

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



Medicare Home Health Benefit



Please note: The information in this publication applies only to the Medicare Fee-For-Service Program (also known as Original Medicare).

The Hyperlink Table, at the end of this document, provides the complete URL for each hyperlink.

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Learn about these home health services topics:

- Qualifying for home health services
- Consolidated billing (CB)
- Therapy services
- Physician billing and payment
- Resources

When “you” is used in this publication, we are referring to home health agencies (HHAs), physicians, and non-physician practitioners (NPPs).



QUALIFYING FOR HOME HEALTH SERVICES

What criteria must be met to qualify for home health services?

Medicare covers home health services when all of these criteria are met:

- The beneficiary to whom services are furnished is eligible and enrolled in Part A and/or Part B of the Medicare Program
- The beneficiary is eligible for coverage of home health services
- The HHA furnishing the services has a valid agreement in effect to participate in the Medicare Program
- The services for which payment is claimed are covered under the Medicare home health benefit
- Medicare is the appropriate payer
- The services are not otherwise excluded from payment

What criteria must a patient meet to be eligible for home health services?

For a patient to be eligible for Medicare home health services, he or she must meet these criteria:

1. Be confined to the home (that is, homebound)
2. Need skilled services
3. Be under the care of a physician
4. Receive services under a home health plan of care (POC) established and periodically reviewed by a physician
5. Had a face-to-face encounter related to the primary reason the patient requires home health services with a physician or an allowed NPP no more than 90 days prior to the home health start of care date or within 30 days of the start of the home health care



What does it mean for a patient to be considered confined to the home (that is, homebound)?

An individual is considered confined to the home (that is, homebound) if the following two criteria are met:

1. Criterion 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 criterion one conditions, then the patient must ALSO meet two additional requirements defined in criterion two below.

2. Criterion Two:

- There must exist a normal inability to leave home

AND

- Leaving home must require a considerable and taxing effort

The patient may be considered confined to the home (that is, homebound) if absences from the home are:

- Infrequent
- For periods of relatively short duration
- For the need to receive health care treatment
- For religious services
- To attend adult daycare programs
- For other unique or infrequent events (for example, funeral, graduation, trip to the barber)

Some examples of persons confined to the home (that is, homebound) are:

- A patient who is blind or senile and requires the assistance of another person in leaving their place of residence
- A patient who has just returned from a hospital stay involving surgery, who may be suffering from resultant weakness and pain and therefore their actions may be restricted by their physician to certain specified and limited activities such as getting out of bed only for a specified period of time or walking stairs only once a day
- 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

Who can perform the required face-to-face encounter?

These health care providers can perform the required face-to-face encounter:

- The certifying physician
- The physician who cared for the patient in an acute or post-acute care facility (from which the patient was directly admitted to home health)
- A nurse practitioner or clinical nurse specialist who is working in collaboration with the certifying physician or the acute/post-acute care physician
- A certified nurse-midwife or physician assistant under the supervision of the certifying physician or the acute/post-acute care physician

The face-to-face encounter cannot be performed by any physician or allowed NPP (listed above) who has a financial relationship with the HHA.

As a condition for payment, certain certification requirements must be met. What are these requirements?

- A physician must certify that a patient is eligible for Medicare home health services according to the [Code of Federal Regulations](#) at 42 CFR 424.22(a)(1)(i)-(v)
- The physician who establishes the home health POC must sign and date the certification

CMS does not require a specific form or format for the certification as long as a Medicare-enrolled physician certifies that these five requirements, outlined at 42 CFR Section 424.22(a)(1), are met:

1. The patient needs intermittent skilled nursing (SN) care, physical therapy (PT), and/or speech-language pathology (SLP) services
2. The patient is confined to the home (that is, homebound)
3. A home health POC has been established and will be periodically reviewed by a physician
4. Services will be furnished while the individual was or is under the care of a physician
5. A face-to-face encounter:
 - a. Occurred no more than 90 days prior to the home health start of care date or within 30 days of the start of the home health care
 - b. Was related to the primary reason the patient requires home health services
 - c. Was performed by a physician or allowed NPP



When should the physician complete the certification?

According to the regulations at 42 CFR 424.22(a)(2), the physician should complete the certification when the home health POC is established or as soon as possible thereafter. It is not acceptable to wait until the end of a 60-day episode of care to obtain a completed certification/recertification, and the certification must be complete prior to an HHA billing Medicare for reimbursement.

When should the physician complete the recertification, and what must he or she include in the recertification?

At, or near, the end of the initial 60-day episode, you must make a decision on whether to recertify the patient for a subsequent 60-day episode. Recertification is required at least every 60 days when there is a need for continuous home health care after an initial 60-day episode and unless there is a:

- Patient-elected transfer
- Discharge with goals met and/or no expectation of a return to home health care. If a patient is discharged and then requires a new episode, the physician must complete a new certification (not a recertification)

Medicare does not limit the number of continuous episodes of recertification for patients who continue to be eligible for the home health benefit.

The recertification must:

1. Be signed and dated by the physician who reviews the home health POC
2. Indicate the continuing need for skilled services (the need for occupational therapy [OT] may be the basis for continuing services initiated because the individual needed SN, PT, or SLP services)
3. Estimate how much longer the skilled services will be required

For more information on qualifying for home health services, the face-to-face encounter, and the required physician certification/recertification of patient eligibility, refer to [Certifying Patients for the Medicare Home Health Benefit](#).

CB

What home health services are subject to the CB governing Home Health Prospective Payment System (HH PPS)?

These home health services are subject to the CB governing HH PPS:

- Part-time or intermittent SN and home health aide services – These services can be furnished any number of days per week as long as they are furnished (combined) less than 8 hours each day and 28 or fewer hours each week (or, subject to review on a case-by-case basis as to the need for care, less than 8 hours each day and 35 or fewer hours per week)
- PT
- OT
- SLP services
- Medical social services
- Routine and non-routine medical supplies
- Furnishing negative pressure wound therapy (NPWT) using a disposable device, as defined at 42 CFR 484.202
- Covered osteoporosis drugs as defined in Section 1861(kk) of the Social Security Act (the Act) (but excluding other drugs and biologicals)
- Medical services provided by an intern or resident-in-training of the program of the hospital (if you are affiliated or under common control with a hospital with an approved teaching program)
- Home health services defined in Section 1861(m) of the Act provided under arrangement at hospitals, Skilled Nursing Facilities, or rehabilitation centers when they involve equipment too cumbersome to bring to the home or furnished while the patient is at the facility to receive such services

THERAPY SERVICES

What requirements and standards must be met for therapy services?

Skilled therapy services must be reasonable and necessary for the treatment of the patient's illness or injury. Coverage does not turn on the presence or absence of an individual's potential for improvement, but rather on the beneficiary's need for skilled care within the context of his or her unique medical condition. Skilled care may be necessary to improve a patient's current condition, to maintain the patient's current condition, or to prevent or slow further deterioration of the patient's condition. This means that the therapy services must be:

- Inherently complex, which means that they can be performed safely and/or effectively only by or under the general supervision of a skilled therapist
- Consistent with the nature and severity of the illness or injury and the patient's particular medical needs, which include services that are reasonable in amount, frequency, and duration
- Considered specific, safe, and effective treatment for the patient's condition under accepted standards of medical practice

Refer to [Home Health Prospective Payment System](#) for information on the standards that must be met for skilled therapy services to be considered effective treatment for the patient's condition.

PHYSICIAN BILLING AND PAYMENT

How am I paid under the HH PPS for the Medicare home health services I furnish?

With the exception of certain covered osteoporosis drugs where the patient meets specific criteria, durable medical equipment (DME), and furnishing NPWT using a disposable device, payment for all services and supplies is included in the HH PPS episodic rate for individuals under a home health POC. You must provide the covered home health services (except DME) either directly or under arrangement (an outside supplier furnishes services under arrangement and looks to the HHA for payment). You must bill for such covered home health services, and payment must be made to you.

How am I paid for episodes of care?

The unit of payment under the HH PPS is a 60-day episode of care. A split percentage payment is made for most HH PPS episode periods. There are two payments – initial and final. The first payment is made in response to a Request for Anticipated Payment (RAP), and the last payment is paid in response to a claim. Added together, the first and last payments equal 100 percent of the permissible payment for the episode.

There is a difference in the percentage split of initial and final payments for initial and subsequent episodes for patients in continuous care. For all initial episodes, the percentage split for the two payments is 60 percent in response to the RAP and 40 percent in response to the claim. For all subsequent episodes in periods of continuous care, each of the two percentage payments is 50 percent of the estimated case-mix adjusted episode payment. The case-mix and wage-adjusted national 60-day episode payment is adjusted for case-mix based on the patient's condition and care needs or case-mix assignment. The payment is also adjusted to account for area wage differences.

What codes should I use on physician claims when certifying/recertifying eligibility for home health services?

Use these HCPCS codes on physician claims when certifying/recertifying eligibility for home health services:

- HCPCS code G0180 – Physician certification home health patient for Medicare-covered home health services under a home health plan of care (patient not present)
- HCPCS code G0179 – Physician recertification home health patient for Medicare-covered home health services under a home health plan of care (patient not present)

If a HHA claim is not covered because the certification/recertification of eligibility was not complete or because there was insufficient documentation to support the patient's eligibility for the Medicare home health benefit, a physician's claim for certification/recertification of eligibility for home health services (HCPCS codes G0180 and G0179, respectively) is also not considered a Medicare-covered home health service.

For more information on home health billing and payment, refer to [Home Health Prospective Payment System](#).

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RESOURCES

This table provides home health resource information.

Home Health Resources

For More Information About...	Resource
Home Health Services	Home Health Agency Center Chapter 7 of the Medicare Benefit Policy Manual (Publication 100-02) Chapter 10 of the Medicare Claims Processing Manual (Publication 100-04) Chapter 6 of the Medicare Program Integrity Manual (Publication 100-08)
Code of Federal Regulations	https://www.gpo.gov/fdsys/browse/collectionCfr.action
Compilation of Social Security Laws	http://www.ssa.gov/OP_Home/ssact/title18/1800.htm
All Available MLN Products	MLN Catalog
Provider-Specific Medicare Information	MLN Guided Pathways: Provider Specific Medicare Resources
Medicare Information for Patients	Medicare.gov

HYPERLINK TABLE

Embedded Hyperlinks	Complete URLs
Code of Federal Regulations	https://www.gpo.gov/fdsys/browse/collectionCfr.action
Certifying Patients for the Medicare Home Health Benefit	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1436.pdf
Home Health Prospective Payment System	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1243662.html
Home Health Agency Center	https://www.cms.gov/Center/Provider-Type/Home-Health-Agency-HHA-Center.html
Medicare Benefit Policy Manual	https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c07.pdf
Medicare Claims Processing Manual	https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c10.pdf
Medicare Program Integrity Manual	https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c06.pdf
MLN Catalog	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MLNCatalog.pdf
MLN Guided Pathways: Provider Specific Medicare Resources	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/Guided_Pathways_Provider_Specific_booklet.pdf



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