DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

April is Alcohol Awareness Month - Seniors and others covered by Medicare can be screened for alcohol misuse under *the Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse* benefit. Read more to learn about coverage for this service.

MLN Matters® Number: MM9119 Revised | **Related Change Request (CR) #: CR 9119**

Related CR Release Date: April 22, 2015 | **Effective Date: January 1, 2015**

Related CR Transmittal #: R92GI and R208BP | **Implementation Date: May 11, 2015**

Manual Updates to Clarify Requirements for Physician Certification and Recertification of Patient Eligibility for Home Health Services

Note: This article was revised on April 22, 2015, to reflect an updated Change Request (CR). That CR revised the effective date from May 11, 2015, to January 1, 2015. The CR Release Date, transmittal numbers and links to the transmittals also changed. All other information remains the same.

Provider Types Affected

This MLN Matters® Article is intended for physicians, Non-Physician Practitioners (NPPs), and Home Health Agencies (HHAs) that submit claims to Medicare Administrative Contractors (MACs), including Home Health & Hospice (HH&H) MACs for services provided to Medicare beneficiaries.

Provider Action Needed

CR9119 manualizes policies discussed in the Calendar Year (CY) 2015 Home Health Prospective Payment System (HH PPS) Final Rule published on November 6, 2014. CR9119 instructs MACs to be aware of the revisions to the requirements for physician certification and recertification of patient eligibility for Medicare home health services.

MACs are also instructed to be aware of the revised timeframe for therapy functional reassessments. Make sure that your billing staffs are aware of these changes.

Background

The Centers for Medicare & Medicaid Services (CMS) finalized clarifications and revisions to policies regarding physician certification and recertification of patient eligibility for Medicare home health services in the CY 2015 HH PPS final rule which was published on November 6, 2014 (see **http://www.gpo.gov/fdsys/pkg/FR-2014-11-06/pdf/2014-26057.pdf**). In the final rule, CMS also finalized revisions to the timeframe required for therapy functional reassessments.

Face-to-Face Encounter Requirements

The Affordable Care Act requires that the certifying physician or allowed NPP must have a face-to-face encounter with the beneficiary before they certify the beneficiary's eligibility for the home health benefit.

CMS is implementing the following three changes to the face-to-face encounter requirements for episodes beginning on or after January 1, 2015. These changes will reduce administrative burden and provide HHAs with additional flexibilities in developing individual agency procedures for obtaining documentation supporting patient eligibility for Medicare home health care.

- CMS is eliminating the narrative requirement. The certifying physician is still required to certify (attest) that a face-to-face patient encounter occurred and document the date of the encounter as part of the certification of eligibility. For medical review purposes, Medicare requires 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) to be used as the basis for certification of patient eligibility.
- If a HHA claim is denied, the corresponding physician claim for certifying/re-certifying patient eligibility for Medicare-covered home health services is considered non-covered as well because there is no longer a corresponding claim for Medicare-covered home health services.
- CMS is clarifying that a face-to-face encounter is required for certifications, rather than initial episodes; and that a certification (versus a re-certification) is generally considered to be any time a new start of care assessment is completed to initiate care.

Therapy Reassessments

CMS has eliminated the 13th and 19th visit therapy reassessment requirements. Forepisodes beginning on or after January 1, 2015; at least every 30 calendar days a qualified therapist (instead of an assistant) must provide the needed therapy service and functionally reassess the patient. This policy change will lessen HHAs' burden of counting visits.

This change will reduce the risk of non-covered visits so that therapists can focus more on providing quality care for their patients, while still promoting therapist involvement and quality treatment for all beneficiaries regardless of the level of therapy provided.

Additional Information

The official instruction, CR9119, consists of two transmittals. The first updates the "Medicare General Information, Enrollment and Entitlement Manual" and it is available at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R92GI.pdf** on the CMS website. The second transmittal updates the "Medicare Benefit Policy Manual" and it is at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R208BP.pdf** on the CMS website.

If you have any questions, please contact your MAC at their toll-free number. That number is available at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html** under - How Does It Work.