April 2011

To: All Medicare Advantage (MA) Home Health Agencies, Physicians and Practitioners

Empire Blue Cross and Blue Shield would like to share a change to our Medicare Advantage (MA) products with the home health agencies, physicians & practitioners that treat our Medicare Advantage members. This document provides details regarding additional requirements necessary to receive payment for home health claims.

Effective January 1, 2011, due to provisions mandated by passage of the Affordable Care Act (ACA), there are new statutory requirements regarding face-to-face encounters for certifications applicable to the home health program. Section 6407 of the ACA now requires these face-to-face encounters with a physician for home health certifications. These requirements apply to all Private Fee-for-Service and non-contracting providers who provide services to PFFS, HMO and PPO members. Claims from contracted Medicare Advantage providers will be processed in accordance with the terms of the contract that are specific to Home Health claims.

The Home Health Agency must be acting upon a physician plan of care and a physician certification that meets the following requirements for the services to be covered.

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.

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 of the Medicare Benefit Policy Manual, Chapter 7.
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.
Effective January 1, 2011, 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. 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.


The encounter must occur no more than 90 days prior to the home health start of care date or within 30 days after the start of care. In situations when a physician orders home health care for the patient based on a new condition that was not evident during a visit within the 90 days prior to start of care, the certifying physician or an allowed NPP must see the patient again within 30 days after admission. Specifically, if a patient saw the certifying physician or NPP within the 90 days prior to start of care, another encounter would be needed if the patient’s condition had changed to the extent that standards of practice would indicate that the physician or a non-physician practitioner should examine the patient in order to establish an effective treatment plan. 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 member at the time the service being furnished via a telecommunications system occurs. Members 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.

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 member who qualifies for a subsequent 60-day episode would start the subsequent 60-day episode on day 61. Under the Home Health Prospective Payment System, the plan of care must be reviewed and signed by the physician every 60 days unless the member transfers to another HHA or the member is discharged and returns to the same HHA during the 60-day episode.

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

In addition to the above requirements, effective January 1, 2011 there are new claims reporting requirements for G codes related to therapy and skilled nursing services. The new and revised G-codes should be used for home health episodes beginning on or after January 1, 2011. CMS has issued an article that explains in detail the new and revised G-codes and their descriptions. This article is located on the CMS website at http://www.cms.gov/MLNMattersArticles/Downloads/MM7182.pdf.

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