CMS Manual System

Pub 100-01 Medicare General Information, Eligibility, and Entitlement

Transmittal 28

Department of Health & Human Services

Centers for Medicare & Medicaid Services

Date: AUGUST 12, 2005

Change Request 3912

SUBJECT: Conforming Changes for Change Request 3648 to Pub. 100-01

I. SUMMARY OF CHANGES: Some instructions that were duplicated in Pub 100-02, Section 220 and 230 have been replaced with reference to the appropriate sections. Obsolete terms have been edited, e.g. "speech therapy" to "speech-language pathology" and "direct personal" to "direct.

NEW/REVISED MATERIAL :
EFFECTIVE DATE :September 12, 2005
IMPLEMENTATION DATE : September 12, 2005

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.*

R/N/D	Chapter / Section / SubSection / Title
R	1/10.1/ Hospital Insurance (Part A) for Inpatient Hospital, Hospice and Skilled Nursing Facility (SNF) Services - A Brief Description
R	1/10.2/ Home Health Services
R	1/10.3 /Supplementary Medical Insurance (Part B) - A Brief Description
R	1/20.2 /Discrimination Prohibited
R	1/40/Role of Part A Intermediaries
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R	4/20/ Certification for Hospital Services Covered by the Supplementary Medical Insurance Program
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R	4/30.3 /Recertifications for Home Health Services
R	4/50/ Physician's Certification and Recertification for Outpatient Physical Therapy, Occupational Therapy and Speech-Language Pathology
D	4/50.1/Content of Physician's Certification
D	4/50.2/Recertification
R	5/10.3 /Under Arrangements
R	5/10.4/Term of Agreements
R	5/10.6.4/ Determining Payment for Services Furnished After Termination, Expiration, or Cancellation
R	5/50/Home Health Agency Defined

III. FUNDING:

No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2005 operating budgets.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

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

Attachment - Business Requirements

Pub. 100-01	Transmittal: 28	Date: August 12, 2005	Change Request 3912

SUBJECT: Conforming Changes for CR3648 to Pub. 100-01

I. GENERAL INFORMATION

A. Background: This change was made to delete therapy service certification language from Pub. 100-01 that is also in Pub. 100-02 and to consolidate the information in one place. It also changes the term speech therapy to speech-language pathology, as has been appropriate for many years

B. Policy: There is no new policy.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3912.1	Contractors shall update the terms "speech therapy", and "speech-language therapy" to "speech-language pathology" or "speech-language pathology services" in related LCDs and educational materials whenever they modify these documents or issue new documents. It is not necessary to change the documents merely to update this language.	x		x						
3912.2	Contractors shall update the term "direct personal" supervision to "direct" supervision, when applied to Part B services incident to a physician's or nonphysician practitioner's service.	x		x						

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)

		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	None.									

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: September 12, 2005 **Implementation Date:** September 12, 2005 **Pre-Implementation Contact(s):** Dorothy Shannon 63396 **Post-Implementation Contact(s):** Dorothy Shannon 63396	**No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2005 operating budgets.**

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

10.1 - Hospital Insurance (Part A) for Inpatient Hospital, Hospice and Skilled Nursing Facility (SNF) Services - A Brief Description

(Rev. 28; Issued: 08-12-05; Effective/Implementation: 09-12-05)

Hospital insurance is designed to help patients defray the expenses incurred by hospitalization and related care. In addition to inpatient hospital benefits, hospital insurance covers posthospital extended care in SNFs and posthospital care furnished by a home health agency in the patient's home. Blood clotting factors, for hemophilia patients competent to use such factors to control bleeding without medical or other supervision, and items related to the administration of such factors, are also a Part A benefit for beneficiaries in a covered Part A stay. The purpose of these additional benefits is to provide continued treatment after hospitalization and to encourage the appropriate use of more economical alternatives to inpatient hospital care. Program payments for services rendered to beneficiaries by providers (i.e., hospitals, SNFs, and home health agencies) are generally made to the provider.

In each benefit period, payment may be made for up to 90 inpatient hospital days, and 100 days of posthospital extended care services. Under the latter benefit, the beneficiary must have been in a hospital receiving inpatient hospital services for at least 3 consecutive days (counting the day of admission but not the day of discharge) and be admitted to a SNF or to the SNF level of care in a swing bed hospital within 30 days after the date of hospital discharge. (Under certain circumstances, the 30 days may be extended.)

Where the person became entitled to HI at or after age 65, the hospital discharge must have occurred on or after the first day of the month in which he attained age 65. If his or her current entitlement began before age 65; i.e., he became entitled to HI under the disability or chronic renal disease provisions of the law, the hospital discharge must have occurred while he was so entitled. The 3 consecutive calendar days requirement can be met by stays totaling 3 consecutive days in one or more hospitals.

A SNF provides skilled nursing care and related services for patients who require medical or nursing care, or rehabilitation services. A SNF may be either a separate institution (e.g., a nursing home) or a part of an institution (e.g., a convalescent wing of a hospital). It must be licensed or approved under State or local law, meet the health and safety conditions prescribed by the Secretary of the Department of Health and Human Services (DHHS), and have a written transfer agreement with one or more participating hospitals providing for the transfer of patients between the hospital and the facility, and for the interchange of medical and other information. If an otherwise qualified SNF has attempted in good faith but without success to enter into a transfer agreement, this requirement may be waived by the State agency.

For Medicare purposes, the term SNF does not include any institution which is primarily for the care and treatment of mental diseases. Extended care services include room and board; skilled nursing care by or under the supervision of a registered nurse; physical *therapy*, occupational *therapy*, or speech*-language pathology services*; medical social services, drugs, biologicals, supplies, appliances, and equipment; and other services ordinarily furnished by or under

arrangements made by the facility. No payment may be made for items or services which would not be covered in a hospital, or for custodial care when that is the only type of care that the beneficiary needs.

The services of residents and interns of a hospital with which the facility has a swing bed "transfer" agreement and other diagnostic and therapeutic services furnished by such a hospital are covered, but only if billed through the SNF.

Under §4005(b)(2) of the Omnibus Budget Reconciliation Act of 1987, effective for swing bed agreements entered into after March 31, 1988, hospitals with more than 49 beds (but less than 100 beds) are subject to the following conditions. However, these conditions were eliminated by section 408 of the Balanced Budget Refinement Act of 1999 (BBRA), effective with the start of the facility's fourth cost reporting period that begins on or after July 1, 1998. (For those facilities that received no Medicare payment prior to October 1, 1995, this change is effective as of the date of BBRA's enactment, November 29, 1999.)

If there is an available SNF bed in the geographic region, the hospital must transfer the extended care patient within 5 days of the availability date (excluding weekends and holidays) unless the patient's physician certifies within that 5-day period, that transfer of that patient to that facility is not medically appropriate on the availability date. In order to do this, the hospital must identify all SNFs in the geographic region and enter into agreements with them for the transfer of extended care patients. The agreement must call for the SNF to notify the hospital of the availability of beds and the dates these beds will be available for extended care patients.

For each cost reporting period, payment may not be made for patient days of extended care services that exceed 15 percent of the total number of available patient days (except that such payment shall continue to be made for those patients who are receiving extended care services at the time the hospital reaches the 15% limit). The limit is calculated by multiplying the average number of licensed beds by the total number of days in the cost reporting period.

Hospitals having fewer than 50 beds and rural hospitals which entered into transfer agreements before March 31, 1988 (i.e., those which were licensed for more than 49 beds but who were operating as a 50 or less bed facility), are not subject to the 5-weekday transfer requirement or the payment limitation for extended care days. (See section 2230.10 of the Provider Reimbursement Manual, Part 1, for the explanation of the payment limitation.)

"Geographic region" is an area which includes the SNFs with which a hospital has traditionally arranged transfers and all other SNFs within the same proximity to the hospital. In the case of a hospital without existing transfer practices upon which to base a determination, the geographic region is an area which includes all the SNFs within 50 miles of the hospital unless the hospital can demonstrate that the SNFs are inaccessible to its patients. In the event of a dispute as to whether a SNF is within this region or the SNF is inaccessible to hospital patients, the CMS regional office shall make a determination.

Hospices also provide Part A hospital insurance services such as short-term inpatient care. In order to be eligible to elect hospice care under Medicare, an individual must be entitled to Part A of Medicare and be certified as being terminally ill. An individual is considered to be terminally ill if the individual has a medical prognosis that his or her life expectancy is 6 months or less if the illness runs its normal course.

10.2 - Home Health Services

(Rev. 28; Issued: 08-12-05; Effective/Implementation: 09-12-05)

To qualify for home health benefits under either Part A or Part B of the program, a beneficiary must be confined to his/her home, under the care of a physician, and in need of skilled nursing services on an intermittent basis, physical therapy, or speech*-language pathology services*. Being "confined to the home" does not mean a beneficiary can never leave the home. See Chapter 7 of the Benefit Policy publication for the definition of homebound. A beneficiary who requires one or more of these services in the treatment of his/her illness or injury and otherwise qualifies for home health benefits is eligible to have payment made on his/her behalf for the skilled nursing, physical *therapy* or speech*-language pathology services* he needs, as well as for any of the other home health services specified in the law. These services include occupational therapy, medical social services, the use of medical supplies and medical appliances, and the part-time or intermittent services of home health aides. Conversely, a patient who does not require intermittent skilled nursing or physical *therapy* or speech*-language pathology services* cannot qualify to have payment made under the program for any home health services furnished him. Excluded as home health services are the costs of housekeepers, food service arrangements, and transportation to outpatient facilities.

To be covered, the home health services must be needed for a condition for which the patient required inpatient hospital services or extended care services. See the Chapter 7 of the Benefit Policy publication for a description of services covered. Discharge from the hospital must have occurred in a month in which the patient has attained age 65 or was entitled to health insurance benefits under the disability or chronic renal disease provisions of the law.

Home health services are services provided by a home health agency or by others under arrangements with such an agency. A home health agency is a public agency or private organization which is primarily engaged in providing skilled nursing and other therapeutic services. Where applicable the agency must be licensed under State or local law, or be approved by the State or local licensing agency as meeting the licensing standards. Examples of home health agencies are visiting nurse associations, official health agencies, and hospital-based home care programs. To participate in the health insurance program, a home health agency must meet certain other requirements included in the law as well as health and safety conditions prescribed by the Secretary of the Department of Health and Human Services. It may not qualify under hospital insurance, however, if it is primarily engaged in the treatment of mental diseases; such an agency may qualify only under supplementary medical insurance.

Home health services are usually furnished on a visiting basis in a place of residence used as the individual's home. However, outpatient services in a hospital, SNF, or rehabilitation center are covered home health services, if arranged for by a home health agency, when equipment is required that cannot be made available in the patient's home.

The services of an intern or resident-in-training are covered if the agency has an affiliation with or is under common control of a hospital providing such medical services and the agency bills for such services.

Prior to July 1, 1981, home health services under hospital insurance included up to 100 home health visits, after the beginning of one benefit period and before the beginning of the next. The visits must have been furnished to a patient within 1 year of his/her most recent discharge from a hospital where he was an inpatient for at least 3 consecutive calendar days (counting the day of admission, but not the day of discharge). If, after his/her hospitalization, he had a covered stay in a SNF, the 1 year during which the patient may receive home health services began with the discharge from the SNF. A plan of treatment must have been established within 14 days after the hospital or SNF discharge. Home health services were also provided under supplementary medical insurance where the 100-visit limit under Part A was exceeded.

Effective July 1, 1981, the 100-visit limitation under Parts A and B, and the prior inpatient stay requirement under Part A were eliminated. In addition, a person could qualify for home health services based on his or her need for skilled nursing services on an intermittent basis, physical therapy, speech-*language pathology services*, or occupational therapy. Effective December 1, 1981, occupational therapy was eliminated as a basis for entitlement to home health services. However, if a person has otherwise qualified for home health services because of the need for skilled nursing care, physical *therapy* or speech-*language pathology services*, the patient's eligibility for home health services may be extended solely on the basis of the continuing need for occupational therapy.

Effective January 1, 1998, the first 100 visits must be paid under Part A if the beneficiary is entitled under Part A, and the remainder of the visits may be paid under Part B.

10.3 - Supplementary Medical Insurance (Part B) - A Brief Description

(Rev. 28; Issued: 08-12-05; Effective/Implementation: 09-12-05)

To obtain SMI, an eligible individual must enroll during an enrollment period and pay the required premiums. An individual is eligible to enroll if they are entitled to HI or are 65 years of age and a citizen or resident alien who meets certain residence requirements. SMI provides for payment to participating providers for furnishing covered services after a yearly cash deductible is met. The voluntary medical insurance plan is designed to supplement the basic hospital insurance coverage. It provides coverage for home health visits not available under hospital insurance (e.g., no Part A entitlement or visits after the first 100 visits) and for medical and other health services. Payment may not be made under Part B for any service that may be paid under Part A. However, where payment is not possible under Part A (e.g., no Part A entitlement or benefits are exhausted) payment may be made under Part B if the service is covered.
Subject to coverage and limitations described in the Benefit Policy Publication, the following services are covered under Part B.

- Physicians' services;
- Services and supplies (including drugs and biologicals which are not usually self-administered by the patient) furnished as an incident to a physician's professional service, of kinds which are commonly furnished in physicians' offices and are commonly either rendered without charge or included in the physicians' bills;
- Hospital services (including drugs and biologicals which are not usually self-administered by the patient) incident to physicians' services rendered to outpatients and partial hospitalization services incident to such services;
- Diagnostic services which are-- (i) furnished to an individual as an outpatient by a hospital or by others under arrangements with them made by a hospital, and (ii) ordinarily furnished by such hospital (or by others under such arrangements) to its outpatients for the purpose of diagnostic study;
- Outpatient physical therapy services, occupational therapy services, *and speech-language pathology services*;
- Rural health clinic services and Federally qualified health center services;
- Home dialysis supplies and equipment, self-care home dialysis support services, and institutional dialysis services and supplies;
- Antigens (subject to quantity limitations prescribed in regulations by the Secretary) prepared by a physician, as defined in section 1861(r)(1) of the Act, for a particular patient, including antigens so prepared which are forwarded to another qualified person (including a rural health clinic) for administration to such patient, from time to time, by or under the supervision of another such physician;

- Services furnished pursuant to a contract under section 1876 of the Act to a member of an eligible organization by a physician assistant or by a nurse practitioner and such services and supplies furnished as an incident to his/her service to such a member as would otherwise be covered under this part if furnished by a physician or as an incident to a physician's service; and, services furnished pursuant to a risk-sharing contract under section 1876(g) of the Act to a member of an eligible organization by a clinical psychologist (as defined by the Secretary) or by a clinical social worker, and such services and supplies furnished as an incident to such clinical psychologist's services or clinical social worker's services to such a member as would otherwise be covered under this part if furnished by a physician or as an incident to a physician's service;
- Blood clotting factors, for hemophilia patients competent to use such factors to control bleeding without medical or other supervision, and items related to the administration of such factors, subject to utilization controls deemed necessary by the Secretary for the efficient use of such factors;
- Prescription drugs used in immunosuppressive therapy furnished to an individual who receives an organ transplant for which payment is made under this title;
- Services which would be physicians' services if furnished by a physician and which are performed by a physician assistant under the supervision of a physician and which the physician assistant is legally authorized to perform by the State in which the services are performed, and such services and supplies furnished as incident to such services as would be covered if furnished incident to a physician's professional service; and but only if no facility or other provider charges or is paid any amounts with respect to the furnishing of such services.
- Services which would be physicians' services if furnished by a physician and which are performed by a nurse practitioner or clinical nurse specialist working in collaboration with a physician which the nurse practitioner or clinical nurse specialist is legally authorized to perform by the State in which the services are performed, and such services and supplies furnished as an incident to such services as would be covered if furnished incident to a physician's professional service, but only if no facility or other provider charges or is paid any amounts with respect to the furnishing of such services;
- Certified nurse-midwife services;
- Qualified psychologist services;
- Clinical social worker services;
- Erythropoietin for dialysis patients competent to use such drug without medical or other supervision with respect to the administration of such drug, subject to methods and standards established by the Secretary by regulation for the safe and effective use of such drug, and items related to the administration of such drug;
- Prostate cancer screening tests;
- An oral drug (which is approved by the Federal Food and Drug Administration) prescribed for use as an anticancer chemotherapeutic agent for a given indication, and

containing an active ingredient (or ingredients), which is the same indication and active ingredient (or ingredients) as a drug which the carrier determines would be covered if the drug could not be self-administered;

- Colorectal cancer screening tests;
- Diabetes outpatient self-management training services;
- An oral drug (which is approved by the Federal Food and Drug Administration) prescribed for use as an acute anti-emetic used as part of an anticancer chemotherapeutic regimen if the drug is administered by a physician (or as prescribed by a physician)-- (i) for use immediately before, at, or within 48 hours after the time of the administration of the anticancer chemotherapeutic agent; and (ii) as a full replacement for the anti-emetic therapy which would otherwise be administered intravenously;
- Screening for glaucoma (as defined in subsection (uu)) for individuals determined to be at high risk for glaucoma, individuals with a family history of glaucoma and individuals with diabetes;
- Medical nutrition therapy services in the case of a beneficiary with diabetes or a renal disease who-- (i) has not received diabetes outpatient self-management training services within a time period determined by the Secretary; (ii) is not receiving maintenance dialysis for which payment is made under section 1881 of the Act; and (iii) meets such other criteria determined by the Secretary after consideration of protocols established by dietitian or nutrition professional organizations;
- Diagnostic X-ray tests (including tests under the supervision of a physician, furnished in a place of residence used as the patient's home, if the performance of such tests meets such conditions relating to health and safety as the Secretary may find necessary and including diagnostic mammography if conducted by a facility that has a certificate (or provisional certificate) issued under section 354 of the Public Health Service Act), diagnostic laboratory tests, and other diagnostic tests; X-ray, radium, and radioactive isotope therapy, including materials and services of technicians;
- Surgical dressings, and splints, casts, and other devices used for reduction of fractures and dislocations; Durable medical equipment;
- Ambulance service where the use of other methods of transportation is contraindicated by the individual's condition, but only to the extent provided in regulations;
- Prosthetic and orthotic devices (other than dental) which replace all or part of an internal body organ (including colostomy bags and supplies directly related to colostomy care), including replacement of such devices, and including one pair of conventional eyeglasses or contact lenses furnished subsequent to each cataract surgery with insertion of an intraocular lens;
- Leg, arm, back, and neck braces, and artificial legs, arms, and eyes, including replacements if required because of a change in the patient's physical condition;

- Vaccines: (1) pneumococcal vaccine and its administration and, subject to section 4071(b) of the Omnibus Budget Reconciliation Act of 1987, (2) influenza vaccine and its administration; and (3) hepatitis B vaccine and its administration, furnished to an individual who is at high or intermediate risk of contracting hepatitis B;

  NOTE: A charge separate from the ESRD composite rate will be recognized and paid for administration of the vaccine to ESRD patients.

  NOTE: For Medicare program purposes, the hepatitis B vaccine may be administered upon the order of a doctor of medicine or osteopathy by home health agencies, SNFs, renal dialysis facilities (RDFs), hospital outpatient departments, persons recognized under the "incident to physicians' services" provision of law, and, of course, doctors of medicine and osteopathy.

- Services of a certified registered nurse anesthetist;
- Subject to section 4072(e) of the Omnibus Budget Reconciliation Act of 1987, extra-depth shoes with inserts or custom molded shoes with inserts for an individual with diabetes, if-- (1) the physician who is managing the individual's diabetic condition (a) documents that the individual has peripheral neuropathy with evidence of callus formation, a history of pre-ulcerative calluses, a history of previous ulceration, foot deformity, or previous amputation, or poor circulation, and (b) certifies that the individual needs such shoes under a comprehensive plan of care related to the individual's diabetic condition; (2) the particular type of shoes are prescribed by a podiatrist or other qualified physician (as established by the Secretary); and (3) the shoes are fitted and furnished by a podiatrist or other qualified individual (such as a pedorthist or orthotist, as established by the Secretary) who is not the physician described in (1) above (unless the Secretary finds that the physician is the only such qualified individual in the area);
- Screening mammography;
- Screening pap smear and screening pelvic exam; and
- Bone mass measurement.
- No diagnostic tests performed in any laboratory, including a laboratory that is part of a rural health clinic, or a hospital (which, for purposes of this sentence, means an institution considered a hospital for purposes of section 1814(d)) of the Act shall be included unless such laboratory-

  1. Is situated in any State in which State or applicable local law provides for licensing of establishments of this nature, (1) is licensed pursuant to such law, or (2) is approved, by the agency of such State or locality responsible for licensing establishments of this nature, as meeting the standards established for such licensing;
  2. Meets the certification requirements under section 353 of the Public Health Service Act; and

3. Meets such other conditions relating to the health and safety of individuals with respect to whom such tests are performed as the Secretary may find necessary.

There shall be excluded from the diagnostic services specified any item or service which would not be included if it were furnished to an inpatient of a hospital. None of the items and services referred to in the preceding paragraphs of this subsection which are furnished to a patient of an institution which meets the definition of a hospital for purposes of section 1814(d) of the Act shall be included unless such other conditions are met as the Secretary may find necessary relating to health and safety of individuals with respect to whom such items and services are furnished.

20.2 - Discrimination Prohibited

(Rev. 28; Issued: 08-12-05; Effective/Implementation: 09-12-05)

Participating providers of Part A services under the supplementary medical insurance program (e.g., hospitals, SNFs, HHAs, hospices, outpatient physical therapy, comprehensive outpatient rehabilitation facilities (CORFs), occupational therapy and speech*-language* pathology providers, and renal dialysis facilities) must comply with the requirements of title VI of the Civil Rights Act of 1964. Under the provisions of that Act, a participating provider is prohibited from making a distinction on the grounds of race, color, or national origin, in the treatment of patients, the use of equipment, other facilities, and the assignment of personnel to provide services.

DHHS is responsible for investigating complaints of noncompliance.

40 – Role of Part A Intermediaries

(Rev. 28; Issued: 08-12-05; Effective/Implementation: 09-12-05)

The Part A intermediary is a public or private agency or organization that has entered into an agreement with CMS to enroll legitimate providers into the Medicare program and process Medicare claims under both Part A and Part B services under the supplementary medical insurance program (e.g., hospitals, SNFs, HHAs, hospices, CORFs, OPTs, occupational therapy, and speech-*language* pathology providers, and ESRD facilities).

Intermediaries make payments to providers. The amount of payment to a provider is restricted to the lower of the billed charge, the reasonable cost of covered services or the fee schedule amount. Hospices are paid on a per diem amount that is prospectively set. SNFs and HHAs are paid based on a Prospective Payment System (PPS). (See Provider Reimbursement Manual, Part 1, §§2800ff.)

Hospitals are paid based on the PPS. Under this system, Medicare payment is made at a predetermined, specific rate for each hospital discharge. This statement applies to inpatient for acute care hospitals and to inpatient rehabilitation hospitals. Whereas inpatient acute and rehab PPS payment is based on the discharge date, Outpatient PPS (OPPS) payments are based on Ambulatory Patient Classification payment for the date of service.

The amount of payment to other types of providers is restricted to the lesser of (a) the reasonable cost of covered services and items; or (b) the billed charges with respect to such services; or (c) the fee schedule amount.

In addition, intermediaries assist in applying safeguards against unnecessary use of covered services, furnish consultative services to serve as a center for communicating with providers, conduct audits of provider records, assist in the beneficiary appeals process, and provide information and advice to institutions and organizations that wish to qualify as providers of services.

(See cms.hhs.gov/medicare/incardir.htm for a list of intermediaries and service areas.)

Medicare General Information, Eligibility, and Entitlement
Chapter 3 - Deductibles, Coinsurance Amounts, and Payment Limitations

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(Rev. 28, 08-12-05)

40 - Limitation on *Physical Therapy, Occupational Therapy and Speech-Language Pathology* Services

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40 - Limitation on *Physical Therapy, Occupational Therapy and Speech-Language Pathology* Services

(Rev. 28; Issued: 08-12-05; Effective/Implementation: 09-12-05)

Coverage of outpatient physical *therapy,* occupational therapy*, and speech-language pathology services* under Part B *has been limited in some years. For descriptions of these limitations see Pub 100-04, Chapter 5, §10.2*.

Chapter 4 - Physician Certification and Recertification of Services

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(Rev. 28, 08-12-05)

50 - Physician's Certification and Recertification for Outpatient Physical Therapy*, Occupational Therapy and Speech-Language Pathology*

20 - Certification for Hospital Services Covered by the Supplementary Medical Insurance Program

(Rev. 28; Issued: 08-12-05; Effective/Implementation: 09-12-05)

A physician must certify that medical and other health services covered by medical insurance which were provided by (or under arrangement made by) the hospital were medically required. Physician certification is not required for the following outpatient services furnished on or after January 3, 1968:

- Hospital services and supplies incident to physicians' services rendered to outpatients; and
- Diagnostic services furnished by a hospital or which the hospital arranges to have furnished in other facilities operated by or under the supervision of the hospital or its medical staff.

Hospitals must obtain a physician's certification with respect to other services furnished to outpatients.

Primarily, this means that a certification statement is needed for diagnostic services furnished under arrangements by a facility that is not operated by or under the supervision of the hospital or its organized medical staff, e.g., services obtained from an independent laboratory.

This certification requires a brief description of the services and the signature of the physician. It needs to be made only once for a course of treatment. Where services are provided on a continuing basis, such as a course of radium treatments, the physician's certification may be made at the beginning or end of the course of treatment, or at any other time during the period of treatment.

There is no requirement that the certification be entered on any specific form or handled in any specific way, as long as the approach adopted by the hospital permits the intermediary to determine that the certification requirement is in fact met. Therefore, the certification could be entered or pre-printed on a form the physician already has to sign; or a separate certification form could be used.

Certification by a physician in connection with ambulance services furnished by a participating hospital is required. In cases in which the hospital provides ambulance service to transport the patient from the scene of an accident and no physician is involved until the patient reaches the hospital, any physician in the hospital who examines the patient or has knowledge of the case may certify as to the medical need for the ambulance service.

In addition, physician's certifications are required for the rental and purchase of durable medical equipment (see §70), outpatient therapy*, i.e., physical therapy, occupational therapy and* speech*-language* pathology services *(see Pub. 100-02, Chapter 15, §220)*.

30.1 - Content of the Physician's Certification

(Rev. 28; Issued: 08-12-05; Effective/Implementation: 09-12-05)

Under both the hospital insurance and the supplementary medical insurance programs, no payment can be made for covered home health services that a home health agency provides unless a physician certifies that:

- The home health services are because the individual is confined to his/her home and needs intermittent skilled nursing care, physical therapy and/or speech*-language pathology services*, or continues to need occupational therapy;
- A plan for furnishing such services to the individual has been established and is periodically reviewed by a physician; and
- The services are or were furnished while the individual was under the care of a physician.

Since the certification is closely associated with the plan of care (POC), the same physician who establishes the plan must also certify to the necessity for home health services. Certifications must be obtained at the time the plan of care is established or as soon thereafter as possible.

The attending physician signs and dates the POC/certification prior to the claim being submitted for payment; rubber signature stamps are not acceptable. The form may be signed by another physician who is authorized by the attending physician to care for his/her patients in his/her absence. While the regulations specify that documents must be signed, they do not prohibit the transmission of the POC or oral order via facsimile machine. The Home Health Agency (HHA) is not required to have the original signature on file. However, the HHA is responsible for obtaining original signatures if an issue surfaces that would require verification of an original signature.

HHAs which maintain patient records by computer rather than hard copy may use electronic signatures. However, all such entries must be appropriately authenticated and dated. Authentication must include signatures, written initials, or computer secure entry by a unique identifier of a primary author who has reviewed and approved the entry. The HHA must have safeguards to prevent unauthorized access to the records and a process for reconstruction of the records upon request from the intermediary, state surveyor, or other authorized personnel, in the event of a system breakdown.

See §10.1 for the effects of failure to certify or recertify.)

30.3 - Recertifications for Home Health Services

(Rev. 28; Issued: 08-12-05; Effective/Implementation: 09-12-05)

Under both the hospital insurance and supplementary medical insurance programs, when services are continued for a period of time, the physician must recertify at intervals of at least once every 60 days that there is a continuing need for services and should estimate how long services will be needed. The recertification should be obtained at the time the plan of care is reviewed since the same interval (at least once every 60 days) is required for the review of the plan.

The physician must recertify that an individual needs or needed skilled nursing care on an intermittent basis or physical *therapy* or speech*-language pathology services* or, in the case of an individual who has been furnished home health services based on such a need and who no longer has such a need for such care or therapy, needs or continues to need occupational therapy. Recertifications must be signed by the physician who reviews the plan of treatment. The form of the recertification and the manner of obtaining timely recertifications are up to the individual agency.

50 - Physician's Certification and Recertification for Outpatient Physical Therapy, *Occupational Therapy and Speech-Language Pathology*

(Rev. 28; Issued: 08-12-05; Effective/Implementation: 09-12-05)

For certification and recertification of outpatient physical therapy, occupational therapy and speech-language pathology services see Pub. 100-02, Chapter 15, §220.1.3.

Definitions

10.3 - Under Arrangements

(Rev. 28; Issued: 08-12-05; Effective/Implementation: 09-12-05)

A provider may have others furnish certain covered items and services to their patients through arrangements under which receipt of payment by the provider for the services discharges the liability of the beneficiary or any other person to pay for the service. In permitting providers to furnish services under arrangements, it was not intended that the provider merely serve as a billing mechanism for the other party. Accordingly, for services provided under arrangements to be covered, the provider must exercise professional responsibility over the arranged-for services.

The provider's professional supervision over arranged-for services requires application of many of the same quality controls as are applied to services furnished by salaried employees. The provider must accept the patient for treatment in accordance with its admission policies, and maintain a complete and timely clinical record on the patient, which includes diagnoses, medical history, physician's orders, and progress NOTEs relating to all services received, and must maintain liaison with the attending physician regarding the progress of the patient and the need for revised orders. In the case of home health services and outpatient physical therapy or speech-*language* pathology services, the provider must ensure that the required plan of treatment is periodically reviewed by the physician and secure from the physician the required certifications and recertifications. Additionally, the provider (other than a SNF) must ensure that the medical necessity of such services is reviewed on a sample basis by the utilization review (UR) committee if one is in place, the facility's health professional staff, or an outside UR group. (Effective October 1, 1990, a SNF is no longer required to have a plan for UR.) The provider, including a SNF that conducts optional UR services, is responsible for medical necessity decisions made under arrangement by an outside group.

10.4 - Term of Agreements

(Rev. 28; Issued: 08-12-05; Effective/Implementation: 09-12-05)

An agreement with a hospital, HHA, hospice, and (for the purposes of furnishing outpatient physical therapy, occupational therapy, or speech*-language* pathology services) a clinic, a rehabilitation agency, or public health agency is not time limited and has no fixed expiration date. The agreement remains in effect until such time as there is a voluntary termination, or involuntary termination, or a change of ownership.

10.6.4 - Determining Payment for Services Furnished After Termination, Expiration, or Cancellation

(Rev. 28; Issued: 08-12-05; Effective/Implementation: 09-12-05)

Effective with the date a provider agreement (or swing bed approval) terminates, expires, or is cancelled, no payment is made to the provider under such agreement for the following:

A. Hospital

1. Termination-Hospital Agreement - Inpatient hospital services (including inpatient psychiatric hospital services) and swing bed extended care services furnished on or after the effective date of the hospital's termination, except that payment can continue to be made for up to 30 days of inpatient hospital services and/or swing bed extended care services (total of no more than 30 days) furnished on or after the termination date to beneficiaries who were admitted (at either the acute or extended care level) prior to the termination date.

2. Termination-Swing Bed Approval - Swing bed extended care services furnished on or after the effective date of the termination of the hospital's swing bed approval, except that payment can continue for up to 30 days of extended care services furnished on or after the termination date to beneficiaries who were admitted (at either the acute or extended care level) prior to the termination date.

B. Skilled Nursing Facility

1. Termination-SNF - Posthospital extended care services furnished on or after the effective date of termination of the agreement, where such agreement has been voluntarily terminated by the provider (see §10.6.1 of this chapter) or involuntarily terminated (see 3 below for cancellations) by the Secretary for cause (see §10.6.2 of this chapter), except that payment can continue to be made for up to 30 days of posthospital extended care services furnished on and after the termination date to beneficiaries who were admitted prior to the termination date.

2. Expiration-SNF - Posthospital extended care services furnished on or after the date which follows the last day of the specified term of the agreement, where such agreement has expired at the close of the last day of its specified term (see §10.6.3 of this chapter), except that where the agreement has not been renewed, payment can be made for up to 30 days of posthospital extended care services furnished on and after the date which follows the last day of the specified term of such agreement to beneficiaries who were admitted on or before such last day.

3. Cancellation-SNF - Posthospital extended care services furnished on or after the date which follows the predetermined date specified in a cancellation clause, where such agreement is cancelled by the Secretary pursuant to such cancellation clause (see §10.6.2

of this chapter), except that payment can be made for up to 30 days of posthospital extended care services furnished on and after the date which follows the predetermined date specified in such clause, to beneficiaries who were admitted on or before such predetermined date.

C. HHA and Hospice

Payment may be made for services under a plan of treatment for up to 30 days following the effective termination date of a home health agency or hospice if the plan was established before the termination date.

D. Providers - Termination, Expiration, and Cancellation

Other items and services, including outpatient physical therapy or speech-*language* pathology and diagnostic services, furnished on or after the effective date of termination or, in the case of an expiration or cancellation of a SNF agreement, on or after the day following the close of such agreement.

(See Medicare Claims Processing Manual Chapter 1 for billing instructions concerning providers who are no longer participating.)

50 - Home Health Agency Defined

(Rev. 28; Issued: 08-12-05; Effective/Implementation: 09-12-05)

A home health agency is a public agency or private organization, or a subdivision of such an agency or organization, which meets the following requirements:

- It is primarily engaged in providing skilled nursing services and other therapeutic services, such as physical *therapy,* occupational therapy*, or speech-language pathology*, medical social services, and home health aide services. A public or voluntary nonprofit health agency may qualify by:
    - Furnishing both skilled nursing and at least one other therapeutic service directly to patients, or
    - Furnishing directly either skilled nursing services or at least one other therapeutic service and having arrangements with another public or voluntary nonprofit agency to furnish the services which it does not provide directly.

      NOTE: A proprietary agency can qualify only by providing directly both skilled nursing services and at least one other therapeutic service.
- It has policies established by a professional group associated with the agency or organization (including at least one physician and at least one registered professional nurse) to govern the services, and provides for supervision of such services by a physician or a registered professional nurse;
- It maintains clinical records on all patients;
- It is licensed in accordance with State or local law or is approved by the State or local licensing agency as meeting the licensing standards (where State or local law provides for the licensing of such agencies or organizations); and
- It meets other conditions found by the Secretary of the Department of Health and Human Services to be necessary for health and safety.

A private organization which is not exempt from Federal income taxation under section 501 of the Internal Revenue Code of 1954 (sometimes referred to as a "proprietary" organization) must be licensed pursuant to State law. If the State has no licensing law for such organizations, a proprietary agency cannot participate in the health insurance program.

For services under hospital insurance, the term "home health agency" does not include any agency or organization which is primarily for the care and treatment of mental disease. There is no such restriction under supplementary medical insurance.