEP adjustment would not apply in those situations of beneficiary elected transfer. Those situations would be considered services provided under arrangement on behalf of the originating HHA by the receiving HHA with the ownership interest until the end of the episode. The common ownership exception to the transfer PEP adjustment does not apply if the beneficiary moved out of their *Metropolitan Statistical Area (MSA)* or non-MSA during the 60-day episode before the transfer to the receiving HHA.

E. Beneficiary Elected Transfer Verification

In order for a receiving HHA to accept a beneficiary elected transfer, the receiving HHA must document that the beneficiary has been informed that the initial HHA will no longer receive Medicare payment on behalf of the patient and will no longer provide Medicare covered services to the patient after the date of the patient's elected transfer in accordance with current patient rights requirements at [42 CFR 484.10\(e\)](#). The receiving HHA must also document in the record that it accessed the *Medicare contractor's* inquiry system to determine whether or not the patient was under an established home health plan of care and it must contact the initial HHA on the effective date of transfer. In the rare circumstance of a dispute between HHAs, the *Medicare contractor* is responsible for working with both HHAs to resolve the dispute. If the receiving HHA can provide documentation of its notice of patient rights on Medicare payment liability provided to the patient upon transfer and its contact of the initial HHA of the transfer date, then the initial HHA will be ineligible for payment for the period of overlap in addition to the appropriate PEP adjustment. If the receiving HHA cannot provide the appropriate documentation, the receiving HHA's RAP and/or final claim will be cancelled, and full episode payment will be provided to the initial HHA. For the receiving HHA to properly document that it contacted the initial HHA on the effective date of transfer it must maintain similar information as the initial HHA, including the same basic beneficiary information, personnel contacted, dates and times. The initial HHA must also properly document that it was contacted and it accepted the transfer. Where it disputes a transfer, the initial HHA must call its *Medicare contractor* to resolve the dispute. The *Medicare contractor* is responsible for working with both HHAs to resolve the dispute.

10.10 - Discharge Issues

(Rev. 208, Issued: 04-22-15, Effective: 01-01-15, Implementation: 05-11-15)

A. Hospice Election Mid-Episode

If a patient elects hospice before the end of the episode and there was no PEP or LUPA adjustment, the HHA will receive a full episode payment. *The HH PPS* does not change the current rules that permit a hospice patient to receive home health services for a condition unrelated to *the terminal illness and related conditions*. Consistent with all episodes in which a patient receives four or fewer visits, the episode with four or fewer visits in which a patient elects hospice would be paid at the low utilization payment adjusted amount.

B. Patient's Death

The documented event of a patient's death would result in a full episode payment, unless the death occurred in a low utilization payment adjusted episode. Consistent with all episodes in which a patient receives four or fewer visits, if the patient's death occurred during an episode with four or fewer visits, the episode would be paid at

the low utilization payment adjusted amount. In the event of a patient's death during an adjusted episode, the total adjusted episode would constitute the full episode payment.

C. Patient is No Longer Eligible for Home Health (e.g., no longer homebound, no skilled need)

If the patient is discharged because he or she is no longer eligible for the Medicare home health benefit and has received more than four visits, then the HHA would receive full episode payment. However, if the patient becomes subsequently eligible for the Medicare home health benefit during the same 60-day episode and transferred to another HHA or returned to the same HHA, then *this* would result in a PEP adjustment.

D. Discharge Due to Patient Refusal of Services or is a Documented Safety Threat, Abuse Threat or is Noncompliant

If the patient is discharged because he or she refuses services or becomes a documented safety, abuse, or noncompliance discharge and has received more than four visits, then the HHA would receive full episode payment unless the patient becomes subsequently eligible for the Medicare home health benefit during the same 60-day episode and transferred to another HHA or returned to the same HHA, then *this* would result in a PEP adjustment.

E. Patient *Enrolls in* Managed Care Mid-Episode

If a patient's enrollment in a Medicare Advantage (MA) plan becomes effective mid episode, the 60-day episode payment will be proportionally adjusted with a PEP adjustment since the patient is receiving coverage under MA. Beginning with the effective date of enrollment, the MA plan will receive a capitation payment for covered services.

F. Submission of Final Claims Prior to the End of the 60-day Episode

The claim may be submitted upon discharge before the end of the 60-day episode. However, subsequent adjustments to any payments based on the claim may be made due to an intervening event resulting in a PEP adjustment or other adjustment.

G. Patient Discharge and Financial Responsibility for Part B Bundled Medical Supplies and Services

As discussed in detail under §10.11, below, the law governing the Medicare *HH* PPS requires the HHA to provide all bundled home health services (except DME) either directly or under arrangement while a patient is under a home health plan of care during an open episode. Once the patient is discharged, the HHA is no longer responsible for providing home health services including the bundled Part B medical supplies and therapy services.

H. Discharge Issues Associated With Inpatient Admission Overlapping Into Subsequent Episodes

1. If a patient is admitted to an inpatient facility and the inpatient stay overlaps into what would have been the subsequent episode and there is no recertification *assessment* of the patient, then the *new* certification begins with the new start of care date after inpatient discharge.
2. *If a patient is admitted to an inpatient facility and the inpatient stay overlaps into what would have been the subsequent episode and there was a recertification assessment of the patient during days 56-60 and the patient returns home from the inpatient stay on day 61, if the home health resource group (HHRG) remains the same then the second episode of care would be considered continuous and thus be considered a recertification. However, if the HHRG is different, this would result in a new start of care OASIS and thus be considered a new certification and begins with the new start of care date after inpatient discharge.*

3. *If a patient is admitted to an inpatient facility and the inpatient stay overlaps into what would have been the subsequent episode and there was a recertification assessment of the patient during days 56-60 and the patient returns home from the inpatient stay after day 61 (after the first day of the next episode of care), then a new certification begins with the new start of care date after inpatient discharge.*

10.11 - Consolidated Billing

(Rev. 208, Issued: 04-22-15, Effective: 01-01-15, Implementation: 05-11-15)

For individuals under a home health plan of care, payment for all services and supplies, with the exception of osteoporosis drugs and DME, is included in the *HH PPS base payment rates*. HHAs must provide the covered home health services (except DME) either directly or under arrangement, and must bill for such covered home health services.

Payment must be made to the HHA.

A. Home Health Services Subject to Consolidated Billing Requirements

The home health services included in the consolidated billing governing *the HH PPS* are:

- Part-time or intermittent skilled nursing services;
- Part-time or intermittent home health aide services;
- Physical therapy;
- Speech-language pathology services;
- Occupational therapy;
- Medical social services;
- Routine and nonroutine medical supplies;
- Covered osteoporosis drug as defined in [§1861\(kk\)](#) of the Act, but excluding other drugs and biologicals;
- Medical services provided by an intern or resident-in-training of the program of the hospital in the case of an HHA that is affiliated or under common control with a hospital with an approved teaching program; and
- Home health services defined in [§1861\(m\)](#) provided under arrangement at hospitals, SNFs, or rehabilitation centers when they involve equipment too cumbersome to bring to the home or are furnished while the patient is at the facility to receive such services.

B. Medical Supplies

The law requires *that* all medical supplies (routine and nonroutine) *be provided by* the *HHA* while the patient is under a home health plan of care. The agency that establishes the episode is the only entity that can bill and receive payment for medical supplies during an episode for a patient under a home health plan of care. Both

routine and nonroutine medical supplies are included in the base rates for every Medicare home health patient regardless of whether or not the patient requires medical supplies during the episode.

Due to the consolidated billing requirements, CMS provided additional amounts in the base rates for those nonroutine medical supplies that have a duplicate Part B code that could have been unbundled to Part B prior to **HH PPS**. See §50.4 for detailed discussion of medical supplies.

Medical supplies used by the patient, provider, or other practitioners under arrangement on behalf of the agency (other than physicians) are subject to consolidated billing and bundled *into* the HHA episodic payment rate. Once a patient is discharged from home health and not under a home health plan of care, the HHA is not responsible for medical supplies.

DME, including supplies covered as DME, are paid separately from the **HH PPS** and are excluded from the consolidated billing requirements governing *the HH PPS*. The determining factor is the medical classification of the supply, not the diagnosis of the patient. For example, infusion therapy will continue to be covered under the DME benefit separately and excluded from the consolidated billing requirements governing *the HH PPS*. DME supplies that are currently covered and paid in accordance with the DME fee schedule as category SU are billed under the DME benefit.

The osteoporosis drug (*injectable calcitonin*) *is* included in consolidated billing under the home health benefit. However, payment is not bundled into the **HH PPS** payment *rates*. HHAs must bill for *the* osteoporosis drug in accordance with billing instructions. Payment is in addition to the **HH PPS** payment.

C. Relationship Between Consolidated Billing Requirements and Part B Supplies and Part B Therapies Included in the Baseline Rates That Could Have Been Unbundled Prior to **HH PPS That No Longer Can Be Unbundled**

The HHA is responsible for the services provided under arrangement on their behalf by other entities. Covered home health services at §1861(m) of the Act (except DME) are included in the baseline **HH PPS** rates and subject to the consolidated billing requirements while the patient is under a plan of care of the HHA. The time the services are bundled is while the patient is under a home health plan of care.

Physician services or nurse practitioner services *paid under* the physician fee schedule are not recognized as home health *services* included in the PPS *rates*. Supplies incident to a physician service or related to a physician service billed to the **Medicare contractor** are not subject to the consolidated billing requirements. The physician would not be acting as a supplier billing the DME **Medicare contractor** in this situation.

Therapies (physical therapy, occupational therapy, and speech-language pathology services) are covered home health services that are included in the baseline rates and subject to the consolidated billing requirements. In addition to therapies that had been paid on a cost basis under home health, CMS has included in the rates additional amounts for Part B therapies that could have been unbundled prior to PPS. These therapies are subject to the consolidated billing requirements. There are revenue center codes that reflect the ranges of outpatient physical therapy, occupational therapy, and speech-language pathology services and **Healthcare Common Procedure Coding System (HCPCS)** codes that reflect physician supplier codes that are physical therapy, occupational therapy, and speech-language pathology services by code definition and are subject to the consolidated billing requirements. Therefore, the above-mentioned therapies must be provided directly or under arrangement on behalf of the HHA while a patient is under a home health plan of care *and* cannot be separately billed to Part B during an open 60-day episode.

D. Freedom of Choice Issues

A beneficiary exercises his or her freedom of choice for the services under the home health benefit listed in [§1861\(m\)](#) of the Act, including medical supplies, but excluding DME covered as a home health service by choosing the HHA. Once a home health patient chooses a particular HHA, he or she has clearly exercised freedom of choice with respect to all items and services included within the scope of the Medicare home health benefit (except DME). The HHA's consolidated billing role supersedes all other billing situations the beneficiary may wish to establish for home health services covered under the scope of the Medicare home health benefit during the certified episode.

E. Knowledge of Services Arranged for on Behalf of the HHA

The consolidated billing requirements governing *HH* PPS requires that the HHA provide all covered home health services (except DME) either directly or under arrangement while a patient is under a home health plan of care. Providing services either directly or under arrangement requires knowledge of the services provided during the episode. In addition, in accordance with current Medicare conditions of participation and Medicare coverage guidelines governing home health, the patient's plan of care must reflect the physician ordered services that the HHA provides either directly or under arrangement. An HHA would not be responsible for payment in the situation in which they have no prior knowledge (unaware of physician orders) of the services provided by an entity during an episode to a patient who is under their home health plan of care. An HHA is responsible for payment in the situation in which services are provided to a patient by another entity, under arrangement with the HHA, during an episode in which the patient is under the HHA's home health plan of care. However, it is in the best interest of future business relationships to discuss the situation with any entity that seeks payment from the HHA during an episode in an effort to resolve any misunderstanding and avoid such situations in the future.

20.1.2 - Determination of Coverage

(Rev. 208, Issued: 04-22-15, Effective: 01-01-15, Implementation: 05-11-15)

The *Medicare contractor's* decision on whether care is reasonable and necessary is based on information reflected in the home health plan of care, the OASIS as required by [42 CFR 484.55](#) or a medical record of the individual patient. Medicare does not deny coverage solely on the basis of the reviewer's general inferences about patients with similar diagnoses or on data related to utilization generally, but bases it upon objective clinical evidence regarding the patient's individual need for care. Coverage of skilled nursing care or therapy to perform a maintenance program does not turn on the presence or absence of a patient's potential for improvement from the nursing care or therapy, but rather on the patient's need for skilled care. Skilled care may be necessary to improve a patient's current condition, to maintain the patient's current condition, to prevent or slow further deterioration of the patient's condition.

20.2 - Impact of Other Available Caregivers and Other Available Coverage on Medicare Coverage of Home Health Services

(Rev. 208, Issued: 04-22-15, Effective: 01-01-15, Implementation: 05-11-15)

Where the Medicare criteria for coverage of home health services are met, patients are entitled by law to coverage of reasonable and necessary home health services. Therefore, a patient is entitled to have the costs of reasonable and necessary services reimbursed by Medicare without regard to whether there is someone available to furnish the services. However, where a family member or other person is or will be providing services that adequately meet the patient's needs, it would not be reasonable and necessary for HHA personnel to furnish such services. Ordinarily it can be presumed that there is no able and willing person in the home to provide the services being rendered by the HHA unless the patient or family indicates otherwise and objects to the provision of the services by the HHA, or unless the HHA has first hand knowledge to the contrary.

Similarly, a patient is entitled to reasonable and necessary *Medicare* home health services even if the patient would qualify for institutional care (e.g., hospital care or skilled nursing facility care) *and Medicare payment*

should be made for reasonable and necessary home health services where the patient is also receiving supplemental services that do not meet Medicare's definition of skilled nursing care or home health aide services.

EXAMPLE 1:

A patient who lives with an adult daughter and otherwise qualifies for Medicare coverage of home health services, requires the assistance of a home health aide for bathing and assistance with an exercise program to improve endurance. The daughter is unwilling to bathe her elderly father and assist him with the exercise program. Home health aide services would be reasonable and necessary.

EXAMPLE 2:

A patient who is being discharged from a hospital with a diagnosis of osteomyelitis and requires continuation of the I.V. antibiotic therapy that was begun in the hospital was found to meet the criteria for Medicare coverage of skilled nursing facility services. If the patient also meets the qualifying criteria for coverage of home health services, payment may be made for the reasonable and necessary home health services the patient needs, notwithstanding the availability of coverage in a skilled nursing facility.

EXAMPLE 3:

A patient who needs skilled nursing care on an intermittent basis also hires a licensed practical (vocational) nurse to provide nighttime assistance while family members sleep. The care provided by the nurse, as respite to the family members, does not require the skills of a licensed nurse (as defined in [§40.1](#)) and therefore has no impact on the beneficiary's eligibility for Medicare payment of home health services even though another third party insurer may pay for that nursing care.

30.1.1 - Patient Confined to the Home

(Rev. 208, Issued: 04-22-15, Effective: 01-01-15, Implementation: 05-11-15)

For a patient to be eligible to receive covered home health services under both Part A and Part B, the law requires that a physician certify in all cases that the patient is confined to his/her home. For purposes of the statute, an individual shall be considered "confined to the home" (homebound) if the following two criteria are met:

1. Criteria-One:

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

2. Criteria-Two:

- There must exist a normal inability to leave home;

AND

- Leaving home must require a considerable and taxing effort.

If the patient does in fact leave the home, the patient may nevertheless be considered homebound if the absences from the home are infrequent or for periods of relatively short duration, or are attributable to the need to receive health care treatment. Absences attributable to the need to receive health care treatment include, but are not limited to:

- Attendance at adult day centers to receive medical care;
- Ongoing receipt of outpatient kidney dialysis; or
- The receipt of outpatient chemotherapy or radiation therapy.

Any absence of an individual from the home attributable to the need to receive health care treatment, including regular absences for the purpose of participating in therapeutic, psychosocial, or medical treatment in an adult day-care program that is licensed or certified by a State, or accredited to furnish adult day-care services in a State, shall not disqualify an individual from being considered to be confined to his home. Any other absence of an individual from the home shall not so disqualify an individual if the absence is of an infrequent or of relatively short duration. For purposes of the preceding sentence, any absence for the purpose of attending a religious service shall be deemed to be an absence of infrequent or short duration. It is expected that in most instances, absences from the home that occur will be for the purpose of receiving health care treatment. However, occasional absences from the home for nonmedical purposes, e.g., an occasional trip to the barber, a walk around the block or a drive, attendance at a family reunion, funeral, graduation, or other infrequent or unique event would not necessitate a finding that the patient is not homebound if the absences are undertaken on an infrequent basis or are of relatively short duration and do not indicate that the patient has the capacity to obtain the health care provided outside rather than in the home.

Some examples of homebound patients that illustrate the factors used to determine whether a homebound condition exists *are listed below*.

- A patient paralyzed from a stroke who is confined to a wheelchair or requires the aid of crutches in order to walk.
- A patient who is blind or senile and requires the assistance of another person in leaving their place of residence.
- A patient who has lost the use of their upper extremities and, therefore, is unable to open doors, use handrails on stairways, etc., and requires the assistance of another individual to leave their place of residence.
- A patient in the late stages of ALS or neurodegenerative disabilities. In determining whether the patient has the general inability to leave the home and leaves the home only infrequently or for periods of short duration, it is necessary (as is the case in determining whether skilled nursing services are intermittent) to look at the patient's condition over a period of time rather than for short periods within the home health stay. For example, a patient may leave the home (*meeting both criteria listed above*) more frequently during a short period when the *patient has multiple appointments with health care professionals and medical tests in 1 week*. So long as the patient's overall condition and experience is such that he or she meets these qualifications, he or she should be considered confined to the home.

- A patient who has just returned from a hospital stay involving surgery, who may be suffering from resultant weakness and pain *because of the surgery* 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, walking stairs only once a day, etc.).
- A patient with arteriosclerotic heart disease of such severity that they must avoid all stress and physical activity.
- 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 not be considered safe for the patient to leave home unattended, even if they have no physical limitations.

The aged person who does not often travel from home because of feebleness and insecurity brought on by advanced age would not be considered confined to the home for purposes of receiving home health services unless they meet one of the above conditions.

Although a patient must be confined to the home to be eligible for covered home health services, some services cannot be provided at the patient's residence because equipment is required that cannot be made available there. If the services required by an individual involve the use of such equipment, the HHA may make arrangements with a hospital, SNF, or a rehabilitation center to provide these services on an outpatient basis. (See [§50.6](#).) However, even in these situations, for the services to be covered as home health services the patient must be considered confined to home *and meet both criteria listed above*.

If a question is raised as to whether a patient is confined to the home, the HHA will be requested to furnish the *Medicare contractor* with the information necessary to establish that the patient is homebound as defined above.

30.1.2 - Patient's Place of Residence

(Rev. 208, Issued: 04-22-15, Effective: 01-01-15, Implementation: 05-11-15)

A patient's residence is wherever he or she makes his or her home. This may be his or her own dwelling, an apartment, a relative's home, a home for the aged, or some other type of institution. However, an institution may not be considered a patient's residence if the institution meets the requirements of [§§1861\(e\)\(1\)](#) or [1819\(a\)\(1\)](#) of the Act. Included in this group are hospitals and skilled nursing facilities, as well as most nursing facilities under Medicaid. (See the Medicare State Operations Manual, §2166.)

Thus, if a patient is in an institution or distinct part of an institution identified above, the patient is not entitled to have payment made for home health services under either Part A or Part B since such an institution may not be considered their residence. When a patient remains in a participating SNF following their discharge from active care, the facility may not be considered their residence for purposes of home health coverage.

A patient may have more than one home and the Medicare rules do not prohibit a patient from having one or more places of residence. A patient, under a Medicare home health plan of care, who resides in more than one place of residence during an episode of Medicare covered home health services will not disqualify the patient's homebound status for purposes of eligibility. For example, a person may reside in a principal home and also a second vacation home, mobile home, or the home of a caretaker relative. The fact that the patient resides in more than one home and, as a result, must transit from one to the other, is not in itself, an indication that the patient is not homebound. The requirements of homebound must be met at each location (*i.e., the patient must meet both criteria listed in section 30.1.1 above*).

A. Assisted Living Facilities, Group Homes, and Personal Care Homes

An individual may be "confined to the home" for purposes of Medicare coverage of home health services if he or she resides in an institution that is not primarily engaged in providing to inpatients:

- Diagnostic and therapeutic services for medical diagnosis;
- Treatment;
- Care of injured, disabled or sick persons;
- Rehabilitation services or other skilled services needed to maintain a patient's current condition or to prevent or slow further deterioration; or
- Skilled nursing care or related services for patients who require medical or nursing care.

If it is determined that the assisted living facility (also called personal care homes, group homes, etc.) in which the individuals reside are not primarily engaged in providing the above services, then Medicare will cover reasonable and necessary home health care furnished to these individuals.

If it is determined that the services furnished by the home health agency are duplicative of services furnished by an assisted living facility when provision of such care is required of the facility under State licensure requirements, claims for such services should be denied under [§1862\(a\)\(1\)\(A\)](#) of the Act. Section 1862(a)(1)(A) excludes services that are not necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member from Medicare coverage. Services to people who already have access to appropriate care from a willing caregiver would not be considered reasonable and necessary to the treatment of the individual's illness or injury.

Medicare coverage would not be an optional substitute for the services that a facility is required to provide by law to its patients or where the services are included in the base contract of the facility. An individual's choice to reside in such a facility is also a choice to accept the services it holds itself out as offering to its patients.

B. Day Care Centers and Patient's Place of Residence

The current statutory definition of homebound or confined does not imply that Medicare coverage has been expanded to include adult day care services.

The law does not permit an HHA to furnish a Medicare covered billable visit to a patient under a home health plan of care outside his or her home, except in those limited circumstances where the patient needs to use medical equipment that is too cumbersome to bring to the home. Section 1861(m) of the Act stipulates that home health services provided to a patient be provided to the patient on a visiting basis in a place of residence used as the individual's home. A licensed/certified day care center does not meet the definition of a place of residence.

C. State Licensure/Certification of Day Care Facilities

Per Section [1861\(m\)](#) of the Act, an adult day care center must be either licensed or certified by the State or accredited by a private accrediting body. State licensure or certification as an adult day care facility must be based on State interpretations of its process. For example, several States do not license adult day care facilities as a whole, but do certify some entities as Medicaid certified centers for purposes of providing adult day care under the Medicaid home and community based waiver program. It is the responsibility of the State to determine the necessary criteria for "State certification" in such a situation. A State could determine that Medicaid certification is an acceptable standard and consider its Medicaid certified adult day care facilities to be

"State certified." On the other hand, a State could determine Medicaid certification to be insufficient and require other conditions to be met before the adult day care facility is considered "State certified".

D. Determination of the Therapeutic, Medical or Psychosocial Treatment of the Patient at the Day Care Facility

It is not the obligation of the HHA to determine whether the adult day care facility is providing psychosocial treatment, but only to assure that the adult day care center is licensed/certified by the State or accrediting body. The intent of the law, in extending the homebound exception status to attendance at such adult day care facilities, recognizes that they ordinarily furnish psychosocial services.

30.2.1 - Content of the Plan of Care

(Rev. 208, Issued: 04-22-15, Effective: 01-01-15, Implementation: 05-11-15)

The HHA must be acting upon a physician plan of care that meets the requirements of this section for HHA services to be covered.

The plan of care must contain all pertinent diagnoses, including:

- The patient's mental status;
- The types of services, supplies, and equipment required;
- The frequency of the visits to be made;
- Prognosis;
- Rehabilitation potential;
- Functional limitations;
- Activities permitted;
- Nutritional requirements;
- All medications and treatments;
- Safety measures to protect against injury;
- Instructions for timely discharge or referral; and
- Any additional items the HHA or physician *chooses* to include.

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 patient's illness or injury, and the patient's resultant impairments;

- The plan must include the expected duration of therapy services; and
- The plan must describe a course of treatment which is consistent with the qualified therapist's assessment of the patient's function.

30.2.5 - Use of Oral (Verbal) Orders

(Rev. 208, Issued: 04-22-15, Effective: 01-01-15, Implementation: 05-11-15)

When services are furnished based on a physician's oral order, the orders may be accepted and put in writing by personnel authorized to do so by applicable State and Federal laws and regulations as well as by the HHA's internal policies. The orders must be signed and dated with the date of receipt by the registered nurse or qualified therapist (i.e., physical therapist, speech-language pathologist, occupational therapist, or medical social worker) responsible for furnishing or supervising the ordered services. The orders may be signed by the supervising registered nurse or qualified therapist after the services have been rendered, as long as HHA personnel who receive the oral orders notify that nurse or therapist before the service is rendered. Thus, the rendering of a service that is based on an oral order would not be delayed pending signature of the supervising nurse or therapist. Oral orders must be countersigned and dated by the physician before the HHA bills for the care in the same way as the plan of care.

Services which are provided from the beginning of the 60-day episode certification period based on a request for anticipated payment and before the physician signs the plan of care are considered to be provided under a plan of care established and approved by the physician where there is an oral order for the care prior to rendering the services which is documented in the medical record and where the services are included in a signed plan of care.

Services that are provided in the subsequent 60-day episode certification period are considered provided under the plan of care of the subsequent 60-day episode where there is an oral order before the services provided in the subsequent period are furnished and the order is reflected in the medical record. However, services that are provided after the expiration of the plan of care, but before the acquisition of an oral order or a signed plan of care are not considered provided under a plan of care.

EXAMPLE 1:

The HHA acquires an oral order for I.V. medication administration for a patient to be performed on August 1. The HHA provides the I.V. medication administration August 1 and evaluates the patient's need for continued care. The physician signs the plan of care for the I.V. medication administration on August 15. The visit is covered since it is considered provided under a plan of care established and approved by the physician, and the HHA had acquired an oral order prior to the delivery of services.

EXAMPLE 2:

The patient is under a plan of care in which the physician orders I.V. medication administration every 2 weeks. The last day covered by the initial plan of care is July 31. The patient's next I.V. medication administration is scheduled for August 5 and the physician signs the plan of care for the new period on August 1. The I.V. medication administration on August 5 was provided under a plan of care established and approved by the physician. The episode begins on the 61 day regardless of the date of the first covered visit.

EXAMPLE 3:

The patient is under a plan of care in which the physician orders I.V. medication administration every 2 weeks. The last day covered by the plan of care is July 31. The patient's next I.V. medication administration is

scheduled for August 5 and the physician does not sign the plan of care until August 6. The HHA acquires an oral order for the I.V. medication administration before the August 5 visit, and therefore the visit is considered to be provided under a plan of care established and approved by the physician. The episode begins on the 61 day regardless of the date of the first covered visit.

Any increase in the frequency of services or addition of new services during a certification period must be authorized by a physician by way of a written or oral order prior to the provision of the increased or additional services.

30.3 - Under the Care of a Physician

(Rev. 208, Issued: 04-22-15, Effective: 01-01-15, Implementation: 05-11-15)

The patient must be under the care of a physician who is qualified to sign the physician certification and plan of care in accordance with [42 CFR 424.22](#).

A patient is expected to be under the care of the physician who signs the plan of care. It is expected *that in most instances, the physician who certifies the patient's eligibility for Medicare home health services, in accordance with §30.5 below, will be the same physician who establishes and signs the plan of care.*

30.5 - Physician Certification and Recertification of Patient Eligibility for Medicare Home Health Services

(Rev. 208, Issued: 04-22-15, Effective: 01-01-15, Implementation: 05-11-15)

The HHA must be acting upon a plan of care as described in §30.2, and a physician certification *or recertification that* meets the *requirements of the following sections in order* for HHA services to be covered.

30.5.1 - Physician Certification

(Rev. 208, Issued: 04-22-15, Effective: 01-01-15, Implementation: 05-11-15)

A certification (versus recertification) is considered to be anytime that a Start of Care OASIS is completed to initiate care. In such instances, a physician must certify (attest) that:

1. The home health services are or were needed because the patient is or was confined to the home as defined in §30.1;
2. The patient needs or needed skilled nursing services on an intermittent basis (other than solely venipuncture for the purposes of obtaining a blood sample), or physical therapy, or speech-language pathology services. 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 §40.1.2.2), 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;
3. A plan of care has been established and is periodically reviewed by a physician;
4. The services are or were furnished while the patient is or was under the care of a physician;
5. For episodes with starts of care beginning January 1, 2011 and later, *in accordance with §30.5.1.1 below, a face-to-face encounter occurred no more than 90 days prior to 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. The certifying physician must also document the date of the encounter.*

If the patient is starting home health directly after discharge from an acute/post-acute care setting where the physician, with privileges, that cared for the patient in that setting is certifying the patient's eligibility for the home health benefit, but will not be following the patient after discharge, then the certifying physician must identify the community physician who will be following the patient after discharge. One of the criteria that must be met for a patient to be considered eligible for the home health benefit is that the patient must be under the care of a physician (number 4 listed above). Otherwise, the certification is not valid.

The certification must be complete prior to when an HHA bills Medicare for reimbursement; however, physicians should complete the certification when the plan of care is established, or as soon as possible thereafter. This is longstanding CMS policy as referenced in Pub 100-01, Medicare General Information, Eligibility, and Entitlement Manual, chapter 4, section 30.1. It is not acceptable for HHAs to wait until the end of a 60-day episode of care to obtain a completed certification/recertification.

30.5.1.1 – Face-to-Face Encounter

(Rev. 208, Issued: 04-22-15, Effective: 01-01-15, Implementation: 05-11-15)

1. Allowed Provider Types

As part of the certification of patient eligibility for the Medicare home health benefit, a face-to-face encounter with the patient must be performed by the certifying physician himself or herself, a physician that cared for the patient in the acute or post-acute care facility (with privileges who cared for the patient in an acute or post-acute care facility from which the patient was directly admitted to home health) or an allowed non-physician practitioner (NPP).

NPPs who are allowed to perform the encounter are:

- 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 patient in the acute or post-acute care facility from which the patient 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 patient in the acute or post-acute care facility from which the patient 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 patient in the acute or post-acute care facility from which the patient was directly admitted to home health.*

NPPs performing the encounter are subject to the same financial restrictions with the HHA as the certifying physician, as described in [42 CFR 424.22\(d\)](#).

2. Timeframe Requirements

- The encounter must occur no more than 90 days prior to the home health start of care date or within 30 days after the start of care.
- In situations when a physician orders home health care for the patient based on a new condition that was not evident during a visit within the 90 days prior to start of care, the certifying physician or an allowed NPP must see the patient again within 30 days after admission. Specifically, if a patient saw the

certifying physician or NPP within the 90 days prior to start of care, another encounter would be needed if the patient's condition had changed to the extent that standards of practice would indicate that the physician or a non-physician practitioner should examine the patient in order to establish an effective treatment plan.

3. *Exceptional Circumstances*

When a home health patient dies shortly after admission, before the face-to-face encounter occurs, if the contractor determines a good faith effort existed on the part of the HHA to facilitate/coordinate the encounter and if all other certification requirements are met, the certification is deemed to be complete.

4. *Telehealth*

The face-to-face encounter can be performed via a telehealth service, in an approved originating site. An originating site is considered to be the location of an eligible Medicare beneficiary at the time the service being furnished via a telecommunications system occurs. Medicare beneficiaries are eligible for telehealth services only if they are presented from an originating site located in a rural health professional shortage area or in a county outside of a Metropolitan Statistical Area.

Entities that participate in a Federal telemedicine demonstration project approved by (or receiving funding from) the Secretary of the Department of Health and Human Services as of December 31, 2000, qualify as originating sites regardless of geographic location.

The originating sites authorized by law are:

- The office of a physician or practitioner;
- Hospitals;
- Critical Access Hospitals (CAH);
- Rural Health Clinics (RHC);
- Federally Qualified Health Centers (FQHC);
- Hospital-based or CAH-based Renal Dialysis Centers (including satellites);
- Skilled Nursing Facilities (SNF); and
- Community Mental Health Centers (CMHC).

30.5.1.2 – Supporting Documentation Requirements

(Rev. 208, Issued: 04-22-15, Effective: 01-01-15, Implementation: 05-11-15)

As of January 1, 2015, 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) will be used as the basis upon which patient eligibility for the Medicare home health benefit will be determined. Documentation from 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) used to support the certification of home health eligibility must be provided, upon request, to the home health agency, review entities, and/or the Centers for Medicare and Medicaid Services (CMS). In turn, an HHA must be able to provide, upon request, the supporting documentation that substantiates the eligibility for the Medicare home health benefit to review entities and/or CMS. 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.

The certifying physician and/or the acute/post-acute care facility medical record (if the patient was directly admitted to home health) 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 the skilled services; and*
- *Homebound status;*

The certifying physician and/or the acute/post-acute care facility medical record (if the patient was directly admitted to home health) for the patient 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 patient requires home health services; and*
- *Was performed by an allowed provider type.*

This information can be found most often in clinical and progress notes and discharge summaries.

Information from the HHA, such as the initial and/or comprehensive assessment of the patient required per 42 CFR 484.55, can be incorporated into the certifying physician's medical record for the patient and used to support the patient's homebound status and need for skilled care. However, this information must be corroborated by other medical record entries in the certifying physician's and/or the acute/post-acute care facility's medical record for the patient.

30.5.2 - Physician Recertification

(Rev. 208, Issued: 04-22-15, Effective: 01-01-15, Implementation: 05-11-15)

At the end of the 60-day episode, a decision must be made whether or not to recertify the patient for a subsequent 60-day episode. An eligible beneficiary who qualifies for a subsequent 60-day episode would start the subsequent 60-day episode on day 61. Under HH PPS, the plan of care must be reviewed and signed by the physician every 60 days unless one of the following occurs:

- A beneficiary transfers to another HHA; *or*
- A discharge and return to home health during the 60-day episode.

The physician must include an estimate of how much longer the skilled services will be required and must certify (attest) that:

- 1. The home health services are or were needed because the patient is or was confined to the home as defined in §30.1;*
- 2. The patient needs or needed skilled nursing services on an intermittent basis (other than solely venipuncture for the purposes of obtaining a blood sample), or physical therapy, or speech-language pathology services; or continues to need occupational therapy after the need for skilled nursing care, physical therapy, or speech-language pathology services ceased. 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 §40.1.2.2), the physician must include a brief narrative describing the clinical justification of this need as part of the recertification, or as a signed addendum to the recertification;*
- 3. A plan of care has been established and is periodically reviewed by a physician; and*

4. The services are or were furnished while the patient is or was under the care of a physician.

Medicare does not limit the number of continuous episode recertifications for beneficiaries who continue to be eligible for the home health benefit. The physician certification may cover a period less than but not greater than 60 days.

See §10.4 for counting initial and subsequent 60-day episodes. See §10.5 for recertifications for split percentage payments.

30.5.3 - Who May Sign the Certification *or Recertification*
(Rev. 208, Issued: 04-22-15, Effective: 01-01-15, Implementation: 05-11-15)

The physician who signs the certification *or recertification* must be permitted to do so by [42 CFR 424.22](#).

30.5.4 – Physician Billing for Certification and Recertification
(Rev. 208, Issued: 04-22-15, Effective: 01-01-15, Implementation: 05-11-15)

Physician certification/recertification claims are Part B physician claims paid for under the Physician Fee Schedule. These claims are billed using HCPCS codes G0180 (certification) or G0179 (re-certification). The descriptions of these two codes indicate that they are used to bill for certification or recertification of patient eligibility “for Medicare-covered home health services under a home health plan of care (patient not present), including contacts with the HHA and review of reports of patient status required by physicians to affirm the initial implementation of the plan of care that meets patient's needs, per certification period”. As noted above, these codes are for physician certification or recertification for Medicare-covered home health services. If there are no Medicare-covered home health services, these codes should not be billed or paid. As such, physician claims for certification/recertification of eligibility for home health services (G0180 and G0179, respectively) will not be covered if the HHA claim itself was non-covered because the certification/recertification of eligibility was not complete or because there was insufficient documentation to support that the patient was eligible for the Medicare home health benefit.

40.1.2.15 - Psychiatric Evaluation, Therapy, and Teaching
(Rev. 208, Issued: 04-22-15, Effective: 01-01-15, Implementation: 05-11-15)

The evaluation, psychotherapy, and teaching needed by a patient suffering from a diagnosed psychiatric disorder that requires active treatment by a psychiatrically trained nurse and the costs of the psychiatric nurse's services may be covered as a skilled nursing service. Psychiatrically trained nurses are nurses who have special training and/or experience beyond the standard curriculum required for a registered nurse. The services of the psychiatric nurse are to be provided under a plan of care established and reviewed by a physician.

Because the law precludes agencies that primarily provide care and treatment of mental diseases from participating as HHAs, psychiatric nursing must be furnished by an agency that does not primarily provide care and treatment of mental diseases. If a substantial number of an HHA's patients attend partial hospitalization programs or receive outpatient mental health services, the *Medicare contractor* will verify whether the patients meet the eligibility requirements specified in §30 and whether the HHA is primarily engaged in care and treatment of mental disease.

Services of a psychiatric nurse would not be considered reasonable and necessary to assess or monitor use of psychoactive drugs that are being used for nonpsychiatric diagnoses or to monitor the condition of a patient with a known psychiatric illness who is on treatment but is considered stable. A person on treatment would be considered stable if their symptoms were absent or minimal or if symptoms were present but were relatively stable and did not create a significant disruption in the patient's normal living situation.

EXAMPLE 1:

A patient is homebound for medical conditions, but has a psychiatric condition for which he has been receiving medication. The patient's psychiatric condition has not required a change in medication or hospitalization for over 2 years. During a visit by the nurse, the patient's spouse indicates that the patient is awake and pacing most of the night and has begun ruminating about perceived failures in life. The nurse observes that the patient does not exhibit an appropriate level of hygiene and is dressed inappropriately for the season. The nurse comments to the patient about her observations and tries to solicit information about the patient's general medical condition and mental status. The nurse advises the physician about the patient's general medical condition and the new symptoms and changes in the patient's behavior. The physician orders the nurse to check blood levels of medication used to treat the patient's medical and psychiatric conditions. The physician then orders the psychiatric nursing service to evaluate the patient's mental health and communicate with the physician about whether additional intervention to deal with the patient's symptoms and behaviors is warranted. The home health record at each visit should document the need for the psychiatric skilled nursing services and treatment. The home health record must also reflect the patient/caregiver response to any interventions provided.

EXAMPLE 2:

A patient is homebound after discharge following hip replacement surgery and is receiving skilled therapy services for range of motion exercise and gait training. In the past, the patient had been diagnosed with clinical depression and was successfully stabilized on medication. There has been no change in her symptoms. The fact that the patient is taking an antidepressant does not indicate a need for psychiatric nursing services.

EXAMPLE 3:

A patient was discharged after 2 weeks in a psychiatric hospital with a new diagnosis of major depression. The patient remains withdrawn; in bed most of the day, and refusing to leave home. The patient has a depressed affect and continues to have thoughts of suicide, but is not considered to be suicidal. Psychiatric skilled nursing services are necessary for supportive interventions until antidepressant blood levels are reached and the suicidal thoughts are diminished further, to monitor suicide ideation, ensure medication compliance and patient safety, perform suicidal assessment, and teach crisis management and symptom management to family members. The home health record at each visit should document the need for the psychiatric skilled nursing services and treatment. The home health record must also reflect the patient/caregiver response to any interventions provided.

40.1.3 - Intermittent Skilled Nursing Care

(Rev. 208, Issued: 04-22-15, Effective: 01-01-15, Implementation: 05-11-15)

The law, at [§1861\(m\)](#) of the Act defines intermittent, for the purposes of §§1814(a)(2) and 1835(a)(2)(A), as skilled nursing care that is either provided 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.)

To meet the requirement for "intermittent" skilled nursing care, a patient must have a medically predictable recurring need for skilled nursing services. In most instances, this definition will be met if a patient requires a skilled nursing service at least once every 60 days. The exception to the intermittent requirement is daily skilled nursing services for diabetics unable to administer their insulin (when there is no able and willing caregiver).

Since the need for "intermittent" skilled nursing care makes the patient eligible for other covered home health services, the *Medicare contractor* should evaluate each claim involving skilled nursing services furnished less frequently than once every 60 days. In such cases, payment should be made only if documentation justifies a recurring need for reasonable, necessary, and medically predictable skilled nursing services. The following are examples of the need for infrequent, yet intermittent, skilled nursing services:

1. The patient with an indwelling **silicone** catheter who generally needs a catheter change only at 90-day intervals;
2. The patient who experiences a fecal impaction (i.e., loss of bowel tone, restrictive mobility, and a breakdown in good health habits) and must receive care to manually relieve the impaction. Although these impactions are likely to recur, it is not possible to pinpoint a specific timeframe; or
3. The blind diabetic who self-injects insulin may have a medically predictable recurring need for a skilled nursing visit at least every 90 days. These visits, for example, would be to observe and determine the need for changes in the level and type of care which have been prescribed thus supplementing the physician's contacts with the patient.

There is a possibility that a physician may order a skilled visit less frequently than once every 60 days for an eligible beneficiary if there exists an extraordinary circumstance of anticipated patient need that is documented in the patient's plan of care in accordance with [42 CFR 409.43\(b\)](#). A skilled visit frequency of less than once every 60 days would only be covered if it is specifically ordered by a physician in the patient's plan of care and is considered to be a reasonable, necessary, and medically predictable skilled need for the patient in the individual circumstance.

Where the need for "intermittent" skilled nursing visits is medically predictable but a situation arises after the first visit making additional visits unnecessary, e.g., the patient is institutionalized or dies, the one visit would be paid at the wage-adjusted LUPA amount for that discipline type. However, a one-time order; e.g., to give gamma globulin following exposure to hepatitis, would not be considered a need for "intermittent" skilled nursing care since a recurrence of the problem that would require this service is not medically predictable.

Although most patients require services no more frequently than several times a week, Medicare will pay for part-time (as defined in [§50.7](#)) medically reasonable and necessary skilled nursing care 7 days a week for a short period of time (2 to 3 weeks). There may also be a few cases involving unusual circumstances where the patient's prognosis indicates the medical need for daily skilled services will extend beyond 3 weeks. As soon as the patient's physician makes this judgment, which usually should be made before the end of the 3-week period, the HHA must forward medical documentation justifying the need for such additional services and include an estimate of how much longer daily skilled services will be required.

A person expected to need more or less full-time skilled nursing care over an extended period of time, i.e., a patient who requires institutionalization, would usually not qualify for home health benefits.

40.2.1 - General Principles Governing Reasonable and Necessary Physical Therapy, Speech-Language Pathology Services, and Occupational Therapy *(Rev. 208, Issued: 04-22-15, Effective: 01-01-15, Implementation: 05-11-15)*

The service of a physical therapist, speech-language pathologist, or occupational therapist is a skilled therapy service if the inherent complexity of the service is such that it can be performed safely and/or effectively only by or under the general supervision of a skilled therapist. To be covered, assuming all other eligibility and coverage criteria have been met, the skilled services must also be reasonable and necessary to the treatment of the patient's illness or injury or to the restoration or maintenance of function affected by the patient's illness or

injury. It is necessary to determine whether individual therapy services are skilled and whether, in view of the patient's overall condition, skilled management of the services provided is needed.

The development, implementation, management, and evaluation of a patient care plan based on the physician's orders constitute skilled therapy services when, because of the patient's clinical condition, those activities require the specialized skills, knowledge, and judgment of a qualified therapist to ensure the effectiveness of the treatment goals and ensure medical safety. Where the specialized skills, knowledge, and judgment of a therapist are needed to manage and periodically reevaluate the appropriateness of a maintenance program, such services would be covered, even if the skills of a therapist were not needed to carry out the activities performed as part of the maintenance program.

While a patient's particular medical condition is a valid factor in deciding if skilled therapy services are needed, a patient's diagnosis or prognosis should never be the sole factor in deciding that a service is or is not skilled. The key issue is whether the skills of a therapist are needed to treat the illness or injury, or whether the services can be carried out by unskilled personnel.

A service that is ordinarily considered unskilled could be considered a skilled therapy service in cases where there is clear documentation that, because of special medical complications, skilled rehabilitation personnel are required to perform the service. However, the importance of a particular service to a patient or the frequency with which it must be performed does not, by itself, make an unskilled service into a skilled service.

Assuming all other eligibility and coverage criteria have been met, the skilled therapy services must be reasonable and necessary to the treatment of the patient's illness or injury within the context of the patient's unique medical condition. To be considered reasonable and necessary for the treatment of the illness or injury:

- a. The services must be consistent with the nature and severity of the illness or injury, the patient's particular medical needs, including the requirement that the amount, frequency, and duration of the services must be reasonable; and
- b. The services must be considered, under accepted standards of medical practice, to be specific, safe, and effective treatment for the patient's condition, meeting the standards noted below. The home health record must specify the purpose of the skilled service provided.

To ensure therapy services are effective, at defined points during a course of treatment, for each therapy discipline for which services are provided, a qualified therapist (instead of an assistant) must perform the ordered therapy service. During this visit, the therapist must assess the patient using a method which allows for objective measurement of function and successive comparison of measurements. The therapist must document the measurement results in the clinical record. Specifically:

i. Initial Therapy Assessment

- For each therapy discipline for which services are provided, a qualified therapist (instead of an assistant) must assess the patient's function using a method which objectively measures activities of daily living such as, but not limited to, eating, swallowing, bathing, dressing, toileting, walking, climbing stairs, using assistive devices, and mental and cognitive factors. The measurement results must be documented in the clinical record.
- Where more than one discipline of therapy is being provided, a qualified therapist from each of the disciplines must functionally assess the patient. The therapist must document the measurement results which correspond to the therapist's discipline and care plan goals in the clinical record.

ii. Reassessment at least every 30 days (performed in conjunction with an ordered therapy service)

- At least once every 30 days, for each therapy discipline for which services are provided, a qualified therapist (instead of an assistant) must provide the ordered therapy service, functionally reassess the patient, and compare the resultant measurement to prior assessment measurements. The therapist must document in the clinical record the measurement results along with the therapist's determination of the effectiveness of therapy, or lack thereof.
- *For multi-discipline therapy cases, a qualified therapist from each of the disciplines must functionally reassess the patient. The therapist must document the measurement results which correspond to the therapist's discipline and care plan goals in the clinical record.*
- The 30-day clock begins with the first therapy service (of that discipline) and the clock resets with each therapist's visit/assessment/measurement/documentation (of that discipline).

c. Services involving activities for the general welfare of any patient, e.g., general exercises to promote overall fitness or flexibility and activities to provide diversion or general motivation do not constitute skilled therapy. Unskilled individuals without the supervision of a therapist can perform those services.

d. Assuming all other eligibility and coverage requirements have been met, in order for therapy services to be covered, one of the following three conditions must be met:

1. The skills of a qualified therapist are needed to restore patient function:

- To meet this coverage condition, therapy services must be provided with the expectation, based on the assessment made by the physician of the patient's restorative potential that the condition of the patient will improve materially in a reasonable and generally predictable period of time. Improvement is evidenced by objective successive measurements.
- Therapy is not considered reasonable and necessary under this condition if the patient's expected restorative potential would be insignificant in relation to the extent and duration of therapy services required to reach such potential.
- Therapy is not required to effect improvement or restoration of function where a patient suffers a transient or easily reversible loss of function (such as temporary weakness following surgery) which could reasonably be expected to improve spontaneously as the patient gradually resumes normal activities. Therapy in such cases is not considered reasonable and necessary to treat the patient's illness or injury, under this condition. However, if the criteria for maintenance therapy described in (3) below is met, therapy could be covered under that condition.

2. The patient's clinical condition requires the specialized skills, knowledge, and judgment of a qualified therapist to establish or design a maintenance program, related to the patient's illness or injury, in order to ensure the safety of the patient and the effectiveness of the program, to the extent provided by regulation,

- For patients receiving rehabilitative/restorative therapy services, if the specialized skills, knowledge, and judgment of a qualified therapist are required to develop a maintenance program, the expectation is that the development of that maintenance program would occur during the last visit(s) for rehabilitative/restorative treatment. The goals of a maintenance

program would be to maintain the patient's current functional status or to prevent or slow further deterioration.

- Necessary periodic reevaluations by a qualified therapist of the beneficiary and maintenance program are covered if the specialized skills, knowledge, and judgment of a qualified therapist are required.
- Where a maintenance program is not established until after the rehabilitative/restorative therapy program has been completed, or where there was no rehabilitative/restorative therapy program, and the specialized skills, knowledge, and judgment of a qualified therapist are required to develop a maintenance program, such services would be considered reasonable and necessary for the treatment of the patient's condition in order to ensure the effectiveness of the treatment goals and ensure medical safety. When the development of a maintenance program could not be accomplished during the last visit(s) of rehabilitative/restorative treatment, the therapist must document why the maintenance program could not be developed during those last rehabilitative/restorative treatment visit(s).
- When designing or establishing a maintenance program, the qualified therapist must teach the patient or the patient's family or caregiver's necessary techniques, exercises or precautions as necessary to treat the illness or injury. The instruction of the beneficiary or appropriate caregiver by a qualified therapist regarding a maintenance program is covered if the specialized skills, knowledge, and judgment of a qualified therapist are required. However, visits made by skilled therapists to a patient's home solely to train other HHA staff (e.g., home health aides) are not billable as visits since the HHA is responsible for ensuring that its staff is properly trained to perform any service it furnishes. The cost of a skilled therapist's visit for the purpose of training HHA staff is an administrative cost to the agency.

3. The skills of a qualified therapist (not an assistant) are needed to perform maintenance therapy:

- Coverage of therapy services to perform a maintenance program is not determined solely on the presence or absence of a beneficiary's potential for improvement from the therapy, but rather on the beneficiary's need for skilled care. Assuming all other eligibility and coverage requirements are met, skilled therapy services are covered when an individualized assessment of the patient's clinical condition demonstrates that the specialized judgment, knowledge, and skills of a qualified therapist ("skilled care") are necessary for the performance of a safe and effective maintenance program. Such a maintenance program to maintain the patient's current condition or to prevent or slow further deterioration is covered so long as the beneficiary requires skilled care for the safe and effective performance of the program. When, however, the individualized assessment does not demonstrate such a necessity for skilled care, including when the performance of a maintenance program does not require the skills of a therapist because it could safely and effectively be accomplished by the patient or with the assistance of non-therapists, including unskilled caregivers, such maintenance services will not be covered.
- Further, under the standard set forth in the previous paragraph, skilled care is necessary for the performance of a safe and effective maintenance program only when (a) the particular patient's special medical complications require the skills of a qualified therapist to perform a therapy service that would otherwise be considered non-skilled; or (b) the needed therapy procedures are of such complexity that the skills of a qualified therapist are required to perform the procedure.

e. The amount, frequency, and duration of the services must be reasonable.

As is outlined in home health regulations, as part of the home health agency (HHA) Conditions of Participation (CoPs), the clinical record of the patient must contain progress and clinical notes. Additionally, in Pub. 100-04, Medicare Claims Processing Manual, Chapter 10; "Home Health Agency Billing", instructions specify that for each claim, HHAs are required to report all services provided to the beneficiary during each episode, this includes reporting each visit in line-item detail. As such, it is expected that the home health records for every visit will reflect the need for the skilled medical care provided. These clinical notes are also expected to provide important communication among all members of the home care team regarding the development, course and outcomes of the skilled observations, assessments, treatment and training performed. Taken as a whole then, the clinical notes are expected to tell the story of the patient's achievement towards his/her goals as outlined in the Plan of Care. In this way, the notes will serve to demonstrate why a skilled service is needed.

Therefore the home health clinical notes must document as appropriate:

- the history and physical exam pertinent to the day's visit , (including the response or changes in behavior to previously administered skilled services) and
- the skilled services applied on the current visit, and
- the patient/caregiver's immediate response to the skilled services provided, and
- the plan for the next visit based on the rationale of prior results.

Clinical notes should be written such that they adequately describe the reaction of a patient to his/her skilled care. Clinical notes should also provide a clear picture of the treatment, as well as "next steps" to be taken. Vague or subjective descriptions of the patient's care should not be used. For example terminology such as the following would not adequately describe the need for skilled care:

- Patient tolerated treatment well
- Caregiver instructed in medication management
- Continue with POC

Objective measurements of physical outcomes of treatment should be provided and/or a clear description of the changed behaviors due to education programs should be recorded in order that all concerned can follow the results of the applied services.

When the skilled service is being provided to either maintain the patient's condition or prevent or slow further deterioration, the clinical notes must also describe:

- A detailed rationale that explains the need for the skilled service in light of the patient's overall medical condition and experiences,
- the complexity of the service to be performed, and
- any other pertinent characteristics of the beneficiary or home.

50.7.1 - Impact on Care Provided in Excess of "Intermittent" or "Part-Time" Care *(Rev. 208, Issued: 04-22-15, Effective: 01-01-15, Implementation: 05-11-15)*

Home health aide and/or skilled nursing care, in excess of the amounts of care that meet the definition of part-time or intermittent, may be provided to a home care patient or purchased by other payers without bearing on

whether the home health aide and skilled nursing care meets the Medicare definitions of part-time or intermittent.

EXAMPLE: A patient needs skilled nursing care monthly for a catheter change and the home health agency also renders needed daily home health aide services 24 hours per day that will be needed for a long and indefinite period of time. The HHA bills Medicare for the skilled nursing and home health aide services, which were provided before the 35th hour of service each week, and bills the beneficiary (or another payer) for the remainder of the care. If the *Medicare contractor* determines that the 35 hours of care are reasonable and necessary, Medicare would cover the 35 hours of skilled nursing and home health aide visits.

70.2 - Counting Visits Under the Hospital and Medical Plans

(Rev. 208, Issued: 04-22-15, Effective: 01-01-15, Implementation: 05-11-15)

The number of visits are counted in the same way whether paid under the hospital (Part A) or supplemental medical (Part B) Medicare trust funds

A. Visit Defined

A visit is an episode of personal contact with the patient by staff of the HHA, or others under arrangements with the HHA, for the purpose of providing a covered home health service. Though visits are provided under the HH benefit as part of episodes, and episodes are unlimited, each visit must be uniquely billed as a separate line item on a Medicare HH claim, and data on visit charges is still used in formulating payment rates.

B. Counting Visits

Generally, one visit may be covered each time an HHA employee, or someone providing home health services under arrangements with the HHA, enters the patient's home and provides a covered service to a patient who meets the criteria in [§30](#).

If the HHA furnishes services in an outpatient facility under arrangements with the facility, one visit may be covered for each type of service provided.

If two individuals are needed to provide a service, two visits may be covered. If two individuals are present, but only one is needed to provide the care, only one visit may be covered.

A visit is initiated with the delivery of covered home health services and ends at the conclusion of delivery of covered home health services. In those circumstances in which all reasonable and necessary home health services cannot be provided in the course of a single visit, HHA staff or others providing services under arrangements with the HHA may remain at the patient's home between visits (e.g., to provide noncovered services). However, if all covered services could be provided in the course of one visit, only one visit may be covered.

EXAMPLES:

1. If an occupational therapist and an occupational therapy assistant visit the patient together to provide therapy and the therapist is there to supervise the assistant, **one** visit is counted.
2. If a nurse visits the patient in the morning to dress a wound and later must return to replace a catheter, **two** visits are counted.
3. If the therapist visits the patient for treatment in the morning and the patient is later visited by the assistant for additional treatment, **two** visits are counted.

4. If an individual is taken to a hospital to receive outpatient therapy that could not be furnished in their own home (e.g., hydrotherapy) and, while at the hospital receives speech-language pathology services and other services, **two or more** visits would be charged.
5. Many home health agencies provide home health aide services on an hourly basis (ranging from 1 to 8 hours a day). However, in order to allocate visits properly against a patient's maximum allowable visits, home health aide services are to be counted in terms of visits. Thus, regardless of the number of continuous hours a home health aide spends in a patient's home on any given day, one "visit" is counted for each such day. If, in a rare situation, a home health aide visits a patient for an hour or two in the morning, and again for an hour or two in the afternoon, two visits are counted.

C. Evaluation Visits

The HHAs are required by regulations to have written policies concerning the acceptance of patients by the agency. These include consideration of the physical facilities available in the patient's place of residence, the homebound status, and the attitudes of family members for the purpose of evaluating the feasibility of meeting the patient's medical needs in the home health setting. When personnel of the agency make such an initial evaluation visit, the cost of the visit is considered an administrative cost of the agency and is not chargeable as a visit since at this point the patient has not been accepted for care. If, however, during the course of this initial evaluation visit, the patient is determined suitable for home health care by the agency, and is also furnished the first skilled service as ordered under the physician's plan of care, the visit would become the first billable visit in the 60-day episode.

The *Medicare contractor* will cover an observation and evaluation (or reevaluation) visit made by a nurse (see [§40.1.2.1](#) for a further discussion of skilled nursing observation and evaluation visits) or other appropriate personnel, ordered by the physician for the purpose of evaluating the patient's condition and continuing need for skilled services, as a skilled visit.

A supervisory visit made by a nurse or other appropriate personnel (as required by the conditions of participation) to evaluate the specific personal care needs of the patient or to review the manner in which the personal care needs of the patient are being met by the aide is an administrative function, not a skilled visit.

80.5 - Services Covered Under *the* End Stage Renal Disease (ESRD) Program *(Rev. 208, Issued: 04-22-15, Effective: 01-01-15, Implementation: 05-11-15)*

Renal dialysis services that are covered *and paid for* under the ESRD *PPS*, which include any *item or* service furnished to an ESRD beneficiary that is directly related to that individual's dialysis, are excluded from coverage under the Medicare home health benefit. However, to the extent *that other requirements for coverage are met, an item or* service *that* is not directly related to a patient's dialysis would be covered (e.g., *a skilled* nursing visit to furnish wound care for an abandoned shunt site). Within these restrictions, beneficiaries may simultaneously receive items and services under the ESRD *PPS through their ESRD facility* at home at the same time as receiving *items and* services under the home health benefit *that are* not related to ESRD.

90 - Medical and Other Health Services Furnished by Home Health Agencies *(Rev. 208, Issued: 04-22-15, Effective: 01-01-15, Implementation: 05-11-15)*

Payment may be made by *Medicare contractors* to a home health agency which furnishes either directly or under arrangements with others the following "medical and other health services" to beneficiaries with Part B coverage in accordance with Part B billing and payment rules other than when a home health plan of care is in effect.

1. Surgical dressings (for a patient who is not under a home health plan of care), and splints, casts, and other devices used for reduction of fractures and dislocations;
2. Prosthetic (Except for items excluded from the term "orthotics and prosthetics" in accordance with [§1834\(h\)\(4\)\(C\)](#) of the Act for patients who are under a home health plan of care);
3. Leg, arm, back, and neck braces, trusses, and artificial legs, arms, and eyes and adjustments to these items when ordered by a physician. (See *Pub 100-02*, Medicare Benefit Policy Manual, Chapter 15);
4. Outpatient physical therapy, outpatient occupational therapy, and outpatient speech-language pathology services (for a patient not under a home health plan of care). (See *Pub 100-02*, Medicare Benefit Policy Manual, Chapter 15); and
5. Rental and purchase of durable medical equipment. (See *Pub 100-02*, Medicare Benefit Policy Manual, Chapter 15.) If a beneficiary meets all of the criteria for coverage of home health services and the HHA is providing home health care under the Hospital Insurance Program (Part A), any DME provided and billed to the *Medicare contractor* by the HHA to that patient must also be provided under Part A. Where the patient meets the criteria for coverage of home health services and the HHA is providing the home health care under the Supplementary Medical Insurance Program (Part B) because the patient is not eligible for Part A, the DME provided by the HHA may, at the beneficiary's option, be furnished under the Part B home health benefit or as a medical and other health service. Irrespective of how the DME is furnished, the beneficiary is responsible for a 20 percent coinsurance.
6. Ambulance service. (See *Pub 100-02*, Medicare Benefit Policy Manual, Chapter 10, Ambulance Services)
7. Hepatitis B Vaccine. Hepatitis B vaccine and its administration are covered under Part B for patients who are at high or intermediate risk of contracting hepatitis B. High risk groups currently identified include: end-stage renal disease (ESRD) patients, hemophiliacs who receive factor VIII or IX concentrates, clients of institutions for the mentally retarded, persons who live in the same household as a hepatitis B virus carrier, homosexual men, illicit injectable drug users. Intermediate risk groups currently identified include staff in institutions for the mentally retarded, workers in health care professions who have frequent contact with blood or blood-derived body fluids during routine work. Persons in the above listed groups would not be considered at high or intermediate risk of contracting hepatitis B, however, if there is laboratory evidence positive for antibodies to hepatitis B. ESRD patients are routinely tested for hepatitis B antibodies as part of their continuing monitoring and therapy. The vaccine may be administered, upon the order of a doctor of medicine or osteopathy, by home health agencies.
8. Hemophilia clotting factors. Blood clotting factors for hemophilia patients competent to use such factors to control bleeding without medical or other supervision and items related to the administration of such factors are covered under Part B.
9. Pneumococcal and influenza vaccines. See *Pub 100-02*, Medicare Benefit Policy Manual, Chapter 15, "Covered Medical and Other Health Services," §50.4.2 "Immunizations."
10. Splints, casts. See *Pub 100-02*, Medicare Benefit Policy Manual, Chapter 15, "Covered Medical and Other Health Services."
11. Antigens. See *Pub 100-02*, Medicare Benefit Policy Manual, Chapter 15, "Covered Medical and Other Health Services."

100 - Physician Certification for Medical and Other Health Services Furnished by Home Health Agency (HHA)

(Rev. 208, Issued: 04-22-15, Effective: 01-01-15, Implementation: 05-11-15)

A physician must certify that the medical and other health services covered by medical insurance, which were provided by (or under arrangements made by) the HHA, were medically required. This certification needs to be made only once where the patient may require over a period of time the furnishing of the same item or service related to one diagnosis. There is no requirement that the certification be entered on any specific form or handled in any specific way as long as the approach adopted by the HHA permits the *Medicare contractor* to determine that the certification requirement is, in fact, met. A written physician's order designating the services required would also be an acceptable certification.