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 10757	**Date: May 11, 2021**
	Change Request 12222

SUBJECT: Physician Certification and Recertification of Services Manual Update to Incorporate Allowed Practitioners into Home Health Policy

I. SUMMARY OF CHANGES: This Change Request (CR) updates the Medicare Physician Certification and Recertification of Services Manual, Publication 100-01, Chapter 4. In accordance with section 3708(f) of the CARES Act, CMS amended the regulations to define a nurse practitioner (NP), a clinical nurse specialist (CNS), and a physician assistant (PA) as "allowed practitioners." This means that in addition to a physician, an "allowed practitioner" may certify, establish and periodically review the plan of care, as well as supervise the provision of items and services for beneficiaries under the Medicare home health benefit. Additionally, CMS amended the regulations to reflect that CMS would expect the allowed practitioner to also perform the face-to-face encounter for the patient for whom they are certifying eligibility; however, if a face-to-face encounter is performed by an allowed non-physician practitioner (NPP) in an acute or post-acute facility from which the patient was directly admitted to home health, the certifying practitioner may be different from the provider performing the face-to-face encounter.

EFFECTIVE DATE: March 1, 2020
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: August 11, 2021

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	4/Table of Contents
R	4/30/Certification and Recertification by Physicians and Allowed Practitioners for Home Health Services
R	4/30.1/Content of the Physician's or Allowed Practitioner's Certification

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: 10757	Date: May 11, 2021	Change Request: 12222

SUBJECT: Physician Certification and Recertification of Services Manual Update to Incorporate Allowed Practitioners into Home Health Policy

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I. GENERAL INFORMATION

A. Background: Section 3708 of the CARES Act amended sections 1814(a) and 1835(a) of the Act to allow Nurse Practitioners (NPs), Clinical Nurse Specialists (CNSs), and Physician Assistants (PAs) (as those terms are defined in section 1861(aa) of the Act), to order and certify patients for eligibility under the Medicare home health benefit. Additionally, section 3708 of the CARES Act amended sections 1814(a)(2)(C), 1835 (a)(2)(A)(ii), and 1861(m) of the Act to allow the home health plan of care to be established and periodically reviewed by a physician, NPs, CNS, or PAs where such services are or were furnished while the individual was under the care of a physician, NP, CNS, or PA. The CARES Act also amended sections 1861(o)(2) and 1861(kk) of the Act to allow certified-nurse midwives (CNMs), NPs, CNSs, or PAs to perform the role originally reserved for a physician in establishing Home Health Agency (HHA) policies that govern the services (and supervision of such services) provided to patients under the Medicare home health benefit, as well as certify that an individual has suffered a bone fracture related to postmenopausal osteoporosis and that the individual is unable to learn the skills needed to self-administer the osteoporosis drug or is otherwise mentally or physically incapable of self-administering such drug. Finally, section 3708 of the CARES Act amended section 1895(c) of the Act to allow payment for the furnishing of items and services under the Home Health Prospective Payment System (HH PPS) when these items and services are prescribed by an NP, CNS, or PA. In accordance with section 3708 of the CARES Act, these changes are required to take effect within 6 months of enactment of the law and the Secretary shall issue an Interim Final Rule with Comment Period (IFC), if necessary to comply with the required effective date.

B. Policy: In accordance with section 3708(f) of the CARES Act, CMS amended the regulations at parts 409, 424, and 484 to define an NP, a CNS, and a PA (as such qualifications are defined at §§ 410.74 through 410.76) as an “allowed practitioner”. This means that in addition to a physician, as defined at section 1861(r) of the Act, an “allowed practitioner” may certify, establish and periodically review the plan of care, as well as supervise the provision of items and services for beneficiaries under the Medicare home health benefit. Additionally, CMS amended the regulations to reflect that CMS would expect the allowed practitioner to also perform the face-to-face encounter for the patient for whom they are certifying eligibility; however, if a face-to-face encounter is performed by an allowed non-physician practitioner (NPP), as set out at 42 CFR 424.22(a)(1)(v)(A), in an acute or post-acute facility, from which the patient was directly admitted to HH, the certifying practitioner may be different from the provider performing the face-to-face encounter. CMS implemented these changes in the regulations in the IFC: Medicare and Medicaid Programs, Basic Health Program, and Exchanges; Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency and Delay of Certain Reporting Requirements for the Skilled Nursing Facility Quality Reporting Program. Effective on March 1, 2020, NPs, CNSs, and PAs are able to practice to the top of their state licensure to certify eligibility for HH services, as well as establish and periodically review the HH plan of care. In accordance with section 1861(aa)(5) of the Act, NPs, CNSs, and PAs are required to practice in accordance with state law in the state in which the individual performs such services, as individual states have varying requirements for conditions of practice, which determine whether a practitioner may work independently without a written collaborative agreement or supervision from a physician, or whether general or direct supervision and collaboration is required.

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	
12222.1	The contractors shall be aware of the revisions to Pub. 100-01, Chapter 4 related to the new policies in this CR.			X						
12222.2	Contractors shall note that the revisions to Pub 100-01, Chapter 4 align with policies implemented on 3/1/2020.			X						

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	None					

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): Amanda Barnes, 443-651-1207 or amanda.barnes@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 and Allowed Practitioners for Home Health Services

(Rev. 10757; Issued: 05-11-21; Effective: 03-01-20; Implementation: 08-11-21)

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 or Allowed Practitioner's Certification

(Rev. 10757; Issued: 05-11-21; Effective: 03-01-20; Implementation: 08-11-21)

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 or allowed practitioner certifies that:

- Home 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 or 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;

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

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

- The individual had a face-to-face encounter with a physician or an allowed non-physician practitioner 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 or allowed practitioner 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 or allowed practitioner 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 or allowed practitioner who is authorized by the certifying physician or certifying allowed practitioner who established the plan of care, to care for his/her patients in his/her absence. The HHA is responsible for ensuring that the physician or allowed non-physician practitioner who signs the plan of care and recertification statement was authorized by the physician or allowed practitioner who established the plan of care and completed the certification for his/her patient 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.