



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 2017 reporting period was 32.3 percent, accounting for 16.6 percent of the overall Medicare FFS improper payment rate in 2017. The projected improper payment amount for home health claims during the 2017 report period was \$6.1 billion.

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 documentation to support the certification of home health eligibility requirements. Medicare coverage of home health services requires physician certification of the beneficiary's eligibility for the home health benefit.

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

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
 - 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 below.

2. Criterion Two

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 beneficiary'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 beneficiary's overall health status may include, but is not limited to, such factors as the beneficiary's diagnosis, duration of the beneficiary's condition, clinical course (worsening or improvement), prognosis, nature and extent of functional limitations, other therapeutic interventions and results, etc.

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.

The required elements of the plan of care include:

- The beneficiary's mental status
- The types of services, supplies, and equipment required
- The frequency of the visits to be made
- Prognosis
- Rehabilitation potential
- Functional limitations
- Activities permitted
- Nutritional requirements
- All medications and treatments
- Safety measures to protect against injury
- Instructions for timely discharge or referral

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

- The physician must establish the course of therapy treatment 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
- The plan must describe a course of treatment which is consistent with the qualified therapist's assessment of the beneficiary's function

The physician must review and sign the plan of care every 60 days unless the beneficiary transfers to another HHA or gets discharged and returns to home health during the 60-day episode.

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
 - 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 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
- Was performed by an allowed provider type

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
- 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

FOR MORE INFORMATION ABOUT...	RESOURCE
The Supplementary Appendices for the Medicare Fee-For-Service 2017 Improper Payment Report	https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT/CERT-Reports-Items/2017-Medicare-FFS-Payment-Data.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=-descending
Department of Health and 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, Pub. 100-02, Chapter 7, Section 30.5.1	https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c07.pdf
Medicare Benefit Policy Manual, Pub 100-02, Chapter 7, Section 30.1.1	https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c07.pdf
Medicare Benefit Policy Manual, Pub. 100-02, Chapter 7, Section 30.5.1.2	https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c07.pdf
Medicare Benefit Policy Manual, Pub. 100-02, Chapter 7, Section 30.2.1	https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c07.pdf
Medicare Benefit Policy Manual, Pub. 100-02, Chapter 7, Section 30.2.6	https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c07.pdf
Medicare Benefit Policy Manual, Pub. 100-02, Chapter 7, Section 30.4	https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c07.pdf

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