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CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-02 Medicare Benefit Policy	Centers for Medicare & Medicaid Services (CMS)
Transmittal 139	**Date: February 16, 2011**
	Change Request 7329

SUBJECT: Clarifications for Home Health Face-to-Face Encounter Provisions

I. SUMMARY OF CHANGES: Chapter 7 is being revised to incorporate the new "face-to-face" encounters with a physician due to the provisions mandated by the Affordable Care Act.

EFFECTIVE DATE: January 1, 2011
IMPLEMENTATION DATE: March 10, 2011

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

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	7/Table of Contents
R	7/10.7/Low Utilization Payment Adjustment (LUPA)
R	7/10.8/Partial Episode Payment (PEP) Adjustment
R	7/10.9/Outlier Payments
R	7/10.10/Discharge Issues
R	7/10.11/Consolidated Billing
R	7/10.12/Change of Ownership Relationship to Episodes Under PPS
D	7/10.13/Change of Ownership Relationship to Episodes Under PPS
R	7/30.2.1/Content of the Plan of Care
R	7/30.5/Physician Certification
R	7/30.5.1/Content of the Physician Certification
N	7/30.5.1.1/Face-to-Face Encounter

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R	7/30.5.2/Periodic Recertification

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

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

Unless otherwise specified, the effective date is the date of service.

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Attachment - Business Requirements

Pub. 100-02	Transmittal: 139	Date: February 16, 2011	Change Request: 7329

SUBJECT: Clarifications for Home Health Face-to-Face Encounter Provisions

Effective Date: January 1, 2011
Implementation Date: March 10, 2011

I. GENERAL INFORMATION

A. Background: CMS is including the following clarifications to Pub. 100-02, Medicare Benefit Policy Manual, Chapter 7, Home Health Services:

Due to new provisions mandated by passage of the Affordable Care Act, there are new statutory requirements regarding face-to-face encounters for certifications applicable to the home health program that must be updated in the home health chapter.

B. Policy: Section 6407 of the Affordable Care Act requires these face-to-face encounters with a physician for home health certifications. Details of the policy are provided in the above-mentioned chapter.

II. BUSINESS REQUIREMENTS TABLE

Use "Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7329.1	Medicare contractors shall make providers aware of the clarifications provided in Pub. 100-02, Medicare Benefit Policy Manual, Chapter 7 regarding face-to-face encounters with a physician, including posting this entire instruction or providing a direct link to this instruction on their Web site, and include information about it in a listserv message.	X		X		X					

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III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7329.2	Contractors shall post this entire instruction, or a direct link to this instruction, on their Web sites and include information about it in a listserv message within 1 week of the release of this instruction. In addition, the entire instruction must be included in the Contractors next regularly scheduled bulletin. Contractors are free to supplement it with localized information that would benefit their provider community in billing and administering the Medicare program correctly. Please note that a provider education article related to this instruction is available at http://www.cms.gov/MLNMattersArticles/downloads/SE1038.pdf. Notification of the article has also been released via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message.	X		X		X					

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below:
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
N/A	

Section B: For all other recommendations and supporting information, use this space: N/A

V. CONTACTS

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Post-Implementation Contact(s): Kelly M. Horney, 410-786-0558, kelly.horney1@cms.hhs.gov or contact your Contracting Officer's Technical Representative (COTR) or Contractor Manager, as applicable.

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VI. FUNDING

Section A: ***For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),*** **and/or** ***Carriers*****:**

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: ***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.

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Medicare Benefit Policy Manual
Chapter 7 - Home Health Services

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10.7 - Low Utilization Payment Adjustment (LUPA)

(Rev.139, Issued: 02- 16-11, Effective: 01-01-11, Implementation: 03-10-11)

An episode with four or fewer visits is paid the national per visit amount by discipline adjusted by the appropriate wage index based on the site of service of the beneficiary. Such episodes of four or fewer visits are paid the wage-adjusted per visit amount for each of the visits rendered instead of the full episode amount. The national per visit amounts by discipline (skilled nursing, home health aide, physical therapy, speech-language pathology, occupational therapy, and medical social services) are updated and published annually by the applicable market basket for each visit type.

Beginning in CY 2008, to offset the full cost of longer, initial visits in some LUPA episodes, CMS has modified the LUPA by increasing the payment by an add-on amount for LUPAs that occur as the only episode or the initial episode during a sequence of adjacent episodes. The initial LUPA add-on amount was $92.63 for CY 2008, and is updated annually by the home health market basket update percentage, plus or minus any percentage mandated by Congress.

10.8 - Partial Episode Payment (PEP) Adjustment

(Rev. 139, Issued: 02- 16-11, Effective: 01-01-11, Implementation: 03-10-11)

A. PEP Adjustment Criteria

The PEP adjustment accounts for key intervening events in a patient's care defined as:

- A beneficiary elected transfer; or
- A discharge resulting from the beneficiary reaching the treatment goals in the original plan of care and returning to the same HHA during the 60-day episode.

The intervening event defined as the beneficiary elected transfer or discharge and return to the same HHA during the 60-day episode warrants a new 60-day episode for purposes of payment. A start of care OASIS assessment and physician certification of the new plan of care are required. When a new 60-day episode begins due to the intervening event of the beneficiary elected transfer or discharge and return to the same HHA during the 60-day episode, the original 60-day episode is proportionally adjusted to reflect the length of time the beneficiary remained under the agency's care prior to the intervening event.

Home health agencies have the option to discharge the patient within the scope of their own operating policies. However, an HHA discharging a patient as a result of hospital (SNF or rehab facility) admission with the patient returning to home health services at the same HHA during the 60-day episode will not be recognized by Medicare as a discharge for billing and payment purposes, and thus a Partial Episode Payment (PEP) adjustment would not apply. An intervening hospital (SNF or rehab facility) stay will result in a full 60-day episode spanning the start of care date prior to the hospital (SNF or rehab facility) admission, through and including the days of the hospital admission, and ending 59 days after the original start of care date.

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B. Methodology Used to Calculate PEP Adjustment

The PEP adjustment for the original 60-day episode is calculated to reflect the length of time the beneficiary remained under the care of the original HHA based on the first billable visit date through and including the last billable visit date. The PEP adjustment is calculated by determining the actual days served by the original HHA (first billable visit date through and including last billable visit date as a proportion of 60 multiplied by the original 60-day episode payment).

C. Application of Therapy Threshold to PEP Adjusted Episode

The therapy threshold item included in the case-mix methodology used in home health PPS is not combined or prorated across episodes. Each episode whether full or proportionately adjusted is subject to the therapy threshold for purposes of case-mix adjusting the payment for that individual patient's resource needs.

D. Common Ownership Exception to PEP Adjustment

If an HHA has a significant ownership as defined in 42 CFR 424.22, then the PEP adjustment would not apply in those situations of beneficiary elected transfer. Those situations would be considered services provided under arrangement on behalf of the originating HHA by the receiving HHA with the ownership interest until the end of the episode. The common ownership exception to the transfer PEP adjustment does not apply if the beneficiary moved out of their MSA or non-MSA during the 60-day episode before the transfer to the receiving HHA.

E. Beneficiary Elected Transfer Verification

In order for a receiving HHA to accept a beneficiary elected transfer, the receiving HHA must document that the beneficiary has been informed that the initial HHA will no longer receive Medicare payment on behalf of the patient and will no longer provide Medicare covered services to the patient after the date of the patient's elected transfer in accordance with current patient rights requirements at 42 CFR 484.10(e). The receiving HHA must also document in the record that it accessed the regional home health intermediaries (RHHI) inquiry system to determine whether or not the patient was under an established home health plan of care and it must contact the initial HHA on the effective date of transfer. In the rare circumstance of a dispute between HHAs, the RHHI is responsible for working with both HHAs to resolve the dispute. If the receiving HHA can provide documentation of its notice of patient rights on Medicare payment liability provided to the patient upon transfer and its contact of the initial HHA of the transfer date, then the initial HHA will be ineligible for payment for the period of overlap in addition to the appropriate PEP adjustment. If the receiving HHA cannot provide the appropriate documentation, the receiving HHA's RAP and/or final claim will be cancelled, and full episode payment will be provided to the initial HHA. For the receiving HHA to properly document that it contacted the initial HHA on the effective date of transfer it must maintain similar information as the initial HHA, including the same basic beneficiary information, personnel contacted, dates and times. The initial HHA must also properly document that it was contacted and it accepted

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the transfer. Where it disputes a transfer, the initial HHA must call its RHHI to resolve the dispute. The RHHI is responsible for working with both HHAs to resolve the dispute.

10.9 – *Outlier Payments*

(Rev. 139, Issued: 02- 16-11, Effective: 01-01-11, Implementation: 03-10-11)

When cases experience an unusually high level of services in a 60-day period, Medicare systems will provide additional or "outlier" payments to the case-mix and wage-adjusted episode payment. Outlier payments can result from medically necessary high utilization in any or all-home health service disciplines. CMS makes outlier payments when the cost of care exceeds a threshold dollar amount. The outlier threshold for each case-mix group is the episode payment amount for that group *or the* PEP adjustment amount for the episode, plus a fixed dollar loss amount, *which* is the same for all case-mix groups. The outlier payment is a proportion of the amount of imputed costs beyond the threshold. CMS calculates the imputed cost for each episode by multiplying the national per visit amount of each discipline by the number of visits in the discipline and computing the total imputed cost for all disciplines. If the imputed cost for the episode is greater than the sum of the case-mix and wage-adjusted episode payment plus the fixed dollar loss amount (the outlier threshold), a set percentage (the loss sharing ratio) of the difference between the imputed amount and outlier threshold will be paid to the HHA as a wage-adjusted outlier payment in addition to the episode payment. The amount of the outlier payment is determined as follows:

1. Calculate the case-mix and wage-adjusted episode payment *(including non-routine supplies (NRS))*;

2. Add the wage-adjusted fixed dollar loss amount. The sum of steps 1 and 2 is the outlier threshold for the episode;

3. *Calculate* the wage-adjusted *imputed cost of the episode* by *first multiplying* the total number of visits for each home health discipline *by* the *national per visit amounts, and wage-adjusting those amounts. Sum the per discipline wage-adjusted imputed amounts to* yield the total *wage-adjusted* imputed cost for the episode;

4. Subtract the total imputed cost for the episode (total from Step 3) from the sum of the case-mix and wage-adjusted episode payment and the wage-adjusted fixed dollar loss amount (sum of Steps 1 and 2 - outlier threshold);

5. Multiply the difference by the loss sharing ratio; and

6. That total amount is the outlier payment for the episode.

Effective January 1, 2010, an outlier cap precludes any HHA from receiving more than 10 percent of their total home health payment in outliers.

10.10 - *Discharge Issues*

(Rev. 139, Issued: 02- 16-11, Effective: 01-01-11, Implementation: 03-10-11)

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A. Hospice Election Mid-Episode

If a patient elects hospice before the end of the episode and there was no PEP or LUPA adjustment, the HHA will receive a full episode payment. Home health PPS does not change the current rules that permit a hospice patient to receive home health services for a condition unrelated to his/her reason for hospice election. Consistent with all episodes in which a patient receives four or fewer visits, the episode with four or fewer visits in which a patient elects hospice would be paid at the low utilization payment adjusted amount.

B. Patient's Death

The documented event of a patient's death would result in a full episode payment, unless the death occurred in a low utilization payment adjusted episode. Consistent with all episodes in which a patient receives four or fewer visits, if the patient's death occurred during an episode with four or fewer visits, the episode would be paid at the low utilization payment adjusted amount. In the event of a patient's death during a*n* adjusted episode, the total adjusted episode would constitute the full episode payment. However, the HHA is not constrained to bill for a higher case-mix group if the net effect is a lower payment for the episode than if the *adjustment* had not occurred.

C. Patient is No Longer Eligible for Home Health (e.g., no longer homebound, no skilled need).

If the patient is discharged because he or she is no longer eligible for the Medicare home health benefit and has received more than four visits, then the HHA would receive full episode payment. However, if the patient becomes subsequently eligible for the Medicare home health benefit during the same 60-day episode and later transferred to another HHA or returned to the same HHA, then the latter situation would result in a PEP adjustment.

D. Discharge Due to Patient Refusal of Services or is a Documented Safety Threat, Abuse Threat or is Noncompliant.

If the patient is discharged because he or she refuses services or becomes a documented safety, abuse, or noncompliance discharge and has received more than four visits, then the HHA would receive full episode payment unless the patient becomes subsequently eligible for the Medicare home health benefit during the same 60-day episode and later transferred to another HHA or returned to the same HHA, then the latter situation would result in a PEP adjustment.

E. Patient Becomes Managed Care Eligible Mid-Episode

If a patient's enrollment in a *Medicare Advantage (MA)* plan becomes effective mid episode, the 60-day episode payment will be made proportionally adjusted with a PEP adjustment since the patient is receiving coverage under *MA*. Beginning with the effective date of enrollment, the *MA* plan will receive a capitation payment for covered services.

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F. Submission of Final Claims Prior to the End of the 60-day Episode

The claim may be submitted upon discharge before the end of the 60-day episode. However, subsequent adjustments to any payments based on the claim may be made due to an intervening event resulting in a PEP adjustment or other adjustment.

G. Patient Discharge and Financial Responsibility for Part B Bundled Medical Supplies and Services

As discussed in detail under §10.11, below, the law governing the Medicare home health PPS requires the HHA to provide all bundled home health services (except DME) either directly or under arrangement while a patient is under a home health plan of care during an open episode. The HHA is responsible for providing all covered home health services (except DME) either directly or under arrangement while a patient is under a home health plan of care during an open episode. Once the patient is discharged, the HHA is no longer responsible for providing home health services including the bundled Part B medical supplies and therapy services.

H. Discharge Issues Associated With Inpatient Admission Overlapping Into Subsequent Episodes

If a patient is admitted to an inpatient facility and the inpatient stay overlaps into what would have been the subsequent episode and there is no reassessment or recertification of the patient, then the certification begins with the new start of care date after inpatient discharge.

10.11 - *Consolidated Billing*

(Rev. 139, Issued: 02- 16-11, Effective: 01-01-11, Implementation: 03-10-11)

For individuals under a home health plan of care payment for all services and supplies, with the exception of the osteoporosis drugs and DME, is included in the PPS episodic rate. HHAs must provide the covered home health services (except DME) either directly or under arrangement, and must bill for such covered home health services.

Payment must be made to the HHA.

A. Home Health Services Subject to Consolidated Billing Requirements

The home health services included in the consolidated billing governing home health PPS are:

- Part-time or intermittent skilled nursing services;
- Part-time or intermittent home health aide services;
- Physical therapy;
- Speech-language pathology services;

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- Occupational therapy;
- Medical social services;
- Routine and nonroutine medical supplies;
- Covered osteoporosis drug as defined in §1861(kk) of the Act, but excluding other drugs and biologicals;
- Medical services provided by an intern or resident-in-training of the program of the hospital in the case of an HHA that is affiliated or under common control with a hospital with an approved teaching program; and
- Home health services defined in §1861(m) provided under arrangement at hospitals, SNFs, or rehabilitation centers when they involve equipment too cumbersome to bring to the home or are furnished while the patient is at the facility to receive such services.

B. Medical Supplies

The law requires all medical supplies (routine and nonroutine) bundled to the agency while the patient is under a home health plan of care. The agency that establishes the episode is the only entity that can bill and receive payment for medical supplies during an episode for a patient under a home health plan of care. Both routine and nonroutine medical supplies are included in the base rates for every Medicare home health patient regardless of whether or not the patient requires medical supplies during the episode.

Due to the consolidated billing requirements, CMS provided additional amounts in the base rates for those nonroutine medical supplies that have a duplicate Part B code that could have been unbundled to Part B prior to PPS. See §§50.4 for detailed discussion of medical supplies.

Medical supplies used by the patient, provider, or other practitioners under arrangement on behalf of the agency (other than physicians) are subject to consolidated billing and bundled to the HHA episodic payment rate. Once a patient is discharged from home health and not under a home health plan of care, the HHA is not responsible for medical supplies.

The DME, including supplies covered as DME, are paid separately from the PPS rates and are excluded from the consolidated billing requirements governing PPS. The determining factor is the medical classification of the supply, not the diagnosis of the patient. For example, infusion therapy will continue to be covered under the DME benefit separately paid from the PPS rate and excluded from the consolidated billing requirements governing PPS. The DME supplies that are currently covered and paid in accordance with the DME fee schedule as category SU are billed under the DME benefit and not included in the bundled HHA episodic payment rate. The HHAs are not required to do consolidated billing of SU supplies.

Osteoporosis drugs are included in consolidated billing under the home health benefit. However, payment is not bundled into the episodic payment rate. The HHAs must bill for osteoporosis

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drugs in accordance with billing instructions. Payment is in addition to the episodic payment rate.

C. Relationship Between Consolidated Billing Requirements and Part B Supplies and Part B Therapies Included in the Baseline Rates That Could Have Been Unbundled Prior to PPS That No Longer Can Be Unbundled.

The HHA is responsible for the services provided under arrangement on their behalf by other entities. Covered home health services at §1861(m) of the Act (except DME) are included in the baseline PPS rates and subject to the consolidated billing requirements while the patient is under a plan of care of the HHA. The time the services are bundled is while the patient is under a home health plan of care.

Physician services or nurse practitioner services that are bundled into the physician fee schedule payments are not recognized as a home health service included in the PPS rate. Supplies incident to a physician service or related to a physician service billed to the carrier are not subject to the consolidated billing requirements. The physician would not be acting as a supplier billing the DMERC in this situation.

Therapies (physical therapy, occupational therapy, and speech-language pathology services) are covered home health services that are included in the baseline rates and subject to the consolidated billing requirements. In addition to therapies that had been paid on a cost basis under home health, CMS has included in the rates additional amounts for Part B therapies that could have been unbundled prior to PPS. These therapies are subject to the consolidated billing requirements. There are revenue center codes that reflect the ranges of outpatient physical therapy, occupational therapy, and speech-language pathology services and HCPCS codes that reflect physician supplier codes that are physical therapy, occupational therapy, and speech-language pathology services by code definition and are subject to the consolidated billing requirements. Therefore, the above-mentioned therapies must be provided directly or under arrangement on behalf of the HHA while a patient is under a home health plan of care cannot be separately billed to Part B during an open 60-day episode.

D. Freedom of Choice Issues

A beneficiary exercises his or her freedom of choice for the services under the home health benefit listed in §1861(m) of the Act, including medical supplies, but excluding DME covered as a home health service by choosing the HHA. Once a home health patient chooses a particular HHA, he or she has clearly exercised freedom of choice with respect to all items and services included within the scope of the Medicare home health benefit (except DME). The HHA's consolidated billing role supersedes all other billing situations the beneficiary may wish to establish for home health services covered under the scope of the Medicare home health benefit during the certified episode.

E. Knowledge of Services Arranged for on Behalf of the HHA

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The consolidated billing requirements governing home health PPS requires that the HHA provide all covered home health services (except DME) either directly or under arrangement while a patient is under a home health plan of care. Providing services either directly or under arrangement requires knowledge of the services provided during the episode. In addition, in accordance with current Medicare conditions of participation and Medicare coverage guidelines governing home health, the patient's plan of care must reflect the physician ordered services that the HHA provides either directly or under arrangement. An HHA would not be responsible for payment in the situation in which they have no prior knowledge (unaware of physicians orders) of the services provided by an entity during an episode to a patient who is under their home health plan of care. An HHA is responsible for payment in the situation in which services are provided to a patient by another entity, under arrangement with the HHA, during an episode in which the patient is under the HHA's home health plan of care. However, it is in the best interest of future business relationships to discuss the situation with any entity that seeks payment from the HHA during an episode in an effort to resolve any misunderstanding and avoid such situations in the future.

10.12 *- Change of Ownership Relationship to Episodes Under PPS*

(Rev. 139, Issued: 02- 16-11, Effective: 01-01-11, Implementation: 03-10-11)

A. Change of Ownership With Assignment

When there is a change of ownership and the new owner accepts assignment of the existing provider agreement, the new owner is subject to all the terms and conditions under which the existing agreement was issued. The provider number remains the same if the new HHA owner accepts assignment of the existing provider agreement. As long as the new owner complies with the regulations governing home health PPS, billing, and payment for episodes with applicable adjustments for existing patients under an established plan of care will continue on schedule through the change in ownership with assignment. The episode would be uninterrupted spanning the date of sale. The former owner is required to file a terminating cost report. Instructions regarding when a cost report is filed are in the Provider Reimbursement Manual, *Part 1*, §1500.

B. Change of Ownership Without Assignment

When there is a change of ownership, and the new owner does not take the assignment of the existing provider agreement, the provider agreement and provider number of the former owner is terminated. The former owner will receive partial episode payment adjusted payments in accordance with the methodology set forth in the Medicare Claims Processing Manual, Chapter 10, "Home Health Agency Billing," §40.2, and 42 CFR 484.235, based on the last billable visit date for existing patients under a home health plan of care ending on or before the date of sale. The former owner is required to file a terminating cost report. The new owner cannot bill Medicare for payment until the effective date of the Medicare approval. The new HHA will not be able to participate in the Medicare program without going through the same process as any new provider, which includes an initial survey. Once the new owner is Medicare-approved, the HHA may start a new episode for purposes of payment, OASIS assessment, and certification of the home health plan of care for all new patients in accordance with the regulations governing home health PPS, effective with the date of the new provider certification.

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C. Change of Ownership - Mergers

The merger of a provider corporation into another corporation constitutes a change of ownership. For information on specific procedures, refer to *Pub. 100-07*, State Operations Manual*, chapter 2, section 2202.17*.

30.2.1 - Content of the Plan of Care

(Rev. 139, Issued: 02- 16-11, Effective: 01-01-11, Implementation: 03-10-11)

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 choose 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;*

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- *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.*

30.5 – Physician Certification

(Rev. 139, Issued: 02- 16-11, Effective: 01-01-11, Implementation: 03-10-11)

The HHA must be acting upon a *plan of care as described in §30.2, and a physician certification which* meets the requirement of this section for HHA services to be covered.

30.5.1 - Content of the Physician Certification

(Rev. 139, Issued: 02- 16-11, Effective: 01-01-11, Implementation: 03-10-11)

The physician must certify that:

1. The home health services are or were needed because the patient is or was confined to the home as defined in §20.1;

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 certification and recertification, or as a signed addendum to the certification and recertification*;

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, prior to initially certifying the home health patient's eligibility, the certifying physician must document that he or she, or an allowed non-physician practitioner (NPP) had a face-to-face encounter with the patient as described in §30.5.1.1. The encounter and documentation are a condition of payment. The initial certification is incomplete without them.

30.5.1.1 – Face-to-Face Encounter

(Rev. 139, Issued: 02- 16-11, Effective: 01-01-11, Implementation: 03-10-11)

1. The certifying physician must document that he or she or an allowed non-physician practitioner (NPP) had a face-to-face encounter with the patient.

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Certain NPPs may perform the face-to-face encounter and inform the certifying physician regarding the clinical findings exhibited by the patient during the encounter. However, the certifying physician must document the encounter and sign the certification. NPPs who are allowed to perform the encounter are:

- *A nurse practitioner or clinical nurse specialist working in collaboration with the certifying physician in accordance with State law;*
- *A certified nurse-midwife as authorized by State law;*
- *A physician assistant under the supervision of the certifying physician*

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

2. Encounter Documentation Requirements:

- *The documentation must include the date when the physician or allowed NPP saw the patient, and a brief narrative composed by the certifying physician who describes how the patient's clinical condition as seen during that encounter supports the patient's homebound status and need for skilled services.*
- *The certifying physician must document the encounter either on the certification, which the physician signs and dates, or a signed addendum to the certification. It may be written or typed.*
- *It is acceptable for the certifying physician to dictate the documentation content to one of the physician's support personnel to type. It is also acceptable for the documentation to be generated from a physician's electronic health record.*
- *It is unacceptable for the physician to verbally communicate the encounter to the HHA, where the HHA would then document the encounter as part of the certification for the physician to sign.*

3. 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*

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a non-physician practitioner should examine the patient in order to establish an effective treatment plan.

4. 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.

5. If the below conditions are met, an encounter between the home health patient and the attending physician who cared for the patient during an acute/post acute stay can satisfy the face-to-face encounter requirement.

- *A physician who attended to the patient in an acute or post-acute setting, but does not follow the patient in the community (such as a hospitalist) may certify the need for home health care based on his/her contact with the patient, and establish and sign the plan of care. The acute/post-acute physician would then transfer/hand off the patient's care to a designated community-based physician who assumes care for the patient.*

Or,

- *A physician who attended to the patient in an acute or post-acute setting may certify the need for home health care based on his/her contact with the patient, initiate the orders for home health services, and transfer the patient to a designated community-based physician to review and sign off on the plan of care.*

6. 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);*

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- *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).*

30.5.2 - Periodic Recertification

(Rev. 139, Issued: 02- 16-11, Effective: 01-01-11, Implementation: 03-10-11)

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;

- A discharge and return to the same HHA during the 60-day episode.

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 and recertifications. See §10.5 for recertifications for split percentage payments.