CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-01 Medicare General Information, Eligibility, and Entitlement	Centers for Medicare & Medicaid Services (CMS)
Transmittal 92	**Date: April 22, 2015**
	Change Request 9119

Transmittal 91, dated April 10, 2015, is being rescinded and replaced by Transmittal 92 to revise the effective date of the change.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.

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	4/30/Certification and Recertification by Physicians for Home Health Services
R	4/30.1/Content of the Physician's Certification
R	4/30.2/Method and Disposition of Certifications for Home Health Services
R	4/30.3/Recertifications for Home Health Services

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

Pub. 100-01	Transmittal: 92	Date: April 22, 2015	Change Request: 9119

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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.

B. Policy: 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.

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
9119 - 01.1	Medicare contractors shall be aware of the revisions to the requirements for physician certification and recertification for Medicare home health services.	X	X	X						

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
9119 - 01.2	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:

Section B: All other recommendations and supporting information: N/A

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):
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ATTACHMENTS: 0

30 - Certification and Recertification by Physicians for Home Health Services

(Rev. 92, Issued: 04-22-15, Effective: 01-01-15, Implementation: 05-11-15)

In addition to the content below, refer to Pub. 100-02, Medicare Benefit Policy Manual, chapter 7, section 30.5 for a complete description of the requirements that must be met in order to certify and recertify patient eligibility for Medicare home health services.

30.1 - Content of the Physician's Certification

(Rev. 92, Issued: 04-22-15, Effective: 01-01-15, Implementation: 05-11-15)

Under both the hospital insurance and the supplementary medical insurance programs, no payment can be made for covered home health services that a home health agency *(HHA)* provides unless a physician certifies that:

- *H*ome health services are *needed* because the individual is confined to his/her home;

- *The individual* needs intermittent skilled nursing care, physical therapy and/or speech-language pathology services*. Where a patient's sole skilled service need is for skilled oversight of unskilled services, 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;*

- A plan for furnishing such services to the individual has been established and is periodically reviewed by a physician;

- The services are or were furnished while the individual was under the care of a physician*; and*

- *The individual had a face-to-face encounter with an allowed provider type no more than 90 days prior to or within 30 days after the start of home health care and the encounter was related to the primary reason the patient requires home health services in accordance with requirements described in Pub. 100-02, Medicare Benefit Policy Manual, chapter 7, section 30.5.1.1. The certifying physician must also document the date of the encounter.*

Certifications must be obtained at the time the plan of care is established or as soon thereafter as possible.

The physician *must* sign and date the *plan of care (POC) and the* certification prior to the claim being submitted for payment; rubber signature stamps are not acceptable. The *plan of care* may be signed by another physician who is authorized by the attending physician to care for his/her patients in his/her absence. While the regulations specify that documents must be signed, they do not prohibit the transmission of the POC*,* oral order*, or certification* via facsimile machine. The HHA is not required to have the original signature on file. However, the HHA is responsible for obtaining original signatures if an issue surfaces that would require verification of an original signature.

Home health agencies that maintain patient records by computer rather than hard copy may use electronic signatures. However, all such entries must be appropriately authenticated and dated. Authentication must include signatures, written initials, or computer secure entry by a unique identifier of a primary author who has reviewed and approved the entry. The HHA must have safeguards to prevent unauthorized access to the records and a process for reconstruction of the records upon request from the *Medicare contractor*, state surveyor, or other authorized personnel, in the event of a system breakdown.

See §10.1 for the effects of failure to certify or recertify.

30.2 - Method and Disposition of Certifications for Home Health Services

Rev. 92, Issued: 04-22-15, Effective: 01-01-15, Implementation: 05-11-15)

There is no requirement that the certification or recertification be entered on any specific form or handled in any specific way as long as the *Medicare contractor* can determine, where necessary, that the certification and recertification requirements are met. The certification by the physician must be retained by the *HHA*.

The following instructions pertain to required documentation of the certification and recertification period.

The HHA enters the month, day, year, e.g., MMDDYYYY that identifies the period covered by the physician's POC. The "From" date for the initial certification must match the *start of care (*SOC*)* date. The "*through*" date is up to and including the last day of the episode which is not the first day of the subsequent episode. The "*through*" date can be up to, but never exceed a total of 60 days that includes the SOC date plus 59 days.

Example: Initial certification "From" date 10012000; Initial certification "*through*" date 11292000; Re-certification "From" date 11302000; Re-certification "*through*" date 01282001.

NOTE: Services delivered on 11292000 are covered in the initial certification episode.

30.3 - Recertifications for Home Health Services

Rev. 92, Issued: 04-22-15, Effective: 01-01-15, Implementation: 05-11-15)

Under both the hospital insurance and supplementary medical insurance programs, when services are continued *past an initial 60-day episode of care*, the physician must recertify at intervals of at least once every 60 days that there is a continuing need for services *in accordance with requirements described in Pub. 100-02, Medicare Benefit Policy Manual, chapter 7, section 30.5.2*. The recertification should be obtained at the time the plan of care is reviewed since the same interval (at least once every 60 days) is required for the review of the plan.

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

1. The home health services are or were needed because the patient is or was confined to the home as defined in Pub. 100-02, Medicare Benefit Policy Manual, chapter 7, section 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 Pub. 100-02, Medicare Benefit Policy Manual, chapter 7, section 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.

Recertifications must be signed by the physician who reviews the plan of *care*. The form of the recertification and the manner of obtaining timely recertifications are up to the individual agency.