PROVIDER COMPLIANCE TIPS FOR HOME HEALTH SERVICES (PART A NON DRG)

PROVIDER TYPES AFFECTED

Physicians who refer beneficiaries to home health, order home health services, and/or certify beneficiaries' eligibility for the Medicare home health benefit; home health agencies; and non-physician practitioners (NPPs)

BACKGROUND

The Medicare Fee-For-Service (FFS) improper payment rate for home health claims for the 2018 reporting period was 17.6 percent, accounting for 9.8 percent of the overall Medicare FFS improper payment rate in 2018. The projected improper payment amount for Home Health Services during the 2018 report period was $3.2 billion.[1]

REASON FOR DENIALS

Insufficient documentation accounted for a large proportion of improper payments for home health services. The primary reason for these errors was that the documentation to support the certification of home health eligibility requirements was missing or insufficient. Medicare coverage of home health services requires physician certification of the beneficiary's eligibility for the home health benefit.[2]

TO PREVENT DENIALS

Regarding inadequate physician certification/re-certification

Physicians or Medicare allowed NPPs must certify that:

1. The beneficiary is confined to the home
2. The beneficiary is under the care of a physician and receiving services under a plan of care established and periodically reviewed by a physician
3. The beneficiary is in need of home health services
4. The beneficiary has had a face-to-face encounter with a physician or an allowed NPP related to the primary reason the beneficiary requires home health services that:
   - 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
   - Was related to the primary reason the beneficiary requires home health services[3]

[1] 2018 Medicare Fee-for-Service Supplemental Improper Payment Data

[2] Department of Health & Human Services Agency Financial Report FY 2017

[3] CMS Medicare Benefit Policy Manual, Pub. 100-02, Chapter 7, Section 30.5.1

The beneficiary is confined to the home.

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

1. Criterion One:
    a. The beneficiary 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 to leave their place of residence

        OR

        - Have a condition such that leaving his or her home is medically contraindicated

If the beneficiary meets one of the criterion one conditions, then the beneficiary must ALSO meet two additional requirements defined in criterion two on the next page.

2. Criterion Two:
    To clarify, 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 (for example, 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, and other therapeutic interventions and results.[4]

The beneficiary is under the care of a physician and receiving services under a plan of care established and periodically reviewed by a physician.

The certifying physician's medical record and/or the acute/post-acute care facility's medical records (if the patient was directly admitted to home health) for the beneficiary must contain information that justifies the referral for Medicare home health services. This includes documentation that substantiates the beneficiary's need for the skilled services and homebound status.[5]

For Home Health Agency (HHA) services to be covered, the individualized plan of care must specify the services necessary to meet the patient's specific needs identified in the comprehensive assessment. In addition, the plan of care must include the identification of the responsible discipline(s) and the frequency and duration of all visits as well as those items listed in 42 CFR 484.60(a) that establish the need for such services. All care provided must be in accordance with the plan of care.

[4] CMS Medicare Benefit Policy Manual, Pub 100-02, Chapter 7, Section 30.1.1
[5] CMS Medicare Benefit Policy Manual, Pub. 100-02, Chapter 7, Section 30.5.1.2

If the plan of care includes a course of treatment for therapy services:

- The course of therapy treatment must be established by the physician after any needed consultation with the qualified therapist
- The plan must include measurable therapy treatment goals which pertain directly to the beneficiary's illness or injury, and the beneficiary's resultant impairments
- The plan must include the expected duration of therapy services and
- The plan must describe a course of treatment which is consistent with the qualified therapist's assessment of the beneficiary's function[6]

The plan of care must be reviewed and signed by the physician who established the plan of care, in consultation with HHA professional personnel, at least every 60 days. Each review of a patient's plan of care must contain the signature of the physician and the date of review.[7]

The beneficiary is in need of home health services.

The beneficiary must need one of the following:

1. Skilled nursing care that is
    a. Reasonable and necessary
    b. Needed on an "intermittent" basis and
    c. Not solely needed for venipuncture for the purposes of obtaining blood sample
2. Physical therapy
3. Speech-language pathology services or
4. Have a continuing need for occupational therapy[8]

The beneficiary has had a face-to-face encounter with a physician or an allowed NPP related to the primary reason the beneficiary requires home health services.

The provider must document that a face-to-face encounter with the beneficiary was performed 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. The certifying physician or allowed NPP must also document the date of the encounter.

The certifying physician medical record for the beneficiary must contain the actual clinical note for the face-to-face encounter visit that demonstrates that the encounter:

- Occurred within the required timeframe
- Was related to the primary reason the beneficiary requires home health services and
- Was performed by an allowed provider type

[6] CMS Medicare Benefit Policy Manual, Pub. 100-02, Chapter 7, Section 30.2.1
[7] CMS Medicare Benefit Policy Manual, Pub. 100-02, Chapter 7, Section 30.2.6
[8] CMS Medicare Benefit Policy Manual, Pub. 100-02, Chapter 7, Section 30.4

NPPs who are allowed to perform the encounter are:

- A nurse practitioner or a clinical nurse specialist working in accordance with State law and in collaboration with the certifying physician or in collaboration with an acute or post-acute care physician, with privileges, who cared for the beneficiary in the acute or post-acute care facility from which the beneficiary was directly admitted to home health
- A certified nurse midwife, as authorized by State law, under the supervision of the certifying physician or under the supervision of an acute or post-acute care physician with privileges who cared for the beneficiary in the acute or post-acute care facility from which the beneficiary was directly admitted to home health or
- A physician assistant under the supervision of the certifying physician or under the supervision of an acute or post-acute care physician with privileges who cared for the beneficiary in the acute or post-acute care facility from which the beneficiary was directly admitted to home health[9]

FOR MORE INFORMATION ABOUT...	RESOURCE
2018 Medicare Fee-for-Service Supplemental Improper Payment Data	https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT/Downloads/2018MedicareFFSSuplementalImproperPaymentData.pdf
Department of Health & Human Services Agency Financial Report FY 2017	https://www.hhs.gov/sites/default/files/fy-2017-hhs-agency-financial-report.pdf
Medicare Benefit Policy Manual, Chapter 7	https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c07.pdf

[9] CMS Medicare Benefit Policy Manual, Pub. 100-02, Chapter 7, Section 30.5.1.1