



Provider Compliance Tips for Home Health Services (Part A Non-DRG)



What's Changed?

Updated the improper payment rate for home health claims for the 2020 reporting period.

You'll find substantive content updates in dark red font.

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 2020 reporting period was 9.3%, accounting for 6.9% of the overall Medicare FFS improper payment rate in 2019. We,

CMS, projected the improper payment amount for Home Health Services during the 2019 report period to be **\$1.8 billion**.

Introduction

This publication is meant to educate providers on how to successfully submit Home Health Services claims.

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 ([42 CFR §424.22](#)).

How To Prevent Denials

For inadequate physician certification and re-certification:

We require Physicians or Medicare allowed NPPs to certify that:

Note: A certification (versus recertification) is anytime that an official completes a Start of Care Outcome and Assessment Information Sets (OASIS) to start care.

1. The beneficiary requires home health services because the beneficiary is or was confined to the home.
2. The beneficiary needs or needed intermittent skilled nursing services (other than solely venipuncture for the purposes of obtaining a blood sample), or physical therapy, or speech-language pathology services. If a beneficiary's sole skilled service need is for skilled oversight of unskilled services, we require the physician to include a brief narrative describing the clinical justification of this need as part of the certification, or as a signed addendum to the certification.
3. A physician sets up a plan of care and reviews it periodically.
4. Officials offered the services while the beneficiary is or was under the care of a physician.
5. The beneficiary has met face-to-face with a physician or an allowed NPP that:
 - Occurred no more than 90 days before or within 30 days after the start of the home health care.
 - Was related to the primary reason the beneficiary requires home health services.
 - Was performed by an allowed provider type.
 - The certifying physician or NPP must also document the date of the encounter.

The beneficiary is confined to the home.

We consider an individual "confined to the home" (homebound) if they meet the following criteria:

Criterion 1:

The beneficiary must either:

- Because of illness or injury, need the aid of supportive devices such as crutches, canes, wheelchairs, and walkers; special transportation; or the help of another person to leave their place of residence
- OR
- Have a condition such that leaving their home is medically contraindicated

If the beneficiary meets 1 of the Criterion 1 conditions, then the beneficiary must also meet 2 more requirements defined in Criterion 2.

Criterion 2:

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

To clarify, in determining whether the beneficiary meets Criterion 2 of the homebound definition, the clinician needs to consider the illness or injury for which the beneficiary met Criterion 1 and consider the illness or injury in the context of the beneficiary's overall condition. The clinician isn't required to include standardized phrases showing the beneficiary's condition (for example, repeating the words "taxing effort to leave the home") in the beneficiary's chart, neither are such phrases enough, by themselves, to show that Criterion 2 has been met. For example, longitudinal clinical information about the beneficiary's health status is typically needed to properly show a normal inability to leave the home and that leaving home requires a considerable and taxing effort. Clinical information about the beneficiary's overall health status may include, but isn't limited to, factors such as the beneficiary's diagnosis, duration of the beneficiary's condition, clinical course (worsening or improvement), prognosis, nature and extent of working limitations, and other therapeutic interventions and results.

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

The certifying physician's medical record and or the acute and post-acute care facility's medical records (if the beneficiary 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.

For Medicare to cover Home Health Agency (HHA) services, the individualized plan of care must specify the services necessary to meet the beneficiary'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 show the need for such services. All care provided must follow the plan of care.

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

- The physician sets up the course of therapy treatment after any needed consultation with the qualified therapist.
- The plan includes measurable therapy treatment goals which pertain directly to the beneficiary's illness or injury, and the beneficiary's resultant impairments.

- The plan includes the expected duration of therapy services.
- The plan describes a course of treatment that is consistent with the qualified therapist's assessment of the beneficiary's function.
- The physician who sets up the plan of care must review and sign the plan of care, in consultation with HHA professional personnel, at least every 60 days. Each review of a beneficiary's plan of care has the signature of the physician and the date of review.

The beneficiary needs home health services.

The beneficiary needs 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
4. Have a continuing need for occupational therapy

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

The provider documents that they performed face-to-face with the beneficiary no more than 90 days before 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 also documents the date of the encounter.

The certifying physician medical record for the beneficiary has the actual clinical note for the face-to-face encounter visit that shows 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

NPPs who can perform the encounter are:

- A nurse practitioner or a clinical nurse specialist working under 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

- 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

Resources

- [2020 Medicare Fee-for-Service Supplemental Improper Payment Data](#)
- [Department of Health & Human Services Agency Financial Report FY 2019](#)
- [Medicare Benefit Policy Manual, Chapter 7](#)

This fact sheet is based on Non-Public Health Emergency rules. [Contact your MAC](#) if this service or supply is impacted by The Coronavirus Aid, Relief, and Economic Security (CARES) Act, published March 2020, which deals with Medicare flexibilities related to the COVID-19 crisis.

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