qualifies him for home health services, including home health aide services (presuming that all other qualifying criteria are met).

30.5 - Physician Certification *and Recertification of Patient Eligibility for Medicare Home Health Services*

(Rev. 208, Issued: 04-22-15, Effective: 01-01-15, Implementation: 05-11-15)

The HHA must be acting upon a plan of care as described in §30.2, and a physician certification *or recertification that* meets the *requirements* of *the following sections in order* for HHA services to be covered.

30.5.1 - Physician Certification

(Rev. 208, Issued: 04-22-15, Effective: 01-01-15, Implementation: 05-11-15)

A certification (versus recertification) is considered to be anytime that a Start of Care OASIS is completed to initiate care. In such instances, a physician must certify *(attest)* that:

1. The home health services are or were needed because the patient is or was confined to the home as defined in §30.1;

2. The patient needs or needed skilled nursing services on an intermittent basis (other than solely venipuncture for the purposes of obtaining a blood sample), or physical therapy, or speech-language pathology services. 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 §40.1.2.2), 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;

3. A plan of care has been established and is periodically reviewed by a physician;

4. The services are or were furnished while the patient is or was under the care of a physician;

5. For episodes with starts of care beginning January 1, 2011 and later, *in accordance with §30.5.1.1 below, a face-to-face encounter occurred no more than 90 days prior to 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. The certifying physician must also document the date of the encounter.*

If the patient is starting home health directly after discharge from an acute/post-acute care setting where the physician, with privileges, that cared for the patient in that setting is certifying the patient's eligibility for the home health benefit, but will not be following the patient after discharge, then the certifying physician must identify the community physician who will be following the patient after discharge. One of the criteria that must be met for a patient to be considered eligible for the home health benefit is that the

patient must be under the care of a physician (number 4 listed above). Otherwise, the certification is not valid.

The certification must be complete prior to when an HHA bills Medicare for reimbursement; however, physicians should complete the certification when the plan of care is established, or as soon as possible thereafter. This is longstanding CMS policy as referenced in Pub 100-01, Medicare General Information, Eligibility, and Entitlement Manual, chapter 4, section 30.1. It is not acceptable for HHAs to wait until the end of a 60-day episode of care to obtain a completed certification/recertification.

30.5.1.1 – Face-to-Face Encounter

(Rev. 208, Issued: 04-22-15, Effective: 01-01-15, Implementation: 05-11-15)

1. *Allowed Provider Types*

As part of the certification of patient eligibility for the Medicare home health benefit, a face-to-face encounter with the patient must be performed by the certifying physician himself or herself, a physician that cared for the patient in the acute or post-acute care facility (with privileges who cared for the patient in an acute or post-acute care facility from which the patient was directly admitted to home health) or an allowed non-physician practitioner (NPP).

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 patient in the acute or post-acute care facility from which the patient 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 patient in the acute or post-acute care facility from which the patient 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 patient in the acute or post-acute care facility from which the patient was directly admitted to home health.*

NPPs performing the encounter are subject to the same financial restrictions with the HHA as the certifying physician, as described in 42 CFR 424.22(d).

2. *Timeframe Requirements*

- The encounter must occur no more than 90 days prior to the home health start of care date or within 30 days after the start of care.

- In situations when a physician orders home health care for the patient based on a new condition that was not evident during a visit within the 90 days prior to start of care, the certifying physician or an allowed NPP must see the patient again within 30 days after admission. Specifically, if a patient saw the certifying physician or NPP within the 90 days prior to start of care, another encounter would be needed if the patient's condition had changed to the extent that standards of practice would indicate that the physician or a non-physician practitioner should examine the patient in order to establish an effective treatment plan.

3. *Exceptional Circumstances*

When a home health patient dies shortly after admission, before the face-to-face encounter occurs, if the contractor determines a good faith effort existed on the part of the HHA to facilitate/coordinate the encounter and if all other certification requirements are met, the certification is deemed to be complete.

4. *Telehealth*

The face-to-face encounter can be performed via a telehealth service, in an approved originating site. An originating site is considered to be the location of an eligible Medicare beneficiary at the time the service being furnished via a telecommunications system occurs. Medicare beneficiaries are eligible for telehealth services only if they are presented from an originating site located in a rural health professional shortage area or in a county outside of a Metropolitan Statistical Area.

Entities that participate in a Federal telemedicine demonstration project approved by (or receiving funding from) the Secretary of the Department of Health and Human Services as of December 31, 2000, qualify as originating sites regardless of geographic location.

The originating sites authorized by law are:

- The office of a physician or practitioner;
- Hospitals;
- Critical Access Hospitals (CAH);
- Rural Health Clinics (RHC);
- Federally Qualified Health Centers (FQHC);
- Hospital-based or CAH-based Renal Dialysis Centers (including satellites);
- Skilled Nursing Facilities (SNF); and
- Community Mental Health Centers (CMHC).

30.5.1.2 – Supporting Documentation Requirements

(Rev. 208, Issued: 04-22-15, Effective: 01-01-15, Implementation: 05-11-15)

As of January 1, 2015, documentation in 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) will be used as the basis upon which patient eligibility for the Medicare home health benefit will be determined. 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) used to support the certification of home health eligibility must be provided, upon request, to the home health agency, review entities, and/or the Centers for Medicare and Medicaid Services (CMS). In turn, an HHA must be able to provide, upon request, the supporting documentation that substantiates the eligibility for the Medicare home health benefit to review entities and/or CMS. 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.

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

- *Need for the skilled services; and*
- *Homebound status;*

The certifying physician and/or the acute/post-acute care facility medical record (if the patient was directly admitted to home health) for the patient 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 patient requires home health services; and*
- *Was performed by an allowed provider type.*

This information can be found most often in clinical and progress notes and discharge summaries.

- *Information from the HHA, such as the initial and/or comprehensive assessment of the patient required per 42 CFR 484.55, can be incorporated into the certifying physician's medical record for the patient and used to support the patient's homebound status and need for skilled care. However, this information must be corroborated by other medical record entries in the certifying physician's and/or the acute/post-acute care facility's medical record for the patient.*

30.5.2 - *Physician* Recertification

(Rev. 207, Issued: 04-10-15, Effective: 05-11-15, Implementation: 05-11-15)

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. An eligible beneficiary who qualifies for a subsequent 60-day episode would start the subsequent 60-day episode on day 61. Under

HH PPS, the plan of care must be reviewed and signed by the physician every 60 days unless one of the following occurs:

- A beneficiary transfers to another HHA; *or*
- A discharge and return to home health during the 60-day episode.

The physician must include an estimate of how much longer the skilled services will be required and must certify (attest) that:

1. The home health services are or were needed because the patient is or was confined to the home as defined in §30.1;

2. The patient needs or needed skilled nursing services on an intermittent basis (other than solely venipuncture for the purposes of obtaining a blood sample), or physical therapy, or speech-language pathology services; or continues to need occupational therapy after the need for skilled nursing care, physical therapy, or speech-language pathology services ceased. 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 §40.1.2.2), the physician must include a brief narrative describing the clinical justification of this need as part of the recertification, or as a signed addendum to the recertification;

3. A plan of care has been established and is periodically reviewed by a physician; and

4. The services are or were furnished while the patient is or was under the care of a physician.

Medicare does not limit the number of continuous episode recertifications for beneficiaries who continue to be eligible for the home health benefit. The physician certification may cover a period less than but not greater than 60 days.

See §10.4 for counting initial and subsequent 60-day episodes. See §10.5 for recertifications for split percentage payments.

30.5.3 - Who May Sign the Certification *or Recertification*

(Rev. 208, Issued: 04-22-15, Effective: 01-01-15, Implementation: 05-11-15)

The physician who signs the certification *or recertification* must be permitted to do so by 42 CFR 424.22.

30.5.4 – Physician Billing for Certification and Recertification

(Rev. 208, Issued: 04-22-15, Effective: 01-01-15, Implementation: 05-11-15)

Physician certification/recertification claims are Part B physician claims paid for under the Physician Fee Schedule. These claims are billed using HCPCS codes G0180

(certification) or G0179 (re-certification). The descriptions of these two codes indicate that they are used to bill for certification or recertification of patient eligibility "for Medicare-covered home health services under a home health plan of care (patient not present), including contacts with the HHA and review of reports of patient status required by physicians to affirm the initial implementation of the plan of care that meets patient's needs, per certification period". As noted above, these codes are for physician certification or recertification for Medicare-covered home health services. If there are no Medicare-covered home health services, these codes should not be billed or paid. As such, physician claims for certification/recertification of eligibility for home health services (G0180 and G0179, respectively) will not be covered if the HHA claim itself was non-covered because the certification/recertification of eligibility was not complete or because there was insufficient documentation to support that the patient was eligible for the Medicare home health benefit.

40 - Covered Services Under a Qualifying Home Health Plan of Care
(Rev. 1, 10-01-03)
A3-3118, HHA-205

Section 1861(m)of the Act governs the Medicare home health services that may be provided to eligible beneficiaries by or under arrangements made by a participating home health agency (HHA). Section 1861(m) describes home health services as

- Part-time or intermittent skilled nursing care (other than solely venipuncture for the purposes of obtaining a blood sample);
- Part-time or intermittent home health aide services;
- Physical therapy;
- Speech-language pathology;
- Occupational therapy;
- Medical social services;
- Medical supplies (including catheters, catheter supplies, ostomy bags, supplies related to ostomy care, and a covered osteoporosis drug (as defined in §1861(kk) of the Act), but excluding other drugs and biologicals);
- Durable medical equipment while under the plan of care established by physician;
- Medical services provided by an intern or resident-in-training under an approved teaching program of the hospital in the case of an HHA which is affiliated or under common control with a hospital; and
- Services at hospitals, skilled nursing facilities, or rehabilitation centers when they involve equipment too cumbersome to bring to the home.