

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-08 Medicare Program Integrity	Centers for Medicare & Medicaid Services (CMS)
Transmittal 13972	Date: September 30, 2026
	Change Request 14627

SUBJECT: Updates to Chapter 6, Sections 6.2 of Publication (Pub) 100-08 - Program Integrity Manual (PIM) to Include Allowed Practitioners in the Home Health Manual Instruction

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to update the Home Health sections of chapter 6 of the PIM (Pub. 100-08) to reflect section 3708 of the Coronavirus Aid, Relief, and Economic Security (CARES) Act (Pub. L. 116-136, March 27, 2020).

EFFECTIVE DATE: November 2, 2026

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

IMPLEMENTATION DATE: November 2, 2026

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

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

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

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	6/6.2/6.2.1/Physician or Allowed Practitioner Certification of Patient Eligibility for the Medicare Home Health Benefit
R	6/6.2/6.2.1/6.2.1.1/Certification Requirements
R	6/6.2/6.2.2/Physician or Allowed Practitioner Recertification
R	6/6.2/6.2.2/6.2.2.1/Recertification Elements
R	6/6.2/6.2.3/The Use of the Patient's Medical Record Documentation to Support the Home Health Certification
R	6/6.2/6.2.4/Coding
R	6/6.2/6.2.5/Medical Necessity of Services Provided
R	6/6.2/6.2.6/Examples of Sufficient Documentation Incorporated Into a Physician's or Allowed Practitioner's Medical Record

III. FUNDING:

For Medicare Administrative Contractors (MACs):

The MAC 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

Pub. 100-08	Transmittal: 13972	Date: September 30, 2026	Change Request: 14627
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II. GENERAL INFORMATION

A. Background: Section 3708 of the CARES Act (Pub. L. 116-136, March 27, 2020) amended sections 1814(a) and 1835(a) of the Act to allow Nurse Practitioners (NP)s, Certified Nurse Specialists (CNSs), and Physicians Assistants (PAs) (as those terms are defined in section 1861(aa) of the Act), to order and certify patients for eligibility under the Medicare HH benefit and establish a plan of care.

B. Policy: Section 3708 of the CARES Act (Pub. L. 116-136, March 27, 2020).

III. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
14627.1	Contractors shall accept documentation from a NP, a CNS, or a PA, per the CARES Act, section 3708, and the updates to chapter 6 of the PIM (Pub. 100-08).			X						

IV. PROVIDER EDUCATION

None

Impacted Contractors: None

V. 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: N/A

VI. CONTACTS

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

VII. FUNDING

Section A: For Medicare Administrative Contractors (MACs):

The MAC 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 Program Integrity Manual

Chapter 6 - Medicare Contractor Medical Review Guidelines for Specific Services

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(Rev. 13972; Issued: 09-30-26)

Transmittals for Chapter 6

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6.2.6 - Examples of Sufficient Documentation Incorporated Into a Physician's *or Allowed Practitioner's* Medical Record

6.2.1 - Physician *or Allowed Practitioner* Certification of Patient Eligibility for the Medicare Home Health Benefit

(Rev.: 13972; Issued: 09-30-26; Effective: 11-02-26; Implementation:11-02-26)

A physician *or allowed practitioner* certification/recertification of patient eligibility for the Medicare home health benefit is a condition for Medicare payment per sections 1814(a) and 1835(a) of the Social Security Act (the “Act”) *as amended by the CARES Act (Public Law No: 116-136)*.

The regulations at 42 CFR 424.22 outline requirements to bill for home health services including patient eligibility and the requirement that certification and recertification be provided by physicians and allowed practitioners for patients. Allowed practitioners are defined in 42 CFR 484.2 as a physician assistant, nurse practitioner, or clinical nurse specialist.

The requirements differ for eligibility certification and recertification; however, if the requirements for certification are not met, then claims for subsequent episodes of care, which require a recertification, will be non-covered—even if the requirements for recertification are met.

Home health agencies (HHAs) should obtain as much documentation from the certifying physician’s/*allowed practitioner’s* medical records and/or the acute/post-acute care facility’s medical records (if the patient was directly admitted to home health) as they deem necessary to assure themselves that the Medicare home health patient eligibility criteria for certification and recertification have been met and must be able to provide it to CMS and its review *contractors* upon request. Per the regulations at 42 CFR 424.22(c), 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.

Therefore, for all medical necessity reviews, the Medicare review contractors shall review the certification documentation for any episode initiated with the completion of a start-of-care Outcome and Assessment Information Set (OASIS) assessment. This means that if the subject claim is for a subsequent episode of care, the HHA must submit all certification documentation as well as recertification documentation. The review contractor shall send a documentation request to the billing HHA requesting the supporting documentation from the certifying physician/*allowed practitioner* and/or the acute/post-acute care facility if the patient was directly admitted to home health from such setting (as defined in 42 CFR 424.22) that substantiates the patient’s eligibility for the Medicare home health benefit.

For medical review purposes, the initial order for home health services for a patient initiates the establishment of a plan of care as part of the certification of patient eligibility for the Medicare home health benefit. The ~~physician’s~~ initial order must specify the medical treatment(s) to be furnished and does not eliminate the need for the plan of care as required in 42 CFR 409.43.

Review contractors shall use the documentation in the certifying physician’s/*allowed practitioner’s* medical record for that patient as the basis for the certification of eligibility. *This includes* subsequent supporting documentation from the HHA (if incorporated into the certifying physician’s/*allowed practitioner’s* or acute/post-acute care facility’s medical record for that patient). *If the medical record is* insufficient to demonstrate the patient is or was eligible to receive services under the Medicare home health benefit, the review contractor shall deny payment (in the case of prepayment review) or shall initiate an overpayment demand letter (in the case of post payment review).

The review contractor shall only consider a plan of care and the certification or recertification for home health services from physicians/*allowed practitioners* who do not have a financial

relationship with the HHA. The review contractor shall only consider documentation of the face-to-face encounter from physicians *or non-physician* practitioners (*NPP*) as defined in 42 CFR 424.22(a)(1)(v), who do not have a financial relationship with the HHA (see 6.2.3).

CMS does not require a specific form or format for the certification as long as a physician/*allowed practitioner* certifies that the five certification requirements, outlined in 42 CFR 424.22(a)(1) and section 6.2.1.1, are met.

6.2.1.1 – Certification Requirements

(Rev.: 13972; Issued: 09-30-26; Effective: 11-02-26; Implementation: 11-02-26)

The regulations at 42 CFR 424.22 outline the requirements for certification of home health services. When conducting a medical necessity review, the review contractor shall determine whether the supporting documentation addresses each of the following criteria for which a physician/*allowed practitioner* certified (attested to):

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

a. Criteria-One:

The patient must *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.

b. Criteria-Two:

- There must exist a normal inability to leave home;

AND

- Leaving home must require a considerable and taxing effort.

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

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

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

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

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

6.2.2 – Physician *or Allowed Practitioner* Recertification

(Rev.: 13972; Issued: 09-30-26; Effective: 11-02-26; Implementation: 11-02-26)

At the end of the 60-day *certification*, a decision must be made whether or not to recertify the patient for a subsequent 60-days. The plan of care must be reviewed and signed by the physician/*allowed practitioner* at least every 60 days when there is a need for continuous home care unless the *patient* transfers to another HHA or the *patient* is discharged and subsequently re-admitted (these situations trigger a new certification, rather than a recertification).

6.2.2.1 – Recertification Elements

(Rev.: 13972; Issued: 09-30-26; Effective: 11-02-26; Implementation: 11-02-26)

The regulations at 42 CFR 424.22 outline the requirements for re-certification of home health services. Recertification is required at least every 60 days unless there is a—

- (i) *Patient* elected transfer; or
- (ii) Discharge with goals met and/or no expectation of a return to home health care.

Medicare does not limit the number of continuous *60-day* recertifications for *patients* who continue to be eligible for the home health benefit. The physician/*allowed practitioner* certification may cover a period less than but not greater than 60 days. Because the updated home health plan of care must include the frequency and duration of visits to be made, the physician/*allowed practitioner* does not have to estimate how much longer skilled services will be needed for the recertification.

The recertification statement must indicate the continuing need for services. Need for occupational therapy may be the basis for continuing services that were initiated because the individual needed skilled nursing care or physical therapy or speech therapy. In this case review *contractors shall* look for documentation substantiating the need for continued occupational therapy when the needed skilled nursing care or physical therapy or speech therapy that were initially needed, are no longer needed.

If a patient's underlying condition or complication requires a registered nurse to ensure that essential non-skilled care is achieving its purpose, and necessitates a registered nurse be involved in the development, management, and evaluation of a patient's care plan, the reviewer will look for the physician's/*allowed practitioner's* brief narrative describing the clinical justification of this need. If the narrative is part of the recertification form, then the narrative must be located immediately prior to the physician's signature. If the narrative exists as an addendum to the recertification form, in addition to the physician's/*allowed practitioner's* signature on the recertification form, the physician/*allowed practitioner* must sign immediately following the narrative in the addendum. *For more detailed information about recertification please see the IOM 100-2, Medicare Benefit Policy Manual, Chapter 7.*

As mentioned earlier in this section, the reviewer will confirm that all elements of the certification are included in the documentation sent for the recertification claim review. If the submitted certification documentation (submitted with the recertification documentation) does not support home health eligibility, the claim associated with the recertification period will not be paid.

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

(Rev.: 13972; Issued: 09-30-26; Effective: 11-02-26; Implementation: 11-02-26)

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

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

As noted earlier, per 42 CFR 424.22 (a) and (c) it is the patient's medical record held by the certifying physician/*allowed practitioner* and/or the acute/post-acute care facility that must support the patient's eligibility for home health services. Therefore, any documentation used to support certification that was generated by the home health agency must be signed off by the certifying physician/*allowed practitioner* and incorporated into the medical record held by the physician/*allowed practitioner* or the acute/post-acute care facility's

medical record. Any information provided to the certifying physician/*allowed practitioner* by the HHA and incorporated into the patient's medical record held by the physician/*allowed practitioner* or the acute/post-acute care facility's medical record (if the patient was directly admitted to home health) must corroborate the rest of the patient's medical record. This means that the HHA information, along with the certifying physician's/*allowed practitioner's* and/or the acute/post-acute care facility's medical record, creates a clinically consistent picture that the patient is eligible for Medicare home health services. This could include, but is not limited to, the plan of care required per 42 CFR 409.43, the initial and/or the comprehensive assessment of the patient required per 42 CFR 484.55, the inpatient discharge summary or multi-disciplinary clinical notes, etc., which must correspond to the dates of service being billed and not contradict the certifying physician's/*allowed practitioner's* and/or the acute/post-acute care facility's own documentation or medical record entries. Once incorporated into the certifying physician's/*allowed practitioner's* medical record for the patient, the HHA information can be used to support the patient's homebound status and need for skilled care, the reviewer shall consider all documentation from the HHA that has been signed off in a timely manner and incorporated into the physician/*allowed practitioner*/hospital record when making its coverage determination. HHA documentation that is used to support the home health certification is considered to be incorporated timely when it is signed off prior to or at the time of claim submission. See section 6.2.6 Examples of Sufficient Documentation Incorporated into a Physician's Medical Record.

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

6.2.4 - Coding

(Rev.: 13972; Issued: 09-30-26; Effective: 11-02-26; Implementation: 11-02-26)

If the patient's comprehensive assessment or recertification assessment was signed off and incorporated into the certifying physician's/*allowed practitioner's* medical record for the patient (or the acute/post-acute care facility's medical record if the patient was directly admitted to home health), contractors shall use it to determine whether the *Patient-Driven Groupings Model (PDGM)* codes billed were accurate and appropriate. In addition, if the comprehensive assessment is incorporated into the certifying physician's/*allowed practitioner's* record for the patient and is used to support that the patient meets the home health eligibility criteria, then the diagnoses and conditions listed on the start of care assessment must be corroborated by information in the certifying physician's/*allowed practitioner's* and/or the acute/post-acute care facility's own medical record documentation.

The contractor shall use the *Home Health Prospective Payment System Grouper* provided by CMS to recode claims as appropriate.

6.2.5 - Medical Necessity of Services Provided

(Rev.: 13972; Issued: 09-30-26; Effective: 11-02-26; Implementation: 11-02-26)

In addition to certification and recertification requirement documentation, contractors shall also review the medical record documentation to determine whether services provided were medically necessary. Again, home health generated information must be reviewed, signed off by the certifying physician/*allowed practitioner* and incorporated into the certifying physician/*allowed practitioner* medical record for the patient or the acute/post-acute care

facility's medical record for the patient (if the patient was directly admitted to home health) if used to support certification/recertification.

6.2.6 - Examples of Sufficient Documentation Incorporated Into a Physician's *or Allowed Practitioner's* Medical Record *(Rev.: 13972; Issued: 09-30-26; Effective: 11-02-26; Implementation: 11-02-26)*

To be eligible for Medicare home health services, a patient must have Medicare Part A and/or Part B and, per §1814(a)(2)(C) and §1835(a)(2)(A) of the Act:

- Be confined to the home;
- Need skilled services;
- Be under the care of a physician *or allowed practitioner*;
- Receive services under a plan of care established and reviewed by a physician/*allowed practitioner*; and
- Have had a face-to-face encounter with a physician or *NPP*.

EXAMPLE *ONE*:

Does the below submitted documentation support the certification statement stating that the patient meets the eligibility criteria for home health benefit certification? Yes.

Records received by the reviewer for a HHA claim for dates of service starting on *April 15, 2026*:

1. Patient was admitted to the hospital with a right-sided femur fracture sustained from a fall requiring surgery. A discharge summary dated April 14, *2026*, signed by the inpatient attending physician. Included in the summary was a description of the patient's injury, DME required, non-weight-bearing status, and the name of and appointment date for the community orthopedic *practitioner* who would continue to follow-up with patient, and the notation of the order for home physical therapy for home safety evaluation, gait training and strengthening 2-3 times per week for 6 weeks to be delivered by an HHA.

Meets requirements for a face-to-face encounter (occurred within the required timeframe, was performed by an allowed provider type, and related to the primary reason the patient requires home health). Identifies the need for skilled services and alludes to the fact that the patient is most likely homebound because of the non-weight-bearing status and the order for DME. Identifies physician/*allowed practitioner* who will be providing care while patient is receiving home health services. Plan of care established with physician/*allowed practitioner* orders.

2. HHA generated comprehensive assessment (admission OASIS) dated *April 15, 2026* along with physical therapy progress notes. PT progress note documents patient is non-weight bearing on right leg and requires use of a two-handed device to walk alone on a level surface, and requires assistance to negotiate stairs or steps or uneven surfaces. The HHA assessment with progress notes has been signed by the community orthopedic certifying *practitioner (and therefore incorporated per § 6.2.3)*.

PT progress note further supports that patient is confined to the home.

3. The community orthopedic physician-signed certification statement for HH services for start of care date of April 15, *2026*.

Certification statement signed by certifying physician/*allowed practitioner*.

4. HHA generated plan of care, which specifies the type, frequency and goals for therapies. The plan of care includes the signature of the certifying physician.

Supports that plan of care has been established and reviewed by the certifying physician/*allowed practitioner*.

EXAMPLE TWO:

Does the below submitted documentation support the certification statement stating that the patient meets the eligibility criteria for home health benefit certification? Yes.

Records received by the reviewer for a HHA claim for dates of service starting on February 1, *2026*

1. Primary care physician progress note dated November 15, *2025*. States reason for visit is patient has a non-healing left foot diabetic foot ulcer measuring 1 cm x 1 cm x 0.5 cm. Patient instructed on wound care with hydroactive gel dressing to be changed every 3 days. Patient able to return demonstrate application of dressing without difficulties.

Meets requirements for a face-to-face encounter (occurred within the required timeframe, was performed by an allowed provider type, and related to the primary reason the patient requires home health).

2. Clinical note in physician record states that patient called primary care physician (PCP) on January 30th stating that the wound has gotten larger and there is copious purulent drainage causing the dressing to be saturated. She states she is unable to adequately change the dressing and keep it in place because of the size of the wound and the amount of drainage. Patient just recovering from pneumonia and she says she is unable to come into the physician's office because she cannot drive. PCP made referral to HHA for skilled nursing services to evaluate the wound.

Identifies the need for skilled services.

3. HHA generated comprehensive assessment (admission OASIS) dated *February 1, 2026* along with skilled nursing notes which includes wound measurements, condition of wound, and documentation of physician phone call to report findings and receipt of verbal orders for daily wound care for 3 weeks, monitor and teach on signs and symptoms of infection and initiation of oral antibiotics twice a day for 14 days. Nursing notes also states that the patient is significantly deconditioned, as a result of recent pneumonia, requires the use of a walker to ambulate from chair to bathroom with frequent stops to rest.

HHA skilled nursing notes further support that patient needs skilled services to initiate new wound care regimen, monitor for infection and that the patient is confined to the home. Physician's verbal orders for daily wound care establish the plan of care.

4. The primary care physician-signed certification statement for HH services for start of care date of February 1, *2026*.

Certification statement signed by certifying physician/*allowed practitioner*.

5. HHA generated plan of care, which specifies the wound care orders, frequency of skilled nursing visits and goals for home health services. The plan of care includes the signature of the certifying physician.

Supports that plan of care has been established and reviewed by the certifying physician/*allowed practitioner*.