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National Government Services

Documenting the Home Health Eligibility Criteria Session Seven

April 22, 2022

DATASOFTLOGIC
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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Today's Presenters

NGS Provider Experience
Innovative Solutions • Meaningful Education • Reduced Burden

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Disclaimer

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  - This applies to our webinars, teleconferences, live events and any other type of National Government Services educational events

Objectives

- To offer federal Medicare regulatory direction to home health agencies (*as well as any/all provider types ordering/referring home health services*) in an effort to provide assistance in the comprehension of documentation requirements required to support homebound status, need for skilled services, the home health plan of care, physician and allowed practitioner oversight of services and the face-to-face encounter. Certification and recertification of all home health eligibility criteria will be discussed, as well as documentation collaboration with other agencies, offices and facilities in an effort to ensure appropriate documentation within the medical record.

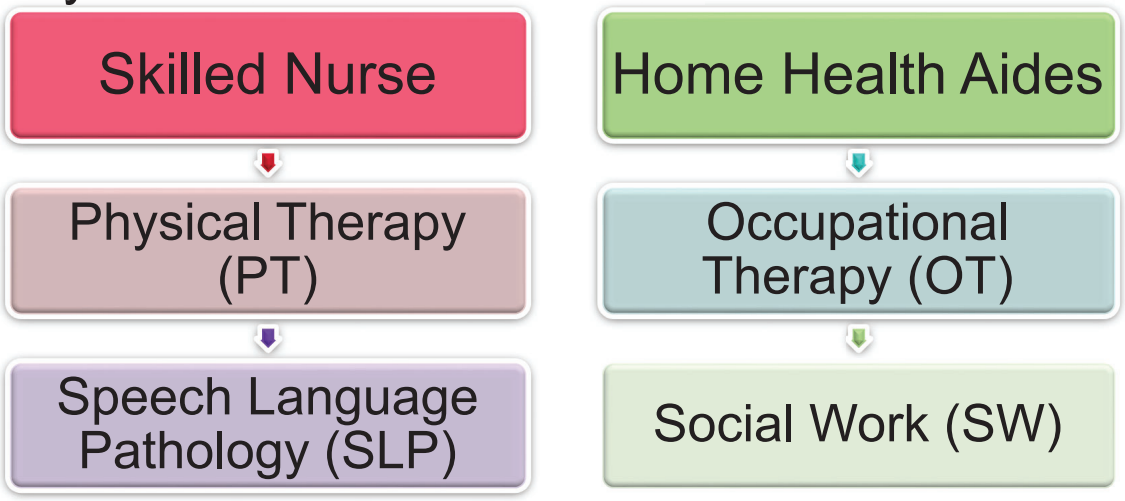
Agenda

- The Medicare Home Health Benefit
- Home Health Eligibility Criteria
  - Homebound Status
  - The Need for Skilled Service
  - The Plan of Care
  - Under the Care of a Physician or Allowed Practitioner
  - The Face-to-Face Encounter
- Certification & Recertification of Eligibility Criteria
- Documentation Collaboration
- Discharge from Home Health Services
- Reason Code 37253
- References & Resources
- Question & Answer Period

The Medicare Home Health Benefit

The Medicare Home Health Benefit

- Services that the Medicare beneficiary/patient may receive at home include:



Home Health Eligibility Requirements

Eligibility Requirements

- Homebound
- Need for Skilled Service
- Under the Care of a Physician or Allowed Practitioner
- Plan of Care
- Face-to-Face Encounter

Homebound Status

Homebound Status

Criteria One

(One Standard Must Be Met)

- 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 to leave their place of residence;
- **or**
- Have a condition such that leaving his or her is medically contraindicated

Criteria Two

(Both Standards Must Be Met)

- There must exist a normal inability to leave home;
- **and**
- Leaving home must require a considerable and taxing effort

Homebound

Homebound Status

- **Criteria One**
  - Verify the **type of support** and/or supportive device or **assistance** required to assist the patient in leaving home

or

  - Verify the reason why leaving home is **medically contraindicated**

Homebound Status

- **Criteria Two**
  - Clinical information about the patient's health status including their:
    - **Normal inability** to leave the home
    - Leaving home requires a **considerable and taxing effort**
      - Prior level of function
      - Current diagnosis
      - Duration of condition
      - Clinical course (worsening or improvement)
      - Prognosis
      - Nature and extent of functional limitations
      - Therapeutic interventions and results

Homebound Status

- Explain the patient's normal inability to leave home
- Define the taxing effort
- Ensure the information is patient specific
- For example:
  - Pain medications
  - Rest periods
  - Oxygen
  - Incontinence
  - Confusion
  - Safety concerns
  - Alternative accommodations

Homebound Status

- If the patient does in fact leave the home, the patient may nevertheless be considered homebound if the absences from the home are:

Infrequent → For Periods of Relatively Short Duration → Attributable to the Need to Receive Health Care Treatment

  - For medical appointments/treatments
  - For religious services
  - To attend adult daycare centers for medical care
  - For other unique or infrequent events
    - Funeral, graduation, hair care

Homebound Status

- Documentation must:
  - **Include** information about the injury/illness and the type of support and/or supportive device/assistance required for illness/injury to assist the patient in leaving home **or**
  - **Explain** in detail how the patient's current condition makes leaving home medically contraindicated
  - **Clarify** exactly the distinct difference in the patient's normal ability versus their normal inability
  - **Describe** exactly what effects are causing the considerable and taxing effort for this patient when leaving home

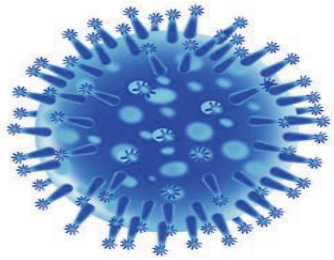
Homebound Status

- Declaring any portion of the regulation as a blanket statement copied from the CMS manual is vague

"It's a taxing effort for the patient to leave home."
"The patient leaves home for periods of short duration."
"The patient leaves home infrequently."
"The patient leaves home for religious services."
"The patient has a normal inability to leave their home."

Public Health Emergency

- Homebound Definition
  - A beneficiary is considered homebound when their physician advises them not to leave the home because of a confirmed or suspected COVID-19 diagnosis or if the patient has a condition that makes them more susceptible to contract COVID-19
  - As a result, if a beneficiary is homebound due to COVID-19 and needs skilled services, a home health agency can provide those services under the Medicare home health benefit



The Need for Skilled Services

Need for Skilled Services

- Home health agencies must continue to document the need for skilled services throughout the patient's medical record.
- The medical record documentation must include the reasons WHY the patient continues to require a skilled professional in their home.

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Need for Skilled Services

- Distinguish exactly what services are going to be provided by the skilled professional in the patient's home

Registered Nurse for Daily Sacral Wound Dressing Changes x3 weeks

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Need for Skilled Services

- Explain why a “skilled professional” is required to provide the home health services requested

Need for Skilled Services

- **Disclose** clinical information (beyond a list of recent diagnoses, injury or procedure) that is individual and specific to the patient

Need for Skilled Services

- **Include** the findings from the face-to-face encounter to support the primary reason for the skilled services being provided

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Need for Skilled Services

- **Skilled nursing services** are covered when an individualized assessment of the patient's clinical condition demonstrates that the specialized judgment, knowledge and skills of a registered nurse are necessary

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Need for Skilled Services

- To be considered a "skilled service," the service must be so inherently complex that it can only be safely and effectively performed by or under the supervision of a skilled professional

Need for Skilled Services

- A skilled professional must document the services specific to the care provided as it pertains to the current diagnosis relative to the reason for home health services during every visit

Need for Skilled Services

- When the patient no longer meets eligibility criteria and skilled services are no longer required, the reason for discharge from home health services should be documented within the medical record and the provider monitoring patient care should be notified

The Plan of Care

The Plan of Care

- All care provided by the home health agency must be in accordance with the plan of care

The Plan of Care

- The orders on the plan of care must indicate the type of services to be provided to the patient, both with respect to the professional who will provide them and the nature of the individual services, as well as the frequency and duration of the services

The Plan of Care

- The patient must be under the care of a physician or non-physician practitioner who is qualified to sign the physician certification and plan of care

The Plan of Care

- It is expected that in most instances, the physician or non-physician practitioner who certifies the patient's eligibility for Medicare home health services will be the same physician or non-physician practitioner who establishes and signs the plan of care

The Plan of Care

- The home health agency staff will further develop and evolve the plan of care in collaboration with the community physician or non-physician practitioner that is monitoring the home health services

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The Plan of Care

- There are **no federally mandated forms** for the plan of care

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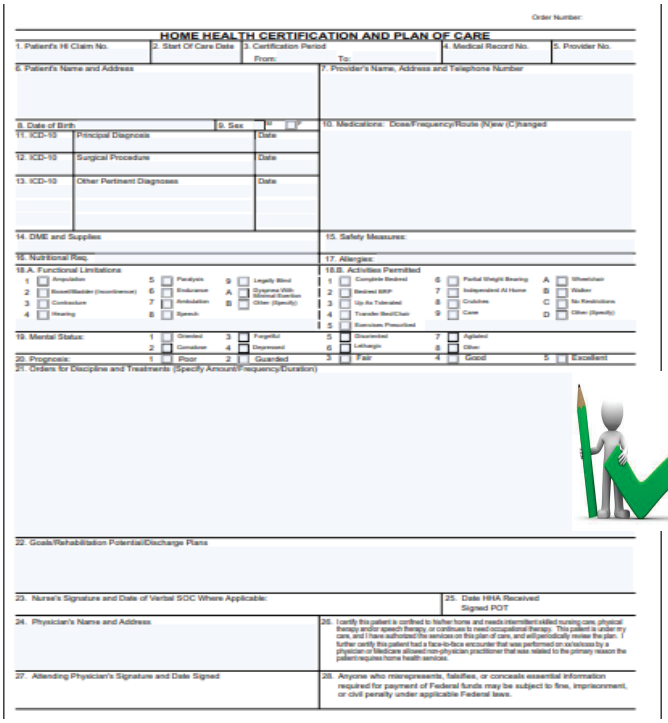
The Plan of Care



HOME HEALTH CERTIFICATION AND PLAN OF CARE

1. Patient's HI Claim No. | 2. Start Of Care Date | 3. Certification Period From: To: | 4. Medical Record No. | 5. Provider No.

6. Patient's Name and Address | 7. Provider's Name, Address and Telephone Number

8. Date of Birth | 9. Sex M F

10. Medications: Dose/Frequency/Route (N)ew (C)hanged

11. ICD-10 Principal Diagnosis | Date

12. ICD-10 Surgical Procedure | Date

13. ICD-10 Other Pertinent Diagnoses | Date

14. DME and Supplies

15. Safety Measures:

16. Nutritional Req.

17. Allergies:

18.A. Functional Limitations

18.B. Activities Permitted

19. Mental Status: 1 Oriented 2 Comatose 3 Forgetful 4 Depressed 5 Disoriented 6 Lethargic 7 Agitated 8 Other

20. Prognosis: 1 Poor 2 Guarded 3 Fair 4 Good 5 Excellent

21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration)

22. Goals/Rehabilitation Potential/Discharge Plans

23. Nurse's Signature and Date of Verbal SOC Where Applicable:

25. Date HHA Received Signed POT

24. Physician's Name and Address

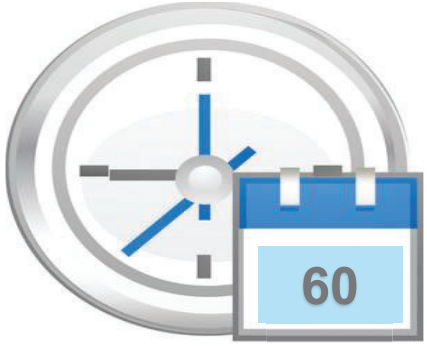
26. I certify this patient is confined to his/her home and needs intermittent skilled nursing care, physical therapy and/or speech therapy, or continues to need occupational therapy. This patient is under my care, and I have authorized the services on this plan of care, and will periodically review the plan. I further certify this patient had a face-to-face encounter that was performed on or/unless by a physician or Medicare allowed non-physician practitioner that was related to the primary reason the patient requires home health services.

27. Attending Physician's Signature and Date Signed

28. Anyone who misrepresents, falsifies, or conceals essential information required for payment of Federal funds may be subject to fine, imprisonment, or civil penalty under applicable Federal laws.

The Plan of Care

- The plan of care must be reviewed and signed by the physician or non-physician practitioner who established the plan of care, in consultation with home health agency professional personnel, as frequently as the patient's condition requires, but no less frequently than every 60 days



The Plan of Care

- Each review of a patient's plan of care must be signed by the physician or non-physician practitioner who established the plan of care in consultation with the home health agency staff

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The Plan of Care

- Home health agencies that maintain patient records via computer may utilize appropriately authenticated and dated electronic signatures

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The Plan of Care

- The plan of care is considered terminated if the patient does not receive at least one covered skilled service within a 60-day certification period unless a physician or non-physician practitioner documents that the interval without care is appropriate to the treatment of the patient's illness/injury

Under the Care of a Physician or Allowed Practitioner

Under the Care of a Physician or Allowed Practitioner

- **Plans of Care and Certifying/Recertifying Patient Eligibility**: In addition to a physician, section 3708 of the CARES Act allows a Medicare-eligible home health patient to be under the care of a nurse practitioner, clinical nurse specialist, or a physician assistant who is working in accordance with State law. These physicians/practitioners can:
  1. order home health services;
  2. establish and periodically review a plan of care for home health services (e.g., sign the plan of care),
  3. certify and re-certify that the patient is eligible for Medicare home health services
- **This is a permanent change**
  - These changes are effective for Medicare claims with a "claim through date" on or after 3/1/2020

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Under the Care of a Physician or Allowed Practitioner

- Physician
  - A doctor of medicine, osteopathy, or podiatric medicine
- Non-Physician Practitioner
  - Nurse Practitioner (NP)

    Physician Assistant (PA)

    Clinical Nurse Specialist (CNS)

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Under the Care of a Physician or Allowed Practitioner

- The patient must remain under the care of a physician/NPP who is qualified to sign the certification and plan of care

Under the Care of a Physician or Allowed Practitioner

- If the referring physician names a physician/NPP other than him/herself to monitor home health services, that information must be documented within the patient's medical record and shared with the home health agency

Dr. Joseph Lister

has agreed to monitor the patient's

home health services

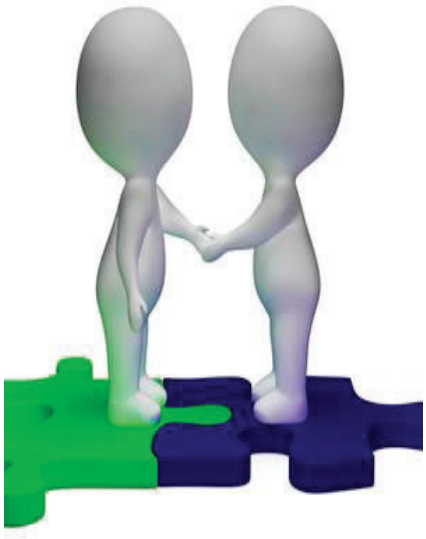
Under the Care of a Physician or Allowed Practitioner

- It is expected that in most instances, the physician/NPP who certifies the patient's eligibility for Medicare home health services will be the same physician/NPP who establishes and signs the plan of care

Under the Care of a Physician or Allowed Practitioner

Physician or Non-Physician Practitioner

- Order and/or refer a patient to home health services
- Monitor patient's home health plan of care and services in the home
- Ensure that a face-to-face encounter has been completed
- Certify & re-certify eligibility



Under the Care of a Physician or Allowed Practitioner

When the physician or non-physician practitioner is referring, certifying and monitoring home health services

- Is the beneficiary eligible for home health services?
- Is the patient homebound as per the CMS definition?
- Is there a need for skilled services in the home?
- Is a plan of care in place or will one be developed with the home health agency?
- Has a face-to-face encounter been completed?
  - Was all of this documentation from the face-to-face visit that prompted the referral to home health subsequently shared with the home health agency upon referral?
- Is the certification statement complete, signed & dated?

Medicare Home Health Benefit & Eligibility Criteria

When the physician or non-physician practitioner is referring a patient for home health services but NOT certifying eligibility or monitoring home health care

- Is the beneficiary eligible for home health services?
- Is the patient homebound as per the CMS definition?
- Is there a need for skilled services in the home?
- **Has a physician/NPP that will be monitoring the home health plan of care and services been identified within the patient's medical record?**
- Has a face-to-face encounter been completed?
  - Was all of this documentation from the face-to-face visit that prompted the referral to home health subsequently shared with the home health agency upon referral?
- Is the certification statement complete, signed & dated?

The Face-to-Face Encounter

The Face-to-Face Encounter

- Documentation of a 1:1 patient visit with a physician or allowed non-physician practitioner
  - Provider Office
  - Acute Care Facility (Hospital, Urgent Care Center)
  - Post Acute Care Facility (Skilled Nursing Facility, Rehabilitation Center)

The Face-to-Face Encounter

- Examples of face-to-face encounter documentation include:
  - The Admitting History & Physical
  - The Discharge Summary
  - The Progress Notes

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The Face-to-Face Encounter

- Non-physician practitioners allowed to perform the encounter include:
  - Nurse Practitioner
  - Clinical Nurse Specialist
  - Certified Nurse Midwife
  - Physician Assistant

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The Face-to-Face Encounter

90 Days Prior to the Home Health Start of Care

Related to the Primary Reason the Patient Requires Home Health Services

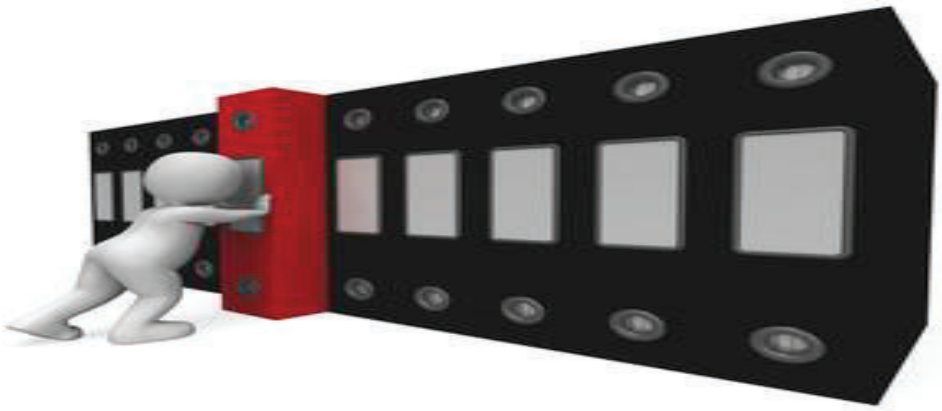
Performed by an Allowed Provider Type

The Face-to-Face Encounter

- Skilled oversight of unskilled care requires a written narrative

The Face-to-Face Encounter

- Documentation to support that an encounter occurred by an allowed provider type should be provided to the home health agency



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The Face-to-Face Encounter

- The provider performing the encounter **must not** be employed by, or have a financial relationship with the home health agency

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The Face-to-Face Encounter

- Telehealth

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The Face-to-Face Encounter

- Telehealth & the Public Health Emergency

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Certification and Recertification of Eligibility Criteria

Certification of Eligibility Criteria

- Is the patient eligible to utilize their home health benefit?

- Does the patient meet **all** of the eligibility criteria?

Certification of Eligibility Criteria

The certifying/re-certifying physician or allowed practitioner is attesting to the fact that all five eligibility criteria have been met:

1. The patient is confined to the home (homebound)
2. Has a need for skilled services in the home
3. A plan of care has been established and will be periodically reviewed by a physician or allowed practitioner
4. Services will be furnished while the patient is under the care of a physician or allowed practitioner
5. A face-to-face encounter occurred by a physician or allowed practitioner for the current diagnosis

Certification of Eligibility Criteria

- **Certifying physician** must be enrolled in the Medicare Program and be a Doctor of Medicine, a Doctor of Osteopathy; or a Doctor of Podiatric Medicine
- **Certifying allowed practitioner** must be a nurse practitioner, clinical nurse specialist, or a physician assistant who is working in accordance with state law
  - **Certifying physician/allowed practitioner** must be enrolled in PECOS
  - **Certifying physician/allowed practitioner** cannot have financial relationship with the home health agency unless it meets one of exceptions within the Code of Federal Regulations: 42 CFR 411.355-42 and CFR 411.357

Certification of Eligibility Criteria

- The certification statement can be signed at the time of referral by the ordering/referring physician or by the community physician/allowed practitioner that has agreed to oversee the patients home health services

Certification of Eligibility Criteria

- If the certifying or allowed practitioner is an acute/post-acute care provider **and will not be following the patient** while they are receiving home health services, the medical record documentation **must identify the name of community physician who will be monitoring the home health services and signing the plan of care**

Certification of Eligibility Criteria

- The certification must be complete prior to when the home health agency bills Medicare for reimbursement
- Certification should be completed when the plan of care is established, or as soon as possible thereafter
- It is not acceptable for the home health agency to wait until the end of a 60-day certification period to obtain a completed certification or recertification

Certification of Eligibility Criteria

- **Certification Statement Example**
  - The ordering/referring physician or allowed practitioner is certifying eligibility for home health services, **but is not monitoring** the patients home health care
    - *I certify this patient is confined to his/her home and needs intermittent skilled nursing care, physical therapy and/or speech therapy, or continues to need occupational therapy.* ***I have authorized the services on the initial plan of care which will be further developed by Dr. XXX who has agreed to monitor home health services.*** *I further certify this patient had a face-to-face encounter that was performed on (include date) by (include name of physician or allowed practitioner that completed the face-to-face encounter) that was related to the primary reason the patient requires home health services.*

Certification of Eligibility Criteria

Certification Statement Example

- The ordering physician or allowed practitioner is certifying eligibility and **will be monitoring** the patients home health care
  - *I certify this patient is confined to his/her home and needs intermittent skilled nursing care, physical therapy and/or speech therapy, or continues to need occupational therapy.* ***This patient is under my care.*** *I have authorized the services on this plan of care and will continue to monitor home health services. I further certify this patient had a face-to-face encounter that was performed on (include date) by (include name of physician or allowed practitioner that completed the face-to-face encounter) that was related to the primary reason the patient requires home health services.*

Recertification of Eligibility Criteria

- Recertification is required at least every 60 days
- Medicare does not limit the number of continuous episode re-certifications for patients who continue to be eligible for the HH benefit
- The physician or allowed practitioner recertifying the patient's eligibility is the same provider that has been continually monitoring the plan of care and providing oversight of home health services

Recertification of Eligibility Criteria

Recertification Statement Example

- *I recertify this patient continues to be confined to the home and has a continued need for skilled services. This patient remains under my care; I have authorized the services on the plan of care and will continue to monitor home health services. I also re-certify that this patient had a face-to-face encounter performed on (include date) by (include name of physician or allowed practitioner that completed the face-to-face encounter) that continues to be related to the primary reason the patient requires home health services.*

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26. I certify/recertify that this patient is confined to his/her home and needs intermittent skilled nursing care, physical therapy and/or speech therapy or continues to need occupational therapy. The patient is under my care, and I have authorized services on this plan of care and will periodically review the plan.

What is Missing from this Certification Statement?

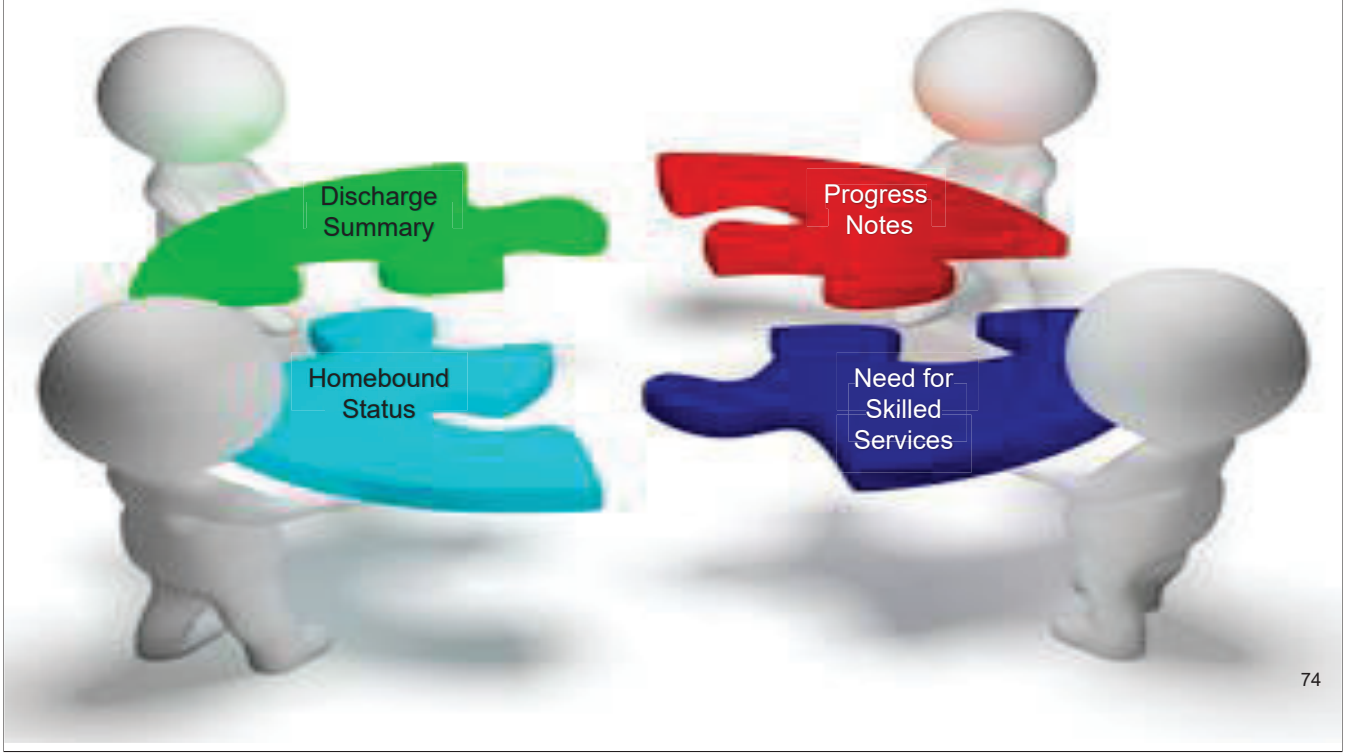
Certification of Eligibility Criteria

26. I certify this patient is confined to his/her home and needs intermittent skilled nursing care, physical therapy and/or speech therapy, or continues to need occupational therapy. This patient is under my care, and I have authorized the services on this plan of care, and will periodically review the plan. I further certify this patient had a face-to-face encounter that was performed on xx/xx/xxxx by a physician or Medicare allowed non-physician practitioner that was related to the primary reason the patient requires home health services.

CMS POC/Certification

Documentation Collaboration

Documentation Collaboration



Documentation Collaboration

Acute Care Facility	• Must forward any & all supporting documentation
Post-Acute Care Facility	• Must forward any & all supporting documentation
Physician's Office	• Must forward any & all supporting documentation
Other Services (including Ambulance, Oxygen, Intravenous therapy, etc.)	• Must forward any & all supporting documentation

Home Health Agency

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Documentation Collaboration

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Documentation Collaboration

Documentation Collaboration

- Home health agencies require as much documentation from the certifying physician/allowed practitioner medical records and/or the acute/post-acute care facility's medical records as necessary to assure that the patient eligibility criteria have been met
- The home health agency must be able to provide all documentation to CMS and its review entities upon request

Documentation Collaboration

- Documentation within the certifying physician/allowed practitioner 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 Collaboration

- Examples of documentation to share **at the point of referral**
  - Referral and orders for home health services
  - Documentation (from anywhere in the medical record) supporting homebound status and the need for skilled services
  - The face-to-face encounter documentation which would Include a discharge summary or interoffice progress notes documenting the one-on-one physician/allowed practitioner visit

Documentation Collaboration

- The home health agency generated medical record documentation for the patient, by itself, is not sufficient in demonstrating the patient's eligibility for Medicare home health services
- 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

Documentation Collaboration

- Incorporating home health agency documentation into the physician/allowed practitioner record
  - Information from the home health can be incorporated into the certifying physician/allowed practitioner medical record for the patient
  - The certifying physician/allowed practitioner must review and sign any documentation used to support the certification of eligibility criteria
  - If this documentation is to be used for verification of the eligibility criteria, it must be dated prior to submission of the claim

Discharge from Home Health Services

Discharge from Home Health Services

- When the patient no longer meets (just one) eligibility criteria and skilled services are no longer required, the reason for discharge from home health services should be documented within the medical record and the provider monitoring patient care should be notified

Discharge from Home Health Services

- Face-to-Face Encounter
- Initial Certification and Recertification
- Narrative if Skilled Oversight is Required
- All Signed Physician or Allowed Practitioner Orders
- Home Health Generated Documentation and Discipline Notes for all Services Billed
- Initial Therapy Evaluation & Documentation
- Plan of Care
- Documentation to Support Homebound Status & the Need for Skilled Services
- ABN (if generated)

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Reason Code: 37253

Reason Code: 37253

- Claim has no matching OASIS assessment found in iQIES
- If there is no matching assessment found in iQIES when a claim is submitted, the HHA's claim will be returned with reason code 37253.
- There are several areas that need to be verified to help correct/avoid this error.
- If a claim gets returned for this reason code, please use the link below as checklist to ensure all areas have been verified and corrected:

Correcting Reason Code 37253

References and Resources

References & Resources

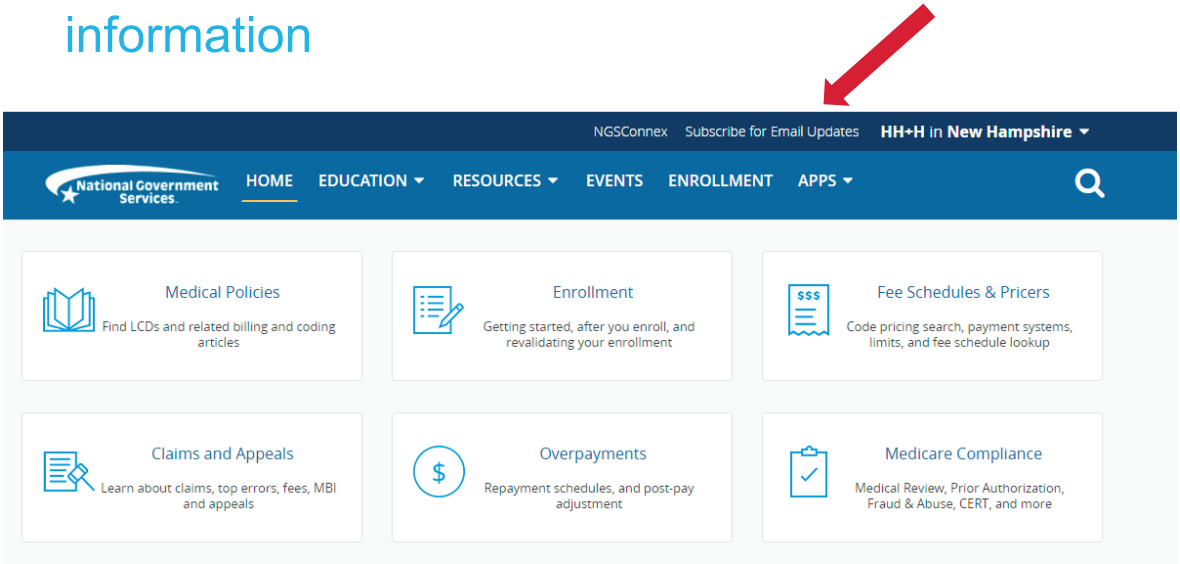
- CMS IOM Publication 100-01, *Medicare General Information, Eligibility and Entitlement Manual*, Chapter 4, Section 30
- CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 7
- CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 10
- CMS IOM Publication 100-08, *Medicare Program Integrity Manual*, Chapter 6
- HH PPS web page
- Correcting Reason Code 37253

References & Resources

- NGS Website
  - Resources
  - Medicare Compliance
  - Fraud and Abuse

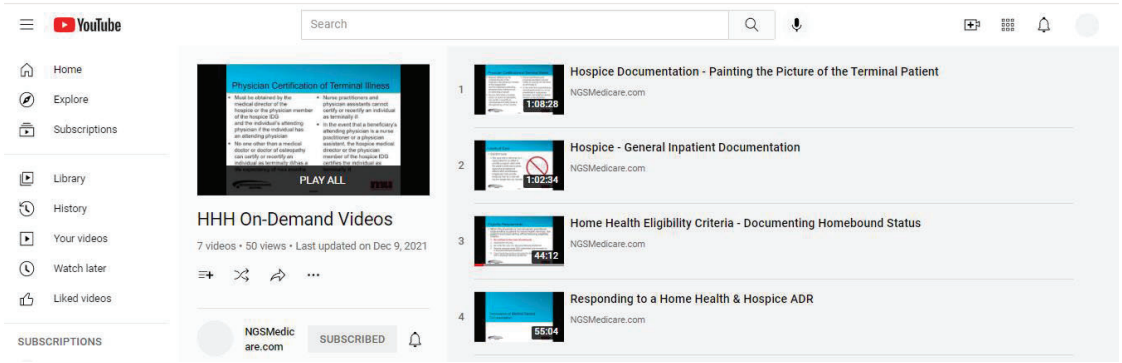
NGS Email Updates

- Subscribe to receive the latest Medicare information



YouTube

NGS HHH On-Demand Videos



Medicare University

- Interactive online system available 24/7
- Educational opportunities available
  - Computer-based training courses
  - Teleconferences, webinars, live seminars/face-to-face training
- Self-report attendance
- Medicare University website

Continuing Education Credits

- All National Government Services Part A and Part B Provider Outreach and Education attendees can now receive one CEU from AAPC for every hour of National Government Services education received
- If you are accredited with a professional organization other than AAPC, and you plan to request continuing education credit, please contact your organization not National Government Services with your questions concerning CEUs

Provider Contact Center Procedures

- The Provider Contact Center should always be your first option when contacting National Government Services
  - Required to log and track all incoming inquires
- Tiered system to respond accurately to all provider inquiries

Provider Contact Center

State/Region	Toll-Free Number	Interactive Voice Response (IVR)	Hours of Service
Alaska, Arizona, California, Hawaii, Idaho, Nevada, Oregon, Washington, American Samoa, Guam, Northern Mariana Island	866-590-6724 TTY: 888-897-7523	866-277-7287	Monday–Friday 8:00 a.m.–4:00 p.m. PT Thursday, closed for training 12:00–2:00 p.m. PT

Thank You!

- Questions?

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