

Medicare Home Health Benefit



What's Changed?

- Added Allowed Practitioners, PDGM, and Covered Home Health Services sections (pages 4, 6, 8)
- Physicians and allowed NPPs may conduct the required face-to-face encounter via telehealth when the patient is at home (page 5)
- The LUPA threshold changed to a variable threshold (page 7)

You'll find substantive content updates in dark red font.

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Introduction

This booklet educates home health providers about:

- Patient qualifications for home health services
- Allowed practitioners
- Face-to-face encounters
- The Patient-Driven Groupings Model (PDGM)
- Covered services under the home health benefit

Qualifying for Home Health Services

Medicare covers home health services when:

- The patient is enrolled in Part A, Part B, or both parts of the Medicare Program
- The patient is eligible for coverage of home health services
- The Home Health Agency (HHA) providing the services has a valid agreement to participate in the Medicare Program
- A claim is submitted for covered services
- The services for which payment is claimed aren't otherwise excluded from payment

Patient Eligibility

Patients must meet several requirements to be eligible for Medicare home health services. They must:

- Be confined to the home (homebound)
- Need intermittent skilled nursing care, physical therapy, or speech-language pathology
- Have a continuing need for occupational therapy
- Be under the care of a physician or allowed practitioner
- Get services under a home health plan of care (POC) that a physician or allowed practitioner establishes and periodically reviews

To be considered homebound, a patient must meet 2 criteria:

Criterion 1:

- The patient needs the aid of supportive devices (such as crutches, canes, wheelchairs, or walkers) because of an illness or injury; uses special transportation; or requires someone's help to leave their place of residence

Or

- Leaving home is medically contraindicated for the patient

Criterion 2:

- The patient is unable to leave home

And

- Leaving home requires a considerable and taxing effort for the patient

A patient can still be considered homebound if they leave the home infrequently, for a short time, or for health care services. For example, homebound patients can leave to attend:

- Religious services
- Adult daycare programs
- Unique or infrequent events (such as a funeral, a graduation, a walk around the block, or a trip to the barber)

Examples of homebound patients:

- A patient who's blind or has dementia and needs someone's help to leave home
- A patient paralyzed from a stroke who is confined to a wheelchair or requires the aid of crutches to walk
- A patient returns home after surgery and a physician or allowed practitioner has restricted their actions to certain specified and limited activities (such as only getting out of bed for a specified period of time or only walking stairs once a day)
- A patient with a psychiatric illness who refuses to leave home or whose physician or allowed practitioner considers it unsafe for the patient to leave home unattended, even if they have no physical limitations

Allowed Practitioners

Beginning March 1, 2020, certain practitioners may certify that patients are eligible for Medicare home health services, order these services, and establish and review home health plans of care (POCs). These changes are effective for Medicare claims with a date on or after March 1, 2020. Previously, only physicians were allowed to do so.

Allowed practitioners include:

- A nurse practitioner collaborating with a physician
- A clinical nurse specialist collaborating with a physician
- A physician assistant working in accordance with state law

Allowed practitioners may bill the following codes:

- G0179: Physician or allowed practitioner re-certification for Medicare-covered home health services under a home health POC (patient not present)
 - Includes contact with HHA
 - Includes review of patient status reports required by physicians and allowed practitioners to affirm the beginning of the POC
- G0180: Physician or allowed practitioner certification for Medicare-covered home health services under a home health POC (patient not present)
 - Includes contacts with HHA
 - Includes review of patient status reports required by physicians and allowed practitioners to affirm the beginning of the POC
- G0181: Physician or allowed practitioner supervision of a patient getting Medicare-covered services from

a participating HHA (patient not present) requiring complex and multidisciplinary care modalities involving regular physician and allowed practitioner development or revision of care plans

Face-to-Face Encounter

As part of the certification process, a face-to-face encounter with the patient must be conducted by:

- The certifying physician or allowed practitioner
- A physician or allowed practitioner that cared for the patient in the acute or post-acute care facility that sent the patient to home health
- An allowed non-physician practitioner

The following non-physician practitioners are allowed to perform the encounter under the supervision of the certifying physician or the physician who cared for the patient in the acute or post-acute care facility:

- A nurse practitioner or a clinical nurse specialist
- A certified nurse midwife
- A physician assistant

Providers that have a financial relationship with the HHA can't perform the face-to-face encounter.

Note: The face-to-face encounter can be performed via a telehealth service, in an approved originating site. An originating site is the location of an eligible Medicare patient at the time the service is furnished via a telecommunications system. The patient's home isn't considered an originating site. However, the [March 2020 COVID-19 Interim Final Rule](#) amended the regulations to allow physicians and allowed non-physician practitioners (NPPs) to conduct the required face-to-face encounter via telehealth when the patient is at home for the duration of the Public Health Emergency (PHE) for the COVID-19 pandemic. Telehealth refers to 2-way audio-video telecommunications technology that allows for real-time interaction between the physician or allowed practitioner and the patient.

Recertification for Home Health Services

The initial certification period lasts 60 days. Near the end of this initial period, the physician or allowed practitioner must decide whether to recertify the patient for a subsequent 60-day certification period. Recertification is required at least every 60 days unless the patient elects to transfer services to another HHA. There's no need to recertify if discharge goals are met or if there's no expectation that the patient will return to home health care. Medicare doesn't limit the number of continuous 60-day recertification periods for patients who continue to be eligible for the home health benefit.

If a patient is discharged and then requires a new episode, the physician must complete a new certification (not a recertification).

For a recertification, the physician or allowed practitioner must:

- Sign and date the POC once reviewed
- Show the continuing need for skilled services, occupational therapy, speech-language pathology

services, or physical therapy when applicable

Medicare doesn't cover the physician or allowed practitioner's claim for certification or recertification of eligibility for home health services (HCPCS codes G0180 and G0179, respectively) when:

- An HHA claim isn't covered because the physician or allowed practitioner didn't complete the certification or recertification
- The medical record didn't contain enough documentation to show the patient's eligibility to receive Medicare home health services

PDGM

In November 2018, CMS finalized the Patient Driven Groupings Model (PDGM) case-mix adjustment payment model effective for home health periods of care beginning on or after January 1, 2020. Medicare now pays HHAs a national, standardized rate based on a 30-day period of care. The PDGM case-mix method adjusts this rate based on clinical characteristics of the patient and their resource needs. Some of this information is found on the Medicare claims and some from certain Outcome and Assessment Information Set (OASIS) items. Medicare also uses a wage index to adjust the payment rate to reflect differences in wages between geographical areas. There are no changes to timeframes for recertifying eligibility and reviewing the home health plan of care, both of which will occur every 60 days (or in the case of updates to the plan of care, more often as the patient's condition warrants).

Case-mix adjustment

The PDGM places each 30-day period into 1 of 432 case-mix groups. The case-mix payment rate adjustment is based on these groups. In particular, 30-day periods are placed into different subgroups for each of the following broad categories.

Information obtained from Medicare claims:

- **Admission Source** (2 subgroups)
 - Community
 - Institutional
- **Timing of the 30-Day Period** (2 subgroups)
 - Early
 - Late
- **Clinical Grouping** based on the reported principal diagnosis (12 subgroups)
 - Musculoskeletal rehabilitation
 - Neuro and stroke rehabilitation
 - Wounds
 - Medication Management, Teaching, and Assessment (MMTA) - Surgical Aftercare
 - MMTA - Cardiac and Circulatory
 - MMTA – Endocrine
 - MMTA - Gastrointestinal Tract and Genitourinary System

- MMTA - Infectious Disease, Neoplasms, and Blood-forming Diseases
- MMTA - Respirator
- MMTA- Other
- Behavioral Health
- Complex Nursing Interventions
- **Comorbidity Adjustment** based on the reported secondary diagnoses (3 subgroups)
 - None
 - Low
 - High

Information obtained from the OASIS assessment:

- **Functional Impairment Level** (3 subgroups)
 - Low
 - Medium
 - High

In total, there are $2*2*12*3*3 = 432$ possible case-mix adjusted payment groups.

LUPA

Medicare makes a Low Utilization Payment Adjustment (LUPA) payment for 30-day periods where the number of visits is below the case-mix group's threshold.

- Each of the 432 case-mix groups has a threshold that determines if the 30-day period gets a LUPA
- For each case-mix group, the 10th percentile value of visits is used to create a case-mix, group-specific LUPA threshold with a minimum threshold of at least 2 for each group
- Medicare pays for a 30-day period with a total number of visits below the LUPA threshold per-visit rather than paying the case-mix adjusted 30-day payment amount

For LUPA periods that occur as the only period or the first period in a sequence of adjacent periods for a patient, Medicare makes an increased payment for the front-loading of assessment costs and administrative costs.

In CY 2020, the LUPA threshold changed:

- From a fixed threshold of 4 visits
- To a variable LUPA threshold that ranges from 2 to 6 visits based on the Health Insurance Prospective Payment System (HIPPS) payment code billed

Covered Home Health Services

Skilled Therapy

Medicare covers skilled therapy services when the patient's current condition requires skilled therapy to maintain their current condition or to prevent or slow further deterioration.

The therapy services must be:

- Inherently complex, which means they can only be safely and effectively performed by a skilled therapist or therapist assistant under the supervision of a skilled therapist
- Consistent with the nature and severity of the illness or injury and the patient's particular medical needs, which include a reasonable amount, frequency, and duration of services
- Considered specific, safe, and effective treatment for the patient's condition under accepted standards of medical practice

Skilled Nursing

Medicare covers skilled nursing services (other than solely venipuncture for the purposes of obtaining a blood sample) when:

- The patient needs the specialized judgment, knowledge, and skills of a registered nurse or a licensed vocational nurse (when allowed by regulation)
- The patient's current condition requires skilled nursing services to maintain their current condition or to prevent or slow further deterioration

Medicare covers these services so long as the patient requires skilled care for the services and the provider delivers them safely and effectively.

Intermittent Skilled Nursing Care

CMS defines intermittent skilled nursing care as skilled nursing care provided or needed on fewer than 7 days each week or less than 8 hours each day, for periods of 21 days or less (with extensions in exceptional circumstances when the need for additional care is finite and predictable).

To meet the requirement for intermittent skilled nursing care, the patient must have a medically predictable recurring need for skilled nursing services. Typically, a patient meets this requirement if they require a skilled nursing service at least once every 60 days.

Home Health Aide

Medicare covers home health aide services such as:

- Personal care
- Assistance with activities that support skilled therapy services
- Personal care of prosthetic or orthotic devices

To provide these services, a home health aide must:

- Be certified with the competency evaluation requirements
- Provide hands-on personal care or services that help treat the patient's illness or injury, or that are needed to maintain the patient's health
- Perform tasks only permitted under state law

The order for home health aide services must indicate how often the patient needs these services.

Medical Social Services

Medicare covers medical social services when:

- The POC explains why the needed services can only be provided safely and effectively by a qualified medical social worker or a social work assistant under the supervision of a qualified medical social worker
- The services resolve social or emotional problems that impede the effective treatment of the patient's medical condition or rate of recovery

Resources

- [Code of Federal Regulations](#)
- [42 CFR, Chapter IV, Subchapter B, Part 409](#)
- [42 CFR, Chapter IV, Subchapter B, Part 414](#)
- [42 CFR, Chapter IV, Subchapter B, Part 424](#)
- [42 CFR, Chapter IV, Subchapter G, Part 484](#)
- [Home Health Prospective Payment System booklet](#)
- [Home Health Prospective Payment System Regulations and Notices](#)
- [Home Health Agency Center](#)
- [Medicare Benefit Policy Manual Chapter 7 - Home Health Services](#)
- [Medicare Claims Processing Manual Chapter 10 - Home Health Agency Billing](#)
- [Medicare Program Integrity Manual \(Publication 100-08\), Chapter 6](#)
- [The Medicare Learning Network®](#)

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