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| <b>CMS Manual System</b>                     | <b>Department of Health &amp; Human Services (DHHS)</b>   |
| <b>Pub 100-08 Medicare Program Integrity</b> | <b>Centers for Medicare &amp; Medicaid Services (CMS)</b> |
| <b>Transmittal 870</b>                       | <b>Date: March 22, 2019</b>                               |
|  | <b>Change Request 11104</b>                               |

**SUBJECT: Manual Updates Related to Home Health Certification and Recertification Policy Changes**

**I. SUMMARY OF CHANGES:** This Change Request (CR) updates the Medicare Benefit Policy Manual, (Pub. 100-02), Chapter 7 and the Medicare Program Integrity Manual (Pub. 100-08), Chapter 6, to reflect policy changes finalized in the CY 2019 Home Health Prospective Payment System (HH PPS) Final Rule (83 FR 56406), related to recertification for home health services. This CR also updates the Medicare Benefit Policy Manual (Pub. 100-02), Chapter 7, to reflect Condition of Participation changes finalized in the Medicare Home Health Conditions of Participation Final Rule (82 FR 4504).

**EFFECTIVE DATE: April 22, 2019**

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

**IMPLEMENTATION DATE: April 22, 2019**

*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-*Only One Per Row.*

| <b>R/N/D</b> | <b>CHAPTER / SECTION / SUBSECTION / TITLE</b> |
|--------------|---|
| R            | 6/6.2.2.1/Recertification Elements            |

**III. FUNDING:**

**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**

# Attachment - Business Requirements

|             |                  |                      |                       |
|-------------|------------------|----------------------|-----------------------|
| Pub. 100-08 | Transmittal: 870 | Date: March 22, 2019 | Change Request: 11104 |
|-------------|------------------|----------------------|-----------------------|

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## I. GENERAL INFORMATION

**A. Background:** The regulations at 42 Code of Federal Regulations (CFR) 424.22(b)(2) set forth the requirements for the content and basis for recertification for home health services. Currently, the regulations require that the certifying physician must include a statement to indicate the continuing need for services and estimate how much longer the services will be required. In response to feedback received from CMS' request for information on ways to reduce regulatory burden, in the CY 2019 Home Health Prospective Payment System Final Rule (83 FR 56406), CMS finalized a change to the physician recertification requirements.

**B. Policy:** In the CY 2019 HH PPS final rule (83 FR 56406), CMS eliminated the requirement at 42 CFR 424.22(b)(2) that the certifying physician must estimate how much longer skilled care will be required when recertifying the patient for home health care. Eliminating this requirement would reduce denials that result solely from when this estimate is missing from the recertification statement. This is effective for recertifications made on and after January 1, 2019. All other recertification requirements under §424.22(b)(2) would remain unchanged.

## II. BUSINESS REQUIREMENTS TABLE

*"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.*

| Number          | Requirement   | Responsibility |   |             |             |                                  |                  |                  |             |       |  |
|-----------------|---|----------------|---|-------------|-------------|----------------------------------|------------------|------------------|-------------|-------|--|
|                 |   | A/B<br>MAC     |   |             | D<br>M<br>E | Shared-<br>System<br>Maintainers |                  |                  |             | Other |  |
|                 |   | A              | B | H<br>H<br>H |             | F<br>M<br>V<br>C                 | M<br>I<br>C<br>S | V<br>M<br>S<br>S | C<br>W<br>F |       |  |
| 11104 -<br>08.1 | The contractors shall be aware of the revisions to Pub. 100-08, Chapter 6 related to the new policies in this CR. |                |   | X           |             |                                  |                  |                  |             |       |  |

### III. PROVIDER EDUCATION TABLE

| Number       | Requirement   | Responsibility |   |             |   |   |
|--------------|---|----------------|---|-------------|---|---|
|              |   | A/B<br>MAC     |   |             | D<br>M<br>E<br>D<br>I<br>C<br>A<br>N<br>S | C<br>O<br>N<br>T<br>R<br>A<br>C<br>T<br>O<br>R<br>S |
|              |   | A              | B | H<br>H<br>H |   |   |
| 11104 - 08.2 | MLN Article: CMS will make available an MLN Matters provider education article that will be marketed through the MLN Connects weekly newsletter shortly after the CR is released. MACs shall follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1, instructions for distributing MLN Connects information to providers, posting the article or a direct link to the article on your website, and including the article or a direct link to the article in your bulletin or newsletter. You may supplement MLN Matters articles with localized information benefiting your provider community in billing and administering the Medicare program correctly. Subscribe to the "MLN Matters" listserv to get article release notifications, or review them in the MLN Connects weekly newsletter. |                |   | X           |   |   |

### IV. SUPPORTING INFORMATION

**Section A: Recommendations and supporting information associated with listed requirements: N/A**  
*"Should" denotes a recommendation.*

| X-Ref Requirement Number | Recommendations or other supporting information: |
|--------------------------|--|
|                          |  |

**Section B: All other recommendations and supporting information: N/A**

### V. CONTACTS

**Pre-Implementation Contact(s):** Kelly Vontran, 410-786-0332 or kelly.vontran@cms.hhs.gov.

**Post-Implementation Contact(s):** Contact your Contracting Officer's Representative (COR).

### VI. FUNDING

**Section A: 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.

**ATTACHMENTS: 0**

### **6.2.2.1 – Recertification Elements**

**(Rev. 870, Issued: 03-22-19, Effective: 04-22-19, Implementation: 04-22-19)**

Recertification is required at least every 60 days when there is a need for continuous home health care after an initial 60-day episode. Recertification should occur at the time the plan of care is reviewed, and must be signed and dated by the physician who reviews the plan of care. Recertification is required at least every 60 days unless there is a—

- (i) Beneficiary elected transfer; or
- (ii) Discharge with goals met and/or no expectation of a return to home health care.

*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. Because the updated home health plan of care must include the frequency and duration of visits to be made, the physician does not have to estimate how much longer skilled services will be needed for the recertification.*

*The recertification statement must indicate the continuing need for services.* Need for occupational therapy may be the basis for continuing services that were initiated because the individual needed skilled nursing care or physical therapy or speech therapy. In this case reviewers will look for documentation substantiating the need for continued occupational therapy when the needed skilled nursing care or physical therapy or speech therapy that were initially needed, are no longer needed.

If a patient's underlying condition or complication requires a registered nurse to ensure that essential non-skilled care is achieving its purpose, and necessitates a registered nurse be involved in the development, management, and evaluation of a patient's care plan, the reviewer will look for the physician's brief narrative describing the clinical justification of this need. If the narrative is part of the recertification form, then the narrative must be located immediately prior to the physician's signature. If the narrative exists as an addendum to the recertification form, in addition to the physician's signature on the recertification form, the physician must sign immediately following the narrative in the addendum.

As mentioned earlier in this section, the reviewer will confirm that all elements of the certification are included in the documentation sent for the recertification claim review. If the submitted certification documentation (submitted with the recertification documentation) does not support home health eligibility, the claim associated with the recertification period will not be paid.