CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-02 Medicare Benefit Policy	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 258	**Date: March 22, 2019**
	Change Request 11104

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.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	7/30.2.1/Content of the Plan of Care
R	7/30.5.2/Physician Recertification

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. 100-02	Transmittal: 258	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.

In the Medicare and Medicaid Programs: Conditions of Participation for Home Health Agencies Final Rule (82 FR 4504-4591), CMS finalized revisions to the Conditions of Participation (CoPs) that Home Health Agencies (HHAs) must meet in order to participate in the Medicare and Medicaid programs.

B. Policy: In the CY 2019 HH Prospective Payment System (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.

In the January 13, 2017 Home Health Conditions of Participation final rule (82 FR 4504), changes were made to the content requirements of the home health plan of care at 42 CFR 484.60(a)(2). As a condition for payment, the plan of care should include those items that establish the need for home health services. CMS is making changes to the Medicare Benefit Policy Manual, Chapter 7, section 30.2.1- Content of the Plan of Care, to state that the plan of care must include the identification of the responsible discipline(s) and the frequency and duration of all visits as well as those items listed in 42 CFR 484.60(a) that establish the need for such services.

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
11104 - 02.1	The contractors shall be aware of the revisions to Pub. 100-02, Chapter 7 related to the new policies in this CR.			X						

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
11104 - 02.2	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):
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ATTACHMENTS: 0

30.2.1 - Content of the Plan of Care

(Rev. 258, Issued: 03-22-19, Effective: 04-22-19, Implementation: 04-22-19)

The HHA must be acting upon a physician plan of care that meets the requirements of this section for HHA services to be covered. *For HHA services to be covered, the individualized plan of care must specify the services necessary to meet the patient-specific needs identified in the comprehensive assessment. In addition, the plan of care must include the identification of the responsible discipline(s) and the frequency and duration of all visits as well as those items listed in 42 CFR 484.60(a) that establish the need for such services. All care provided must be in accordance with the plan of care.*

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.

30.5.2 - Physician Recertification

(Rev. 258, Issued: 03-22-19, Effective: 04-22-19, Implementation: 04-22-19)

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 beneficiary who qualifies for a subsequent 60-day episode would start the subsequent 60-day episode on day 61. Under HH PPS, the plan of care must be reviewed and signed by the physician every 60 days unless one of the following occurs:

- A beneficiary transfers to another HHA; or
- A discharge and return to home health during the 60-day episode.

For recertification of home health services, the physician must certify (attest) that:

1. The home health services are or were needed because the patient is or was confined to the home as defined in §30.1;

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 recertification, or as a signed addendum to the recertification;

3. A plan of care has been established and is periodically reviewed by a physician; and

4. The services are or were furnished while the patient is or was under the care of a physician.

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.*

See §10.4 for counting initial and subsequent 60-day episodes. See §10.5 for recertifications for split percentage payments.