CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-08 Medicare Program Integrity	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 602	**Date: July 10, 2015**
	Change Request 9189

SUBJECT: Medical Review of Home Health Services

I. SUMMARY OF CHANGES: Revision to Medical Review of Home Health Services. The purpose of this Change Request (CR) is to manualize policies in the calendar year 2015 Home Health Prospective Payment System Final Rule published on November 6, 2014, in which the Centers for Medicare & Medicaid Services finalized clarifications and revisions to policies regarding physician certification and recertification of patient eligibility for Medicare home health services.

EFFECTIVE DATE: August 11, 2015
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: August 11, 2015

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	6/Table of Contents
R	6/6.2/Medical Review of Home Health Services
N	6/6.2.1/Physician Certification of Patient Eligibility for the Medicare Home Health Benefit
N	6/6.2.1.1/Certification Requirements
N	6/6.2.2/Physician Recertification
N	6/6.2.2.1/Recertification Elements
N	6/6.2.3/The Use of the Patient's Medical Record Documentation to Support the Home Health Certification
N	6/6.2.4/Coding
N	6/6.2.5/Medical Necessity of Services Provided
N	6/6.2.6/Examples of Sufficient Documentation Incorporated Into a Physician's Medical Record
R	6/6.2.7/Medical Review of Home Health Demand Bills

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. 100-08	Transmittal: 602	Date: July 10, 2015	Change Request: 9189

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I. GENERAL INFORMATION

A. Background: The statutory authority for the Medical Review (MR) program includes the following sections of the Social Security Act (the Act):

- Section 1833(e) which states, in part "...no payment shall be made to any provider... unless there has been furnished such information as may be necessary in order to determine the amounts due such provider ...;"

- Section 1842(a)(2)(B) which requires Medicare Administrative Contractors (MACs) to "assist in the application of safeguards against unnecessary utilization of services furnished by providers ...; "

- Section 1862(a)(1) which states no Medicare payment shall be made for expenses incurred for items or services that "are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member;"

- Section 1893(b)(1) establishes the Medicare Integrity Program which allows contractors to review activities of providers of services or other individuals and entities furnishing items and services for which payment may be made under this title (including skilled nursing facilities and home health agencies), including medical and utilization review and fraud review (employing similar standards, processes, and technologies used by private health plans, including equipment and software technologies which surpass the capability of the equipment and technologies. . ."

B. Policy: For all medical necessity reviews, the Medicare review contractors shall review the certification documentation for any episode initiated with the completion of a start-of-care Outcome and Assessment Information Set (OASIS) assessment. This means that if the subject claim is for a subsequent episode of care, the Home Health Agency (HHA) must submit all certification documentation as well as recertification documentation.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
9189.1	For all medical necessity reviews, the Medicare review contractors shall review the certification documentation for any episode initiated with the completion of a start-of-care OASIS assessment. This means that if the subject claim is for a subsequent episode			X						

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	of care, the HHA must submit all certification documentation as well as recertification documentation.									
9189.2	When conducting a medical necessity review, the review contractor shall determine whether the supporting documentation addresses each of the following criteria for which a physician certified (attested to): • Homebound • Skilled Care • Plan of Care • Under Physician Care • Face-to-Face Encounter			X						
9189.3	The contractor shall review for the certifying physician statement which must indicate the continuing need for services and estimate how much longer the services will be required.			X						
9189.4	The contractor shall consider all documentation from the HHA that has been signed off in a timely manner and incorporated into the physician/hospital record when making its coverage determination. HHA documentation that is used to support the home health certification is considered to be incorporated timely when it is signed off prior to or at the time of the certification. Any information provided to the certifying physician from the HHA and incorporated into the patient's medical record held by the physician or the acute/post-acute care facility's medical record (if the patient was directly admitted to home health) must corroborate the rest of the			X						

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	patient's medical record.									
9189.5	Contractors shall use the patient's comprehensive assessment or recertification assessment as part of the medical documentation used to determine whether the HHRG codes billed were accurate and appropriate if the assessments were signed off and incorporated into the certifying physician's medical record for the patient or the acute/post-acute care facility's medical record (if the patient was directly admitted to home health).			X						
9189.5.1	The contractor shall use the web regrouping program provided by CMS to recode claims as appropriate.			X						
9189.6	Contractors shall review the medical record documentation to determine whether services provided were medically necessary.			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): Della Johnson, 410-218-4379 or della.johnson@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: 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.

ATTACHMENTS: 0

Medicare Program Integrity Manual
Chapter 6 – Medicare Contractor Medical Review Guidelines for Specific Services

Table of Contents
(Rev.602 Issued: 07-10-15)

6.2 – *Medical Review of Home Health Services*

(Rev. 602 Issued: 07-10-15, Effective: 08-11-15, Implementation: 08-11-15)

This section applies to Medicare Administrative Contractors (MAC), Supplemental Medical Review Contractor (SMRC), Recovery Auditors and the Comprehensive Error Rate Testing (CERT) contractor.

6.2.1 - *Physician Certification of Patient Eligibility for the Medicare Home Health Benefit*

(Rev. 602 Issued: 07-10-15, Effective: 08-11-15, Implementation: 08-11-15)

A physician certification/recertification of patient eligibility for the Medicare home health benefit is a condition for Medicare payment per sections 1814(a) and 1835(a) of the Social Security Act (the "Act"). The regulations at 42 CFR 424.22 list the requirements for eligibility certification and recertification. The requirements differ for eligibility certification and recertification; however, if the requirements for certification are not met, then claims for subsequent episodes of care, which require a recertification, will be non-covered—even if the requirements for recertification are met.

Home health agencies (HHAs) should obtain as much documentation from the certifying physician's medical records and/or the acute/post-acute care facility's medical records (if the patient was directly admitted to home health) as they deem necessary to assure themselves that the Medicare home health patient eligibility criteria for certification and recertification have been met and must be able to provide it to CMS and its review entities upon request. Per the regulations at 42 CFR 424.22(c), if the documentation used as the basis for the certification of eligibility is not sufficient to demonstrate that the patient is or was eligible to receive services under the Medicare home health benefit, payment will not be rendered for home health services provided.

Therefore, for all medical necessity reviews, the Medicare review contractors shall review the certification documentation for any episode initiated with the completion of a start-of-care Outcome and Assessment Information Set (OASIS) assessment. This means that if the subject claim is for a subsequent episode of care, the HHA must submit all certification documentation as well as recertification documentation. The review contractor shall send a documentation request to the billing HHA requesting the supporting documentation from the certifying physician and/or the acute/post-acute care facility if the patient was directly admitted to home health from such setting (as defined in 42 CFR 424.22) that substantiates the patient's eligibility for the Medicare home health benefit.

For medical review purposes, the referring /certifying physician's initial order for home health services for a patient initiates the establishment of a plan of care as part of the certification of patient eligibility for the Medicare home health benefit. The physician's initial order must specify the medical treatment(s) to be furnished and does not eliminate the need for the plan of care as required in 42 CFR 409.43.

If the review contractor finds that the documentation in the certifying physician's medical record for that patient used as the basis for the certification of eligibility, which includes subsequent supporting documentation from the HHA (if incorporated into the certifying physician's or acute/post-acute care facility's medical record for that patient), is insufficient to demonstrate the patient is or was eligible to receive services under the Medicare home health benefit, the review contractor shall deny payment (in the case of prepayment review) or shall initiate an overpayment demand letter (in the case of post payment review).

The review contractor shall only consider a plan of care and the certification or recertification for home health services from physicians who do not have a financial relationship with the HHA. The review contractor shall only consider documentation of the face-to-face encounter from physicians or allowed non-physician practitioners, as defined in 42 CFR 424.22, who do not have a financial relationship with the HHA (see 6.2.3).

CMS does not require a specific form or format for the certification as long as a physician certifies that the five certification requirements, outlined in 42 CFR 424.22(a)(1) and section 6.2.1.1, are met.

6.2.1.1 – Certification Requirements

(Rev. 602 Issued: 07-10-15, Effective: 08-11-15, Implementation: 08-11-15)

When conducting a medical necessity review, the review contractor shall determine whether the supporting documentation addresses each of the following criteria for which a physician certified (attested to):

1. ***Homebound.*** *Home health services are or were required because the individual is or was confined to the home (as defined in sections 1835(a) and 1814(a) of the Social Security Act).*

2. ***Skilled Care.*** *The patient needs or needed intermittent **skilled** nursing care (other than solely venipuncture for the purposes of obtaining a blood sample), physical therapy, and/or speech language pathology services as defined in 42 CFR 409.42(c).*

   NOTE: *Where a patient's sole skilled service need is for skilled oversight of unskilled services (management and evaluation of the care plan as defined in 42 CFR 409.42(c)), the physician 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. The physician must sign immediately following the narrative.*

3. ***Plan of Care.*** *A plan for furnishing the services has been established and is, or will be, periodically reviewed by a physician who is a doctor of medicine, osteopathy, or podiatric medicine (a doctor of podiatric medicine may perform only plan of treatment functions that are consistent with the functions he or she is authorized to perform under state law). If the physician's orders for home health services meet the requirements specified in 42 CFR 409.43 Plan of Care Requirements, this meets the requirement for establishing a plan of care as part of the certification of patient eligibility for the Medicare home health benefit.*

4. ***Under Physician Care.*** *Home health services will be or were furnished while the individual is or was under the care of a physician who is a doctor of medicine, osteopathy, or podiatric medicine.*

5. ***Face-to-Face Encounter.*** *A face-to-face patient encounter occurred no more than 90 days prior to the home health start of care date or within 30 days after the start of the home health care, was related to the primary reason the patient requires home health services, and was performed by an allowed provider type defined in 42 CFR 424.22(a)(1)(v). The certifying physician must also document the date of the encounter as part of the certification.*

Per 42CFR 424.22 (a) and (c), the patient's medical record must support the certification of eligibility. Documentation in the patient's medical record shall be used as a basis for certification of home health eligibility. Therefore, reviewers will consider HHA documentation if it is incorporated into the patient's medical record held by the certifying physician and/or the acute/post-acute care facility's medical records (if the patient was directly admitted to home health) and signed off by the certifying physician. The documentation does not need to be on a special form.

6.2.2 – Physician Recertification

(Rev. 602 Issued: 07-10-15, Effective: 08-11-15, Implementation: 08-11-15)

At the end of the 60-day episode, a decision must be made whether or not to recertify the patient for a subsequent 60-day episode. The plan of care must be reviewed and signed by the physician at least every 60 days when there is a need for continuous home care unless the beneficiary transfers to another HHA or the beneficiary is discharged and subsequently re-admitted (these situations trigger a new certification, rather than a recertification).

6.2.2.1 – Recertification Elements

(Rev. 602 Issued: 07-10-15, Effective: 08-11-15, Implementation: 08-11-15)

The contractor shall review for the certifying physician statement which must indicate the continuing need for services and estimate how much longer the services will be required.

Recertification is required at least every 60 days when there is a need for continuous home health care after an initial 60-day episode. Recertification should occur at the time the plan of care is reviewed, and must be signed and dated by the physician who reviews the plan of care. Recertification is required at least every 60 days unless there is a—

(i) Beneficiary elected transfer; or
(ii) Discharge with goals met and/or no expectation of a return to home health care.

Need for occupational therapy may be the basis for continuing services that were initiated because the individual needed skilled nursing care or physical therapy or speech therapy. In this case reviewers will look for documentation substantiating the need for continued occupational therapy when the needed skilled nursing care or physical therapy or speech therapy that were initially needed, are no longer needed.

If a patient's underlying condition or complication requires a registered nurse to ensure that essential non-skilled care is achieving its purpose, and necessitates a registered nurse be involved in the development, management, and evaluation of a patient's care plan, the reviewer will look for the physician's brief narrative describing the clinical justification of this need. If the narrative is part of the recertification form, then the narrative must be located immediately prior to the physician's signature. If the narrative exists as an addendum to the recertification form, in addition to the physician's signature on the recertification form, the physician must sign immediately following the narrative in the addendum.

As mentioned earlier in this section, the reviewer will confirm that all elements of the certification are included in the documentation sent for the recertification claim review. If the submitted certification documentation (submitted with the recertification documentation) does not support home health eligibility, the claim associated with the recertification period will not be paid.

6.2.3 – The Use of the Patient's Medical Record Documentation to Support the Home Health Certification

(Rev. 602 Issued: 07-10-15, Effective: 08-11-15, Implementation: 08-11-15)

As mentioned in section 6.2.1.1 – Certification Requirements, for home health services to be covered by Medicare, the certifying physician's and/or the acute/post-acute care facility's medical record for the patient must contain sufficient documentation of the patient's medical condition(s) to substantiate eligibility for home health services. The information 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, other therapeutic interventions and results, etc.

The HHA's generated medical record documentation for the patient, by itself, is not sufficient in demonstrating the patient's eligibility for Medicare home health services. As noted earlier, per 42CFR424.22 (a) and (c) it is the patient's medical record held by the certifying physician and/or the acute/post-acute care facility that must support the patient's eligibility for home health services. Therefore, any documentation used to support certification that was generated by the home health agency must be signed off by the certifying physician and incorporated into the medical record held by the physician or the acute/post-acute care facility's medical record. ***Any information provided to the certifying physician from the HHA and incorporated into the patient's medical record held by the physician or the acute/post-acute care facility's medical record (if the patient was directly admitted to home health) must corroborate the rest of the patient's medical record****. This could include, but is not limited to, the comprehensive assessment, plan of care, the inpatient discharge summary or multi-disciplinary clinical notes, etc., which must correspond to the dates of service being billed and not contradict the certifying physician's and/or the*

acute/post-acute care facility's own documentation or medical record entries. The reviewer shall consider all documentation from the HHA that has been signed off in a timely manner and incorporated into the physician/hospital record when making its coverage determination. HHA documentation that is used to support the home health certification is considered to be incorporated timely when it is signed off prior to or at the time of claim submission. ***See section 6.2.6 Examples of Sufficient Documentation Incorporated Into a Physician's Medical Record****.*

It is important to apply the review process to the entire patient's medical record that is received by the reviewer. Doing so assures that the reviewer is establishing that the HHA generated medical record documentation corroborates other patient medical records received and used to support the patient's eligibility for home health services. Therefore, the HHA generated documentation does not necessarily need to restate pertinent facts or conditions, but instead the HHA generated medical records for the patient should be in alignment with other received patient records. The HHA generated medical record for the patient together with other medical records received must lead the reviewer to confirm that the patient is eligible for home health services as established in 42 CFR 424.22(a)(1).

6.2.4 - Coding

(Rev. 602 Issued: 07-10-15, Effective: 08-11-15, Implementation: 08-11-15)

If the patient's comprehensive assessment or recertification assessment was signed off and incorporated into the certifying physician's medical record for the patient (or the acute/post-acute care facility's medical record if the patient was directly admitted to home health), contractors shall use it to determine whether the Home Health Resource Group (HHRG) codes billed were accurate and appropriate. In addition, if the comprehensive assessment is incorporated into the certifying physician's record for the patient and is used to support that the patient meets the home health eligibility criteria, then the diagnoses and conditions listed on the start of care assessment must be corroborated by information in the certifying physician's and/or the acute/post-acute care facility's own medical record documentation.

The contractor shall use the web regrouping program provided by CMS to recode claims as appropriate.

6.2.5 - Medical Necessity of Services Provided

(Rev. 602 Issued: 07-10-15, Effective: 08-11-15, Implementation: 08-11-15)

In addition to certification and recertification requirement documentation, contractors shall also review the medical record documentation to determine whether services provided were medically necessary. Again, home health generated information must be reviewed, signed off by the certifying physician and incorporated into the certifying physician medical record for the patient or the acute/post-acute care facility's medical record for the patient (if the patient was directly admitted to home health) if used to support certification/recertification.

6.2.6 - Examples of Sufficient Documentation Incorporated Into a Physician's Medical Record

(Rev. 602 Issued: 07-10-15, Effective: 08-11-15, Implementation: 08-11-15)

To be eligible for Medicare home health services, a patient must have Medicare Part A and/or Part B and, per §1814(a)(2)(C) and §1835(a)(2)(A) of the Act:

- *Be confined to the home;*
- *Need skilled services;*
- *Be under the care of a physician;*
- *Receive services under a plan of care established and reviewed by a physician; and*
- *Have had a face-to-face encounter with a physician or allowed non-physician practitioner (NPP).*

EXAMPLE 1:

Does the below submitted documentation support the certification statement stating that the patient meets the eligibility criteria for home health benefit certification? Yes.

Records received by the reviewer for a HHA claim for dates of service starting on 4/15/2015:

1. *Patient was admitted to the hospital with a right-sided femur fracture sustained from a fall requiring surgery. A discharge summary dated April 14, 2015, signed by the inpatient attending physician. Included in the summary was a description of the patient's injury, DME required, non-weight-bearing status, and the name of and appointment date for the community orthopedic physician who would continue to follow-up with patient, and the notation of the order for home physical therapy for home safety evaluation, gait training and strengthening 2-3 times per week for 6 weeks to be delivered by an HHA.*

Meets requirements for a face-to-face encounter (occurred within the required timeframe, was performed by an allowed provider type, and related to the primary reason the patient requires home health). Identifies the need for skilled services and alludes to the fact that the patient is most likely homebound because of the non-weight-bearing status and the order for DME. Identifies physician who will be providing care while patient is receiving home health services. Plan of care established with physician orders.

2. *HHA generated comprehensive assessment (admission OASIS) dated 04/15/2015 along with physical therapy progress notes. PT progress note documents patient is non-weight bearing on right leg and requires use of a two-handed device to walk alone on a level surface, and requires assistance to negotiate stairs or steps or uneven surfaces. The HHA assessment with progress notes has been signed by the community orthopedic certifying physician.*

   PT progress note further supports that patient is confined to the home.

3. *The community orthopedic physician-signed certification statement for HH services for start of care date of April 15, 2015.*

Certification statement signed by certifying physician.

4. *HHA generated plan of care, which specifies the type, frequency and goals for therapies. The plan of care includes the signature of the certifying physician.*

   Supports that plan of care has been established and reviewed by the certifying physician.

EXAMPLE TWO:

Does the below submitted documentation support the certification statement stating that the patient meets the eligibility criteria for home health benefit certification? Yes.

Records received by the reviewer for a HHA claim for dates of service starting on February 1, 2015:

1. *Primary care physician progress note dated November 15, 2014. States reason for visit is patient has a non-healing left foot diabetic foot ulcer measuring 1 cm x1 cm x 0.5 cm. Patient instructed on wound care with hydroactive gel dressing to be changed every 3 days. Patient able to return demonstrate application of dressing without difficulties.*

   Meets requirements for a face-to-face encounter (occurred within the required timeframe, was performed by an allowed provider type, and related to the primary reason the patient requires home health).

2. *Clinical note in physician record states that patient called primary care physician (PCP) on January 30th stating that the wound has gotten larger and there is copious purulent drainage causing the*

dressing to be saturated. She states she is unable to adequately change the dressing and keep it in place because of the size of the wound and the amount of drainage. Patient just recovering from pneumonia and she says she is unable to come into the physician's office because she cannot drive. PCP made referral to HHA for skilled nursing services to evaluate the wound.

Identifies the need for skilled services.

3. *HHA generated comprehensive assessment (admission OASIS) dated 02/01/2015 along with skilled nursing notes which includes wound measurements, condition of wound, and documentation of physician phone call to report findings and receipt of verbal orders for daily wound care for 3 weeks, monitor and teach on signs and symptoms of infection and initiation of oral antibiotics twice a day for 14 days. Nursing notes also states that the patient is significantly deconditioned, as a result of recent pneumonia, requires the use of a walker to ambulate from chair to bathroom with frequent stops to rest.*

HHA skilled nursing notes further support that patient needs skilled services to initiate new wound care regimen, monitor for infection and that the patient is confined to the home. Physician's verbal orders for daily wound care establish the plan of care.

4. *The primary care physician-signed certification statement for HH services for start of care date of February 1, 2015.*

Certification statement signed by certifying physician.

5. *HHA generated plan of care, which specifies the wound care orders, frequency of skilled nursing visits and goals for home health services. The plan of care includes the signature of the certifying physician.*

Supports that plan of care has been established and reviewed by the certifying physician.

6.2.7 - *Medical Review of Home Health Demand Bills*

(Rev. 602 Issued: 07-10-15, Effective: 08-11-15, Implementation: 08-11-15)

As a result of litigation settlements, *A/B MACs (A)* must perform complex medical review on 100% of the home health demand bills.