PMB institute

Module 5

STUDY GUIDE

PREPARE FOR SUCCESS

Home Health Medical Billing Certificate

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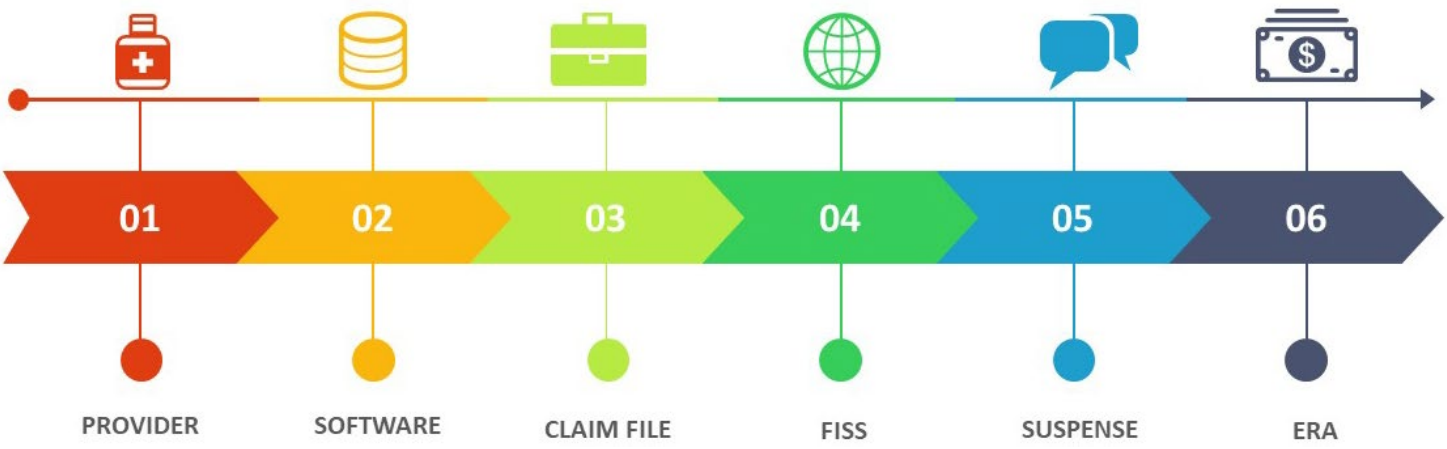
Life Cycle of a Claim



6 Cycles for a Medicare Claim

Billing a Medicare claim is one of the more complex tasks providers must frequently perform. Just what happens to a claim once it's billed? This infographic illustrates the life cycle of a Medicare claim, from the time of a billable patient visit, through final reimbursement and the important stops in between.

PROVIDER

Each and every claim starts with a healthcare provider. Without a provider, there aren't any claims to bill. Many different provider types send claims to Medicare including hospitals, home health, hospice, skilled nursing facilities, ambulatory surgery centers, federally qualified health centers, independent physicians, and more.

SOFTWARE

Providers use a variety of Provider Management Software programs to streamline their operations. While the functionality of the software may differ depending on the facility type, most Provider Management Software programs include features like patient information storage, appointment scheduling and staff management.

CLAIM FILE

Providers must generate an Electronic Claim File (also known as an EDI 837 File) to submit any claim. This file includes Medicare required claim data, and the file can include multiple claims. The 837 holds claim details such as patient description, why treatment was provided, the treatment, and the cost.

FISS

Providers send Medicare Part A claims to the Fiscal Intermediary Standard System (FISS) for processing. After logging into the FISS, providers can manually perform various tasks such as verifying patient eligibility, checking the status of claims, and correcting them if necessary.

SUSPENSE

When a claim is being worked by Medicare it is in "suspense", which means in most cases, the provider won't need to take any action. However, if Medicare finds something wrong with a claim, it can return it to the provider (RTP), reject it, deny it, or request additional development.

When a provider submits a claim that includes incorrect information, Medicare issues a RTP claim indicating the provider needs to make fixes. Sometimes, there are errors in patient name, gender and date of birth the provider must correct for a successful claim.

A rejected claim means that the claim is not payable in its current state and must be corrected and re-submitted. This generally happens when a provider tries to bill the wrong payer or other eligibility issues arise.

Denied claims are the worst-case scenario because Medicare won't pay them and a rebill isn't allowed. The most common cause for denials occurs when Medicare asks for a Request for Additional Development (ADR). The only way to rectify a denied claim is to appeal it or on some odd occasions, you may adjust it.

ERA

After a claim has made its way through the Medicare system, an explanation of the results are sent back to the provider in the form of an Electronic Remittance Advice (ERA). This document provides details on payments and reasons for any non-payment.

Electronic vs Paper Claims Submission

There are two different methods used to deliver insurance claims to the payer: manually (on paper) and electronically. The majority of healthcare providers and insurance companies prefer electronic claim systems. They are faster, more accurate, and are cheaper to process (electronic systems save around $3 per claim). But because paper claims have not yet been completely removed from the insurance claims process, it is important for the medical biller and coder to be well versed with both electronic and hardcopy claims.

How to Submit Claims: Claims may be electronically submitted to a Medicare carrier, Durable Medical Equipment Medicare Administrative Contractor (DMEMAC), or A/B MAC from a provider's office using a computer with software that meets electronic filing requirements as established by the HIPAA claim standard and by meeting CMS requirements contained in the provider enrollment & certification category area of this web site and the EDI Enrollment page in this section of the web site. Providers that bill an A/B MAC are also permitted to submit claims electronically via direct data entry screens.

Providers can purchase software from a vendor, contract with a billing service or clearinghouse that will provide software or programming support, or use HIPAA compliant free billing software that is supplied by Medicare carriers, DMEMACs and A/B MACs. Medicare contractors are allowed to collect a fee to recoup their costs up to $25 if a provider requests a Medicare contractor to mail an initial disk or update disks for this free software. Medicare contractors also maintain a list on their providers' web page that contains the name of vendors whose software is currently being used successfully to submit HIPAA compliant claims to Medicare. This is done for the benefit of providers interested in purchasing electronic billing software for the first time or in changing their current software.

An “electronic claim” is a paperless patient claim form generated by computer software that is transmitted electronically over telephone or computer connection to a health insurer or other third-party payer (payer) for processing and payment. A “manual claim” is a paper claim form that refers to either the Centers for Medicare & Medicaid Services Uniform Billing UB-04 form, which is typically sent to the payer through the mail and require postage. Electronic claims submission helps agencies reduce the administrative burden and expense generally associated with manual claims processing and submission.

The use of electronic claims can result in significant financial savings for both home health agencies and payers. Health information technology (HIT) solutions are on the rise as most home health agencies are submitting electronic claims to payers. By doing so, these agencies may potentially realize increased provider efficiencies and savings in their provider’s claims revenue cycle.

We encourage the use of electronic claims by agencies. Agencies are also encouraged to enhance their electronic data interchange (EDI) capabilities and to contract with vendors and payers that accept Accredited Standards Committee X12 (ASC X12) standards, especially those mandated under Health Insurance Portability and Accountability Act (HIPAA) administrative simplification. These vendors should also provide electronic remittance advice (ERA), eligibility and benefit information, claim status and prior authorization, as well as electronic claims processing.

Agencies can realize several benefits from introducing electronic claims submission into their claims revenue cycle. Electronic claims submission can:

• Reduce the amount of time and resources providers devote to manual administrative functions—time that can be better spent with patients or focused on other agency efficiencies

• Pre-audit claim fields automatically for potential errors before submission to a payer

• Identify claim issues and provide online claim resolution before processing by a payer

• Submit claims almost instantaneously to a payer

• Reduce postage, supplies and mailing expenditures

• Track a claim's progress between intermediaries (e.g., a billing service or clearinghouse) and a payer through an electronic audit trail

• Confirm a payer's receipt of a claim through electronic reports

• Expedite a payer's claims processing turnaround and potential payment time frame

• Improve the provider's accounts receivable

Getting started

Agencies should first consider what method of electronic claims submission is appropriate for their setting. Electronic claims may be transmitted by:

- The Internet, which allows for secure, direct transmittal of claims submission to health plans over the Internet and eliminates the need for transmittal software.

Electronic claims can be generated in a provider management software system and then transmitted either directly to the payer electronically in accordance with the health plan's submission requirements or indirectly through an application service provider (ASP) or cloud computing service, a clearinghouse, a billing service or another third-party vendor.

An ASP or cloud computing service is a company that contracts with a payer and/or provider to supply software applications and/or software-related services for use over the Internet. A clearinghouse is a private company that provides connectivity, often serving as a "middleman" between providers, billing entities, payers and other health care partners for transmission and translation of claims information into the specific format required by payers. A clearinghouse acts for an electronic claim like the Post Office does for a manual claim. Agencies often contract with clearinghouses for a nominal fee. A contracted billing service, an ASP or even a payer may meet the definition of a clearinghouse if it performs such translation and transmission services.

Providers submitting electronic claims directly to a payer must follow the national standard formats currently in place—these require completion of extra fields beyond the standard fields of the CMS-UB04 claim form. Each payer has a companion manual containing specific requirements above and beyond the Health Insurance Portability and Accountability Act (HIPAA) of 1996 mandated requirements that must be met in order for claims to be processed for payment. Those specific requirements should be programmed into your provider management software system electronic claims module and be handled automatically. Health insurers are required by HIPAA to accept electronic claims. The provider should have checks and balances in place to protect the privacy of information and to ensure that the electronic claims are submitted in compliance with HIPAA requirements.

Providers may not have the opportunity or resources to submit electronic claims that meet the payer's specific requirements directly. However, providers can discuss options as to how best to send their manual or

electronic claim information to a clearinghouse, billing service or other transaction entity in order to convert the information into a claim format that can be electronically submitted to the payer.

Pre-auditing claims

Provider management software systems, clearinghouses, billing services or other claims transmission vendors can pre-audit electronic claims for missing or incorrect information (such as an invalid patient identification number, a diagnosis code that is no longer valid or gender misidentification) prior to their submission to a payer. A pre-audit claim check for these types of potential claim issues can help expedite claim processing and reduce payment delays or denials by a payer. Pre-auditing claim checks may also allow for automatic cross-referencing of procedures according to a health plan's requirements to help ensure that only approved procedures are submitted. Verifying electronic claims for accuracy before they are submitted to a payer decreases the time spent on claim review and adjustment, and allows for more timely claims processing and payment by a payer.

Tracking claims

The provider is encouraged to request claim transmission status reports from a payer, clearinghouse or other claims transmission vendor. These reports will supply the provider with an electronic audit trail to assist in tracking the accepted or rejected status of all the electronic claims sent to the various payers. When the provider is notified of a claim rejection electronically, it can quickly and easily correct and resubmit the claim electronically. Manual claim rejections, on the other hand, are received by the provider via mail and offer a paper copy of the payer's explanation of benefits (EOB) form. Based on the information presented on the EOB, the provider must then research, correct and resend a revised manual claim via mail to the payer. This process can add several weeks to the provider's accounts receivable cycle.

Clearinghouse reports will typically list the patient's name, the date of service, ICD-10 codes on the claim, in addition to the payer information and the claim acceptance or rejection remark. The remark description is the stated reason the electronic claim was rejected by the payer.

Providers can use electronic claim forms to submit and resubmit large quantities of claims at one time, in bulk, quickly and efficiently. For example, if categories such as a specific date of service, a date range or a specific patient's claims are required by the payer to be resubmitted, the provider management system or transmission vendor may be able to quickly sort and resubmit these claims. The categories can be resubmitted to the payer in a bulk file without taking up valuable staff resources and time searching, sorting and resubmitting manual claims. Concurrently, health plans will save on the administrative costs generally associated with the manual processing of resubmitted claims.

Providers may consider automating their claims revenue cycle by requesting that EOBs be delivered electronically and that claim payments be automatically transferred through an electronic funds transfer (EFT) by a payer and deposited into the provider's designated bank account. An electronic EOB in the mandated standard format can be posted into the provider's system with little or no staff intervention. An electronic EOB is also known as an electronic remittance advice (ERA). Medicare and other payers offer EFT programs, which,

in contrast to paper checks, use electronic means to transfer monies between parties. EFT payments can be nearly instantaneous (avoiding postal delays) and may reduce administrative steps associated with issuing or depositing payments. However, providers need to fully review the EFT program to determine if the prospective program provides enough flexibility for the provider to maintain banking relationships.

Effective January 1, 2014, all health plans are mandated to offer EFT to any provider that asks for it for their claim payments.

The potential elimination of manual processes from the claims management cycle through the introduction and use of HIT solutions may allow providers to increase their focus on auditing, appeals and collection of claim payments from payers. By streamlining the manual processes, providers can help ensure that they are performing revenue enhancing functions, such as making sure the appropriate reimbursement for providing medical services and procedures is received from patients and payers.

ELIGIBILITY REQUIREMENTS

Eligibility for home health (Part A or Part B)

You can receive home health care coverage under either Medicare Part A or Part B. Under Part B, you are eligible for home health care if you are homebound and need skilled care. There is no prior hospital stay requirement for Part B coverage of home health care. There is also no deductible or coinsurance for Part B-covered home health care.

Eligibility

Verifying patient eligibility for a home health episode lays the foundation for the entire reimbursement cycle.

You should verify:

Personal Information

- Name
- Birth Date
- Medicare Beneficiary Identifier
- Gender

Coverage Information

- Home Health PPS Episodes
- Medicare Advantage (HMO)
- Type of Medicare Coverage (Part A or B)
- Medicare Secondary Payer Insurance

- Hospice Period Benefit
- Home Health/Hospice Provider Detail
- Check Therapy use, if any

Understanding the Medicare Beneficiary Identifier (MBI) Format

How many characters does the MBI have?
The MBI has 11 characters.

Does the MBI's characters have any meaning?
Each MBI is randomly generated. The MBI's characters are "non-intelligent" so they don't have any hidden or special meaning.

What kinds of characters are in the MBI?
MBIs are numbers and upper-case letters. We use numbers 1-9 and all letters from A to Z, except for S, L, O, I, B, and Z. If you use lowercase letters, our system will convert them to uppercase letters.

How does the MBI look on the card?
The MBI has letters and numbers. Here's an example: 1EG4-TE5-MK73

- The MBI's 2nd, 5th, 8th, and 9th characters are always letters.
- Characters 1, 4, 7, 10, and 11 are always numbers.
- The 3rd and 6th characters are letters or numbers.
- We don't use dashes in the MBI. They aren't part of our computer systems and we don't use them in file formats.

MBI Format

Pos.	1	2	3	4	5	6	7	8	9	10	11
Type	C	A	AN	N	A	AN	N	A	A	N	N

Where positions hold numbers and letters?
C – Numeric 1 thru 9 **N** – Numeric 0 thru 9 **AN** – Either A or N **A** – Alphabetic Character (A...Z); Excluding (S, L, O, I, B, Z)

Position 1 – numeric values 1 thru 9
Position 2 – alphabetic values A thru Z (minus S, L, O, I, B, Z)
Position 3 – alpha-numeric values 0 thru 9 and A thru Z (minus S, L, O, I, B, Z)
Position 4 – numeric values 0 thru 9
Position 5 – alphabetic values A thru Z (minus S, L, O, I, B, Z)
Position 6 – alpha-numeric values 0 thru 9 and A thru Z (minus S, L, O, I, B, Z)
Position 7 – numeric values 0 thru 9
Position 8 – alphabetic values A thru Z (minus S, L, O, I, B, Z)
Position 9 – alphabetic values A thru Z (minus S, L, O, I, B, Z)

Position 10 – numeric values 0 thru 9
Position 11 – numeric values 0 thru 9

VERBAL ORDERS

Use of Oral (Verbal) Orders

When services are furnished based on a physician's oral order, the orders may be accepted and put in writing by personnel authorized to do so by applicable State and Federal laws and regulations as well as by the HHA's internal policies. The orders must be signed and dated with the date of receipt by the registered nurse or qualified therapist (i.e., physical therapist, speech-language pathologist, occupational therapist, or medical social worker) responsible for furnishing or supervising the ordered services. The orders may be signed by the supervising registered nurse or qualified therapist after the services have been rendered, as long as HHA personnel who receive the oral orders notify that nurse or therapist before the service is rendered. Thus, the rendering of a service that is based on an oral order would not be delayed pending signature of the supervising nurse or therapist. Oral orders must be countersigned and dated by the physician before the HHA bills for the care in the same way as the plan of care.

Services which are provided from the beginning of the 60-day episode certification period based on a request for anticipated payment and before the physician signs the plan of care are considered to be provided under a plan of care established and approved by the physician where there is an oral order for the care prior to rendering the services which is documented in the medical record and where the services are included in a signed plan of care.

Services that are provided in the subsequent 60-day episode certification period are considered provided under the plan of care of the subsequent 60-day episode where there is an oral order before the services provided in the subsequent period are furnished and the order is reflected in the medical record. However, services that are provided after the expiration of the plan of care, but before the acquisition of an oral order or a signed plan of care are not considered provided under a plan of care.

EXAMPLE 1:

The HHA acquires an oral order for I.V. medication administration for a patient to be performed on August 1. The HHA provides the I.V. medication administration August 1 and evaluates the patient's need for continued care. The physician signs the plan of care for the I.V. medication administration on August 15. The visit is covered since it is considered provided under a plan of care established and approved by the physician, and the HHA had acquired an oral order prior to the delivery of services.

EXAMPLE 2:

The patient is under a plan of care in which the physician orders I.V. medication administration every 2 weeks. The last day covered by the initial plan of care is July 31. The patient's next I.V. medication administration is scheduled for August 5 and the physician signs the plan of care for the new period on August 1. The I.V.

medication administration on August 5 was provided under a plan of care established and approved by the physician. The episode begins on the 61 day regardless of the date of the first covered visit.

EXAMPLE 3:

The patient is under a plan of care in which the physician orders I.V. medication administration every 2 weeks. The last day covered by the plan of care is July 31. The patient's next I.V. medication administration is scheduled for August 5 and the physician does not sign the plan of care until August 6. The HHA acquires an oral order for the I.V. medication administration before the August 5 visit, and therefore the visit is considered to be provided under a plan of care established and approved by the physician. The episode begins on the 61 day regardless of the date of the first covered visit.

Any increase in the frequency of services or addition of new services during a certification period must be authorized by a physician by way of a written or oral order prior to the provision of the increased or additional services.

Content of the Plan of Care

The HHA must be acting upon a physician plan of care that meets the requirements of this section for HHA services to be covered.

The plan of care must contain all pertinent diagnoses, including:

- The patient'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; and
- Any additional items the HHA or physician chooses to include.

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

- The course of therapy treatment must be established by the physician after any needed consultation with the qualified therapist;
- The plan must include measurable therapy treatment goals which pertain directly to the patient’s illness or injury, and the patient’s resultant impairments;
- The plan must include the expected duration of therapy services; and
- The plan must describe a course of treatment which is consistent with the qualified therapist’s assessment of the patient’s function.

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB No. 0938-0357

HOME HEALTH CERTIFICATION AND PLAN OF CARE

1. Patient's HI Claim No.	2. Start Of Care Date	3. Certification Period From: To:	4. Medical Record No.	5. Provider No.

6. Patient's Name and Address	7. Provider's Name, Address and Telephone Number

8. Date of Birth	9. Sex ☐M ☐F	10. Medications: Dose/Frequency/Route (N)ew (C)hanged

11. ICD-9-CM	Principal Diagnosis	Date
12. ICD-9-CM	Surgical Procedure	Date
13. ICD-9-CM	Other Pertinent Diagnoses	Date

14. DME and Supplies	15. Safety Measures:

16. Nutritional Req.	17. Allergies:

18.A. Functional Limitations

1 ☐ Amputation	5 ☐ Paralysis	9 ☐ Legally Blind			
2 ☐ Bowel/Bladder (Incontinence)	6 ☐ Endurance	A ☐ Dyspnea With Minimal Exertion			
3 ☐ Contracture	7 ☐ Ambulation	B ☐ Other (Specify)			
4 ☐ Hearing	8 ☐ Speech				

18.B. Activities Permitted

1 ☐ Complete Bedrest	6 ☐ Partial Weight Bearing	A ☐ Wheelchair			
2 ☐ Bedrest BRP	7 ☐ Independent At Home	B ☐ Walker			
3 ☐ Up As Tolerated	8 ☐ Crutches	C ☐ No Restrictions			
4 ☐ Transfer Bed/Chair	9 ☐ Cane	D ☐ Other (Specify)			
5 ☐ Exercises Prescribed					

19. Mental Status:							
1 ☐ Oriented	3 ☐ Forgetful	5 ☐ Disoriented	7 ☐ Agitated				
2 ☐ Comatose	4 ☐ Depressed	6 ☐ Lethargic	8 ☐ Other				
20. Prognosis:	1 ☐ Poor	2 ☐ Guarded	3 ☐ Fair	4 ☐ Good	5 ☐ Excellent		

21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration)

22. Goals/Rehabilitation Potential/Discharge Plans

23. Nurse's Signature and Date of Verbal SOC Where Applicable:	25. Date HHA Received Signed POT

24. Physician's Name and Address	26. I certify/recertify that this patient is confined to his/her home and needs intermittent skilled nursing care, physical therapy and/or speech therapy or continues to need occupational therapy. The patient is under my care, and I have authorized the services on this plan of care and will periodically review the plan.

27. Attending Physician's Signature and Date Signed	28. Anyone who misrepresents, falsifies, or conceals essential information required for payment of Federal funds may be subject to fine, imprisonment, or civil penalty under applicable Federal laws.

Form CMS-485 (C-3) (02-94) (Formerly HCFA-485) (Print Aligned)

1. Specificity of Orders

The orders on the plan of care must indicate the type of services to be provided to the patient, both with respect to the professional who will provide them and the nature of the individual services, as well as the frequency of the services.

Orders for care may indicate a specific range in the frequency of visits to ensure that the most appropriate level of services is provided during the 60-day episode to home health patients. When a range of visits is ordered, the upper limit of the range is considered the specific frequency.

Orders for services to be furnished "as needed" or "PRN" must be accompanied by a description of the patient's medical signs and symptoms that would occasion a visit and a specific limit on the number of those visits to be made under the order before an additional physician order would have to be obtained.

Who Signs the Plan of Care

The physician who signs the plan of care must be qualified to sign the physician certification and in PECOS.

Timeliness of Signature

A. Initial Percentage Payment

If a physician signed plan of care is not available at the beginning of the episode, the HHA may submit a RAP for the initial percentage payment based on physician verbal orders OR a referral prescribing detailed orders for the services to be rendered that is signed and dated by the physician. If the RAP submission is based on physician verbal orders, the verbal order must be recorded in the plan of care, include a description of the patient's condition and the services to be provided by the home health agency, include an attestation (relating to the physician's orders and the date received per 42 CFR 409.43), and the plan of care is copied and immediately submitted to the physician. A billable visit must be rendered prior to the submission of a RAP.

B. Final Percentage Payment

The plan of care must be signed and dated by a physician as described who meets the certification and recertification requirements of 42 CFR 424.22 and before the claim for each episode for services is submitted for the final percentage payment. Any changes in the plan of care must be signed and dated by a physician.

Diagnosis codes ICD-10

In health care, **diagnosis codes** are used as a tool to group and identify diseases, disorders, symptoms, poisonings, adverse effects of drugs and chemicals, injuries and other reasons for patient encounters. Diagnostic coding is the translation of written descriptions of diseases, illnesses and injuries into codes from a particular classification. In medical classification, diagnosis codes are used as part of the clinical coding process alongside intervention codes. Both diagnosis and intervention codes are assigned by a health professional trained in medical classification such as a clinical coder or Health Information Manager.

Several diagnosis classification systems have been implemented to various degrees of success across the world. The various classifications have a focus towards a particular patient encounter type such as emergency, inpatient, outpatient, mental health as well as surgical care. The International Statistical Classification of Diseases and Related Health Problems (ICD) is one of the most widely used classification systems for diagnosis coding as it allows comparability and use of mortality and morbidity data.

As the knowledge of health and medical advances arise, the diagnostic codes are generally revised and updated to match the most up to date current body of knowledge in the field of health. The codes may be quite frequently revised as new knowledge is attained.

Diagnosis codes are generally used as a representation of admitted episodes in health care settings. The principal diagnosis, additional diagnoses alongside intervention codes essentially depict a patient's admission to the agency.

Diagnoses codes are subjected to ethical considerations as they contribute to the total coded medical record in health services. The diagnoses codes, in particular the Principal Diagnoses and Additional Diagnoses can significantly affect the total funding that an agency will receive for any patient admitted.

The United States healthcare system currently uses the International Classification of Diseases-10th Edition-Clinical Modification (ICD-10-CM) to describe medical conditions and inpatient medical procedures in medical code. Every healthcare provider has a basic knowledge of ICD-10-CM. Professional medical billers and certified medical coders have an in-depth understanding of how this system works, how to apply its principles based on available medical documentation, and how to improve documentation to support the delivery of medically necessary services.

The International Classification of Diseases is a medical coding system devised by the United Nations' World Health Organization. The United States is the last industrial country to use the 10th version of ICD. All other advanced healthcare economies have already implemented ICD-10.

Assigning ICD codes

Every medical code is specifically definition. Diagnosis coding accurately portrays the medical condition that a patient is experiencing. Like all medical codes, ICD diagnostic codes are intended to convey an exact aspect of medical information. ICD diagnostic coding accurately reflects a healthcare providers findings. A healthcare

provider's progress note is composed of four component parts. Firstly, comes the patient's chief complaint, the reason that initiates the healthcare encounter. Secondly, the provider documents his or observations. This includes a review of the patient's history, a review of pertinent medical systems, and a physical examination. Following these, the healthcare provider renders an assessment in the form of a diagnosis, and a plan of care.

In the outpatient setting, a definitive ICD code is assigned only when a definitive diagnosis is reached. In the emergency room, or in an ambulance, a suspected condition is coded to justify the services performed. The same is true in the inpatient setting when conditions may have to be ruled out by performing a variety of tests that turn out to be negative and a conclusive diagnosis is not reached. Different guidelines govern the application of ICD codes depending on the circumstances. In the outpatient setting, a suspected condition is never assigned a code. In these cases, only the symptoms are coded.

Face-to-Face Encounter

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 provider 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

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. While the face-to-face encounter must be related to the primary reason for home health services, the patient's skilled need and homebound status can be substantiated through an examination of all submitted medical record documentation from the certifying physician, acute/post-acute care facility, and/or HHA (see below). The synthesis of progress notes, diagnostic findings, medications, nursing notes, etc., help to create a longitudinal clinical picture of the patient's health status.

- Information from the HHA, such as the plan of care required per 42 CFR §409.43 and 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. This means that the appropriately incorporated HHA information, along with the certifying physician's and/or the acute/post-acute care facility's medical record, creates a clinically consistent picture that the patient is eligible for Medicare home health services.
- The certifying physician demonstrates the incorporation of the HHA information into his/her medical record for the patient by signing and dating the material. Once incorporated, the documentation from the HHA, in conjunction with the certifying physician and/or acute/post-acute care facility documentation, must substantiate the patient's eligibility for home health services.

National 60-Day Episode Rate

A. Services Included

The law requires the 60-day episode to include all covered home health services, including medical supplies, paid on a reasonable cost basis. That means the 60-day episode rate includes costs for the six home health disciplines and the costs for routine and nonroutine medical supplies. The six home health disciplines included in the 60-day episode rate are:

1. Skilled nursing services;
2. Home health aide services;
3. Physical therapy;
4. Speech-language pathology services;
5. Occupational therapy services; and
6. Medical social services.

The 60-day episode rate also includes amounts for nonroutine medical supplies and therapies that could have been unbundled to Part B prior to HH PPS.

Outlier payments - Paying more for the care of the costliest beneficiaries

Additional payments will be made to the 60-day case-mix adjusted episode payments for beneficiaries who incur unusually large costs. These outlier payments will be made for episodes whose imputed cost exceeds a threshold amount for each case-mix group. The amount of the outlier payment will be a proportion of the amount of imputed costs beyond the threshold. Outlier costs will be imputed for each period/episode by applying standard per-visit amounts to the number of visits by discipline (skilled nursing visits, or physical, speech-language pathology, occupational therapy, or home health aide services) reported on the claims. Total national outlier payments for home health services annually will be no more than 2.5 percent of estimated total payments under home health PPS.

Consolidated billing

Under the PPS a HHA must bill for all home health services which includes nursing and therapy services, routine and non-routine medical supplies, home health aide and medical social services, except durable medical equipment (DME). DME was excluded from the BBA established consolidated billing requirement by the BBRA. The law requires that all home health services paid on a cost basis be included in the PPS rate. Therefore, the PPS rate will include all nursing and therapy services, routine and non-routine medical supplies, and home health aide and medical social services.

OASIS

Since OASIS collection was implemented in 1999, national interest in the area of home health care quality measurement and improvement has been ongoing. CMS received hundreds of comments about OASIS from a variety of sources: providers, professional organizations (e.g., American Nurses Association and the American Physical Therapy Association), home care provider organizations, accrediting organizations, researchers, etc. In addition, individuals and groups with expertise in health care quality measurement, such as the Medicare Payment Advisory Commission (MedPAC), the National Quality Forum (NQF), and many technical expert panels commissioned by CMS to guide OASIS evolution have offered suggestions for improving OASIS and expanding the domains of home health quality measurement to address the six aims (safety, timeliness, effectiveness, efficiency, equity, and patient-centeredness) articulated by the Institute of Medicine in their 2001 report "Crossing the Quality Chasm."

Input from the NQF, a nonprofit organization that endorses national consensus standards for measuring and publicly reporting on performance has been especially valuable in guiding the evolution of OASIS and associated performance reports. NQF-endorsed voluntary consensus standards are widely viewed as the gold standard for measurement of health care quality. NQF has endorsed a number of OASIS-based quality measures for public reporting. Endorsed measures are periodically reviewed for continuing endorsement, and, as measure development continues, new or revised measures are submitted to NQF for review.

The Outcome and Assessment Information Set (OASIS) is a group of standard data elements developed, tested, and refined over the course of two decades through a research and demonstration program funded primarily by the Centers for Medicare & Medicaid Services (CMS), with additional funding from the Robert Wood Johnson Foundation and the New York State Department of Health. OASIS data elements were designed to enable systematic comparative measurement of home health care patient outcomes at two points in time.

OASIS-based quality measures can be used for quality improvement efforts that home health agencies (HHAs) can employ to assess and improve the quality of care they provide to patients. CMS provides HHAs with numerous quality measure reports including outcome, process, potentially avoidable event, patient-related characteristic, and patient tally reports. Reports are provided for up to two time intervals selected by the HHA requesting the reports. Process quality measures include indicators of how often the HHA follows best providers to improve patient outcomes. Outcome measures include end-result functional and physical health improvement/stabilization, health care utilization measures, and potentially avoidable events. Potentially avoidable events are negative outcomes that clinical evidence indicates can be influenced (although not necessarily totally avoided) by following best providers in providing care. In addition to quality measurement, certain OASIS data elements are used to adjust per-episode payment rates for patient conditions that affect care needs.

TIME POINTS

OASIS data are collected at the following time points:

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Chapter 1 – OASIS TYPES

- Start of care
- Resumption of care following inpatient facility stay
- Recertification within the last five days of each 60-day recertification period
- Other follow-up during the home health episode of care
- Transfer to an inpatient facility
- Death at home
- Discharge from agency
- **All Items:** This is the entire set of OASIS Items that are collected at any point in time during a home health episode of care. At any one point in time, only a subset of OASIS items is collected.
- **Patient Tracking Sheet**: This information is collected at Start of Care and updated as needed at subsequent time points. Note: Patient Tracking Sheet items are required to be included in the data submission record for each time point, although they are collected at Start of Care and only updated as needed at subsequent time points. Refer to the OASIS Data Specifications on the CMS Web site at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/OASIS/DataSpecifications.html.
- **Start of Care (SOC):** This information is collected at Start of Care in addition to all OASIS items on the Patient Tracking Sheet.
- **Resumption of Care (ROC):** This information is collected at Resumption of Care in addition to M0032 Resumption of Care Date on the Patient Tracking Sheet.
- **Follow-Up (FU):** This information is collected at Recertification and Other Follow-up.
- **Transfer (TRN):** This information is collected at Transfer to Inpatient Facility, with or without Discharge from Home Health Agency.
- **Discharge (DC):** This information is collected at discharge from home health agency other than Death at Home or Transfer to Inpatient Facility.
- **Death at Home (Death):** This information is collected when the patient dies while on service with the home health agency, and died somewhere other than an inpatient/outpatient facility or ED.

All of these assessments, with the exception of transfer to inpatient facility and death at home, require the clinician to have an in-person encounter with the patient during a home visit. The transfer to an inpatient facility requires collection of limited OASIS data (most of which may be obtained through a telephone call). Not all OASIS items are completed at every assessment time point. Some items are completed only at start of care, some only at discharge. The table of "Items to be Used at Specific Time Points" included at the beginning of the OASIS data set allows the home health agency (or its selected medical record vendor) to integrate the necessary OASIS items at each time point into clinical documentation forms or an electronic health record.

At the start of care time point, the comprehensive assessment should be completed within five days after the start of care date.

At the resumption of care, the comprehensive assessment must be completed within 48 hours of return home after inpatient facility discharge, or within 48 hours of knowledge of a qualifying stay in an inpatient facility. A physician- ordered resumption of care (ROC) must be conducted on or within 2 calendar days of the physician-ordered ROC date.

For the transfer to inpatient facility, discharge from home care, death at home, and other follow-up, the assessments must be completed on, or within 48 hours of becoming aware of the significant change in condition, transfer, discharge, or death date.

WHO COMPLETES OASIS?

As identified in (M0080) Discipline of Person Completing Assessment, the comprehensive assessment and OASIS data collection are the responsibility of a registered nurse (RN) or any of the therapies, including physical therapist (PT), speech language pathologist/speech therapist (SLP/ST), or occupational therapist (OT). A licensed practical nurse or licensed vocational nurse (LPN/LVN), physical therapy assistant (PTA), occupational therapy assistant (OTA), medical social worker (MSW), or Aide may not be responsible for completing OASIS assessments.

In cases involving nursing, the RN is responsible for completing the comprehensive assessment document at the SOC, and may elicit input from the patient, caregivers, and other health care personnel, including the physician, the pharmacist and/or other agency staff to assist in completion of any or all OASIS items. Any discipline qualified to perform assessments – RN, PT, SLP, OT – may complete subsequent assessments. For a therapy-only case, the therapist usually conducts the comprehensive assessment. It is acceptable for a PT or SLP to conduct and complete the comprehensive assessment at SOC for a Medicare patient.

An OT may conduct and complete the assessment when the need for occupational therapy establishes program eligibility. Note: Occupational therapy alone does not establish eligibility for the Medicare home health benefit at the start of care; however, occupational therapy may establish eligibility under other programs, such as Medicaid. The Medicare home health patient who is receiving services from multiple disciplines (for example, skilled nursing, physical therapy, and occupational therapy) during the episode of care, can retain eligibility if, over time, occupational therapy is the only remaining skilled discipline providing care. At that time, an OT can conduct OASIS assessments.

Multidisciplinary cases may have multiple points of discipline-specific discharge, though there is only one HHA discharge, which must include completion of the OASIS discharge comprehensive assessment. Other non-OASIS required documentation for recertification and discharge are specified in the Condition of Participation:

Comprehensive Assessment of Patients.1 OASIS items were designed to be discipline-neutral and have been tested and validated with clinicians from various disciplines.

COMPREHENSIVE ASSESSMENT AND PLAN OF CARE

OASIS data are collected as part of the comprehensive assessment required by the Medicare Conditions of Participation (see Appendix A of this manual). OASIS is not intended to represent a comprehensive assessment in and of itself. HHAs are expected to incorporate OASIS items into their comprehensive assessment documentation and follow their own assessment policies and procedures. Agencies are free to rearrange OASIS item sequence in a way that permits logical ordering within their own forms, as long as the actual item content, skip patterns, and OASIS number remain the same. Like other comprehensive assessment documentation, OASIS data are collected using a variety of strategies, including observation, interview, review of pertinent documentation when allowed (for example, hospital discharge summaries), discussions with other healthcare providers where relevant (for example, phone calls to the physician to verify diagnoses), and measurement (for example, intensity of pain). Although one clinician must take responsibility for the comprehensive assessment, collaboration with the patient, caregivers, and other health care personnel, including the physician, pharmacist, and/or other agency staff is appropriate. For items requiring patient assessment, the collaborating healthcare providers must have had direct contact with the patient. OASIS data should be collected at each time point based on a unique patient assessment, not simply carried over from a previous assessment. Comprehensive assessment data form the basis of the physician-ordered Plan of Care. Thus, there should be congruence between documentation of findings from the comprehensive assessment and the Plan of Care.

Agencies may have the comprehensive assessment completed by one clinician. If collaboration with other health care personnel and/or agency staff is utilized, the agency is responsible for establishing policies and providers related to collaborative efforts, including how assessment information from multiple clinicians will be documented within the clinical record, ensuring compliance with applicable requirements, and accepted standards of provider.

Encoding OASIS Data

Once the comprehensive assessment has been completed and OASIS data collected, HHAs not already utilizing electronic capture of their OASIS data would enter the OASIS information into the computer system, referred to as “encoding.” All the time points of the OASIS assessments have a uniform time frame of thirty days from the date the assessment is completed (M0090 – Date Assessment Completed) for encoding and submitting the data. Once the OASIS data are encoded (in software available from CMS, or other software that conforms to the CMS standard data submission specifications), the agency will review each assessment and edit it for transmission to a centralized data submission system. During this preparation period, the HHA must run a software application that subjects each patient data set to the CMS edit specifications and makes it transmission-ready. The agency must correct any information that does not pass the CMS-specified edits (e.g., data is missing, incorrect, or inconsistent). If errors are identified or suspected, staff entering data or preparing for submission may need to contact the qualified clinician who was responsible for completing the comprehensive assessment document, allowing necessary corrections to be made per agency policy. Delaying data entry or submission may impact the assessing clinician’s recall, and the resulting data accuracy.

HHAs have flexibility in the method used to encode their data. Data can be encoded directly by the skilled professional who conducts the assessment into a laptop, hand-held, or tablet computer, by a clerical staff member from a hard copy of the completed assessment, or by a data entry operator or service with whom the HHA may contract to enter the data. Any of these are acceptable methods of meeting the regulatory reporting requirements for OASIS. However, the HHA is ultimately responsible for meeting the reporting requirements as well as maintaining patient confidentiality.

Once the OASIS data are encoded, HHAs use their software to review and edit the data prior to data submission. When editing the data prior to transmission, it is important to remember that the edits include an electronic safety net to preclude the transmission of erroneous or inconsistent information and enforce the required formatting for the data set items. When transmitted, the patient assessment data are stabilized at the time point of the assessment, preventing the override of current assessment information with future or past information.

Accuracy of Encoded OASIS Data

The encoded OASIS data must accurately reflect the patient's status at the time of assessment. Before transmission, the HHA must ensure that data items on its own clinical record match the encoded data that are sent to the centralized data submission system. We expect that once the qualified skilled professional (specifically, RN, PT, SLP/ST, or OT) completes the assessment, the HHA will develop a means to ensure that the OASIS data input into the computer and transmitted to a centralized data submission system exactly reflect the data collected by the skilled professional. Appendix B contains recommendations for conducting data quality audits on a routine basis. In addition, the State survey process for HHAs may include review of OASIS data collected versus data encoded and transmitted.

Transmission of OASIS Data

CMS requires that the HHA electronically transmit the accurate, completed, and encoded OASIS data to a centralized data submission system within 30 days of the completion of the assessment (M0090 Date Assessment Completed). As long as the submission time frame is met, HHAs are free to develop schedules for transmitting the data that best suit their needs. Data must be transmitted in a format that meets the requirements specified in the data format standard (i.e., conforming to the CMS standard electronic record layouts, edit specifications, and data dictionary). HHAs that are required to submit OASIS data must do so using a secure connection to a network maintained by CMS or its contractor.

OASIS Guidance Manual Appendix E Final Validation Report

Once transmitted, the data submission is validated and feedback is provided to the HHA via the OASIS Final Validation Report or OASIS Submitter Final Validation Report as to whether the submission file(s) has been accepted or rejected and whether each submitted record meets the data format and edit requirements. An entire submission or individual records may be rejected for a variety of reasons. The HHA must make corrections and resubmit the data for any assessments that are rejected. If an assessment record causes non-

fatal warning messages to be generated, the HHA may elect to submit a corrected assessment record but is not required to do so.

HHAs must use a CMS-assigned branch identification number (where applicable) to identify branch-specific assessment information in a uniform fashion nationwide. This procedure finalized a process that began in January 2004, uniquely identifying every branch of every HHA certified to participate in the Medicare home health program. The system links the parent to the branch HHA and gives CMS the capability of monitoring the quality of care delivered by agencies down to the HHA branch level.

Centers for Medicare & Medicaid Services

For Medicare fee-for-service patients, the transmitted OASIS data also are utilized for billing. The HHA can submit a Request for Anticipated Payment (RAP) to their Medicare Administrative Contractor (MAC) when all of the four following conditions are met:

- After the OASIS assessment is complete, locked or export ready, or there is an agency-wide internal policy for establishing that the OASIS data is finalized for transmission to the centralized data submission system,
- A physician's verbal orders for home care have been received and documented,
- A plan of care has been established and sent to the physician, and
- The first service visit under that plan has been delivered.

An episode will be opened on Common Working File (CWF) with the receipt and processing of the RAP. RAPs, or in special cases claims, must be submitted for initial HH PPS episodes, subsequent HH PPS episodes, or in transfer situations to start a new HH PPS episode when another episode is already open at a different agency. HHAs should submit the RAP as soon as possible after care begins to assure they are established as the primary HHA for the beneficiary.

jHAVEN

jHAVEN (Home Assessment Validation and Entry System) v1.4.0, currently available under the related links section at the bottom of this webpage, is a Java-based application which allows Home Healthcare providers to collect and maintain agency, patient and OASIS assessment data for subsequent submission to the appropriate national data repository. jHAVEN is a free software application provided by the Centers for Medicare and Medicaid Services (CMS).

Conditions Patient Must Meet to Qualify for Coverage of Home Health Services

To qualify for the Medicare home health benefit a Medicare beneficiary must meet the following requirements:

- Be confined to the home;

- Under the care of a physician;
- Receiving services under a plan of care established and periodically reviewed by a physician;
- Be in need of skilled nursing care on an intermittent basis or physical therapy or speech-language pathology; or
- Have a continuing need for occupational therapy.

For purposes of benefit eligibility "intermittent" means skilled nursing care that is either provided or needed on fewer than 7 days each week or less than 8 hours of each day for periods of 21 days or less (with extensions in exceptional circumstances when the need for additional care is finite and predictable).

A patient must meet each of the criteria specified in this section. Patients who meet each of these criteria are eligible to have payment made on their behalf for services.

30.1.1 - Patient Confined to the Home

For a patient to be eligible to receive covered home health services under both Part A and Part B, the law requires that a physician certify in all cases that the patient is confined to his/her home. For purposes of the statute, an individual shall be considered “confined to the home” (homebound) if the following two criteria are met:

1. Criterion One:

The patient 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 in order to leave their place of residence

OR

- Have a condition such that leaving his or her home is medically contraindicated.

If the patient meets one of the criterion one conditions, then the patient must ALSO meet two additional requirements defined in criterion two below.

2. Criterion Two:

- There must exist a normal inability to leave home;

AND

- Leaving home must require a considerable and taxing effort.

To clarify, 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 (e.g., 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 patient'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 patient's overall health status 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.

If the patient does in fact leave the home, the patient may nevertheless be considered homebound if the absences from the home are infrequent or for periods of relatively short duration, or are attributable to the need to receive health care treatment. Absences attributable to the need to receive health care treatment include, but are not limited to:

- Attendance at adult day centers to receive medical care;
- Ongoing receipt of outpatient kidney dialysis; or
- The receipt of outpatient chemotherapy or radiation therapy.

Any absence of an individual from the home attributable to the need to receive health care treatment, including regular absences for the purpose of participating in therapeutic, psychosocial, or medical treatment in an adult day-care program that is licensed or certified by a state, or accredited to furnish adult day-care services in a state, shall not disqualify an individual from being considered to be confined to his home. Any other absence of an individual from the home shall not so disqualify an individual if the absence is of an infrequent or of relatively short duration. For purposes of the preceding sentence, any absence for the purpose of attending a religious service shall be deemed to be an absence of infrequent or short duration. It is expected that in most instances, absences from the home that occur will be for the purpose of receiving health care treatment. However, occasional absences from the home for nonmedical purposes, e.g., an occasional trip to the barber, a walk around the block or a drive, attendance at a family reunion, funeral, graduation, or other infrequent or unique event would not necessitate a finding that the patient is not homebound if the absences are undertaken on an infrequent basis or are of relatively short duration and do not indicate that the patient has the capacity to obtain the health care provided outside rather than in the home.

Some examples of homebound patients that illustrate the factors used to determine whether a homebound condition exists are listed below.

- A patient paralyzed from a stroke who is confined to a wheelchair or requires the aid of crutches in order to walk.
- A patient who is blind or senile and requires the assistance of another person in leaving their place of residence.

- A patient who has lost the use of their upper extremities and, therefore, is unable to open doors, use handrails on stairways, etc., and requires the assistance of another individual to leave their place of residence.
- A patient in the late stages of ALS or neurodegenerative disabilities. In determining whether the patient has the general inability to leave the home and leaves the home only infrequently or for periods of short duration, it is necessary (as is the case in determining whether skilled nursing services are intermittent) to look at the patient's condition over a period of time rather than for short periods within the home health stay. For example, a patient may leave the home (meeting both criteria listed above) more frequently during a short period when the patient has multiple appointments with health care professionals and medical tests in 1 week. So long as the patient's overall condition and experience is such that he or she meets these qualifications, he or she should be considered confined to the home.
- A patient who has just returned from a hospital stay involving surgery, who may be suffering from resultant weakness and pain because of the surgery and; therefore, their actions may be restricted by their physician to certain specified and limited activities (such as getting out of bed only for a specified period of time, walking stairs only once a day, etc.).
- A patient with arteriosclerotic heart disease of such severity that they must avoid all stress and physical activity.
- A patient with a psychiatric illness that is manifested in part by a refusal to leave home or is of such a nature that it would not be considered safe for the patient to leave home unattended, even if they have no physical limitations.

The aged person who does not often travel from home because of feebleness and insecurity brought on by advanced age would not be considered confined to the home for purposes of receiving home health services unless they meet one of the above conditions.

Although a patient must be confined to the home to be eligible for covered home health services, some services cannot be provided at the patient's residence because equipment is required that cannot be made available there. If the services required by an individual involve the use of such equipment, the HHA may make arrangements with a hospital, SNF, or a rehabilitation center to provide these services on an outpatient basis. However, even in these situations, for the services to be covered as home health services the patient must be considered confined to home and meet both criteria listed above.

If a question is raised as to whether a patient is confined to the home, the HHA will be requested to furnish the Medicare contractor with the information necessary to establish that the patient is homebound as defined above.

485 Plan of Care

All services provided under the Medicare home health benefit must be ordered by a physician. Basic requirements for ordering services are:

- The physician must be enrolled in Medicare, in PECOS;
- The ordering National Provider Identifier (NPI) must be for an individual physician (not an organizational NPI); and
- The physician must be of a specialty type that is eligible to order and refer.
- The patient must be under the care of a physician who is qualified to sign the physician certification and plan of care
- A patient is expected to be under the care of the physician who signs the plan of care. It is expected that in most instances, the physician who certifies the patient's eligibility for Medicare home health services will be the same physician who establishes and signs the plan of care.
- The plan of care must be reviewed and signed by the physician who established the plan of care, in consultation with HHA professional personnel, at least every 60 days. Each review of a patient's plan of care must contain the signature of the physician and the date of review.

F2F: Face-to-Face Encounter

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)

Use of Oral (Verbal) Orders

When services are furnished based on a physician's oral order, the orders may be accepted and put in writing by personnel authorized to do so by applicable State and Federal laws and regulations as well as by the HHA's internal policies. The orders must be signed and dated with the date of receipt by the registered nurse or qualified therapist (i.e., physical therapist, speech-language pathologist, occupational therapist, or medical social worker) responsible for furnishing or supervising the ordered services. The orders may be signed by the supervising registered nurse or qualified therapist after the services have been rendered, as long as HHA personnel who receive the oral orders notify that nurse or therapist before the service is rendered. Thus, the rendering of a service that is based on an oral order would not be delayed pending signature of the supervising nurse or therapist. Oral orders must be countersigned and dated by the physician before the HHA bills for the care in the same way as the plan of care.

Services which are provided from the beginning of the 60-day episode certification period based on a request for anticipated payment and before the physician signs the plan of care are considered to be provided under a plan of care established and approved by the physician where there is an oral order for the care prior to

rendering the services which is documented in the medical record and where the services are included in a signed plan of care.

Services that are provided in the subsequent 60-day episode certification period are considered provided under the plan of care of the subsequent 60-day episode where there is an oral order before the services provided in the subsequent period are furnished and the order is reflected in the medical record. However, services that are provided after the expiration of the plan of care, but before the acquisition of an oral order or a signed plan of care are not considered provided under a plan of care.

Beneficiaries Who Are Part A Only or Part B Only

If a beneficiary is enrolled only in Part A and qualifies for the Medicare home health benefit, then all of the home health services are financed under Part A. The 100-visit limit does not apply to beneficiaries who are only enrolled in Part A. If a beneficiary is enrolled only in Part B and qualifies for the Medicare home health benefit, then all of the home health services are financed under Part B. There is no 100-visit limit under Part B. The new definition of post-institutional home health services provided during a home health spell of illness only applies to those beneficiaries who are enrolled in both Part A and Part B and qualify for the Medicare home health benefit.