Home Health Therapy Documentation

Nebraska Home Care Association
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Home Health Coverage Resources

CMS "Medicare Benefit Policy Manual" (CMS Pub. 100-02)

Chapter 7; Home Health

- **http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c07.pdf**

Medicare Benefit Policy Manual
Chapter 7 - Home Health Services

Table of Contents
(Rev. 208, 05-11-15)

Transmittals for Chapter 7

10 - Home Health Prospective Payment System (HH PPS)

Homebound Status

Homebound Status

CGS Homebound Web page

http://www.cgsmedicare.com/hhh/coverage/HH_Coverage_Guidelines/1C.html

Homebound

Medicare Benefit Policy Manual (CMS Pub. 100-02, Ch. 7 §30.1, §30.1.1) PDF

One of Medicare's qualifying criteria for home health care is that the beneficiary is homebound and that the physician certifies that he or she believes the beneficiary is homebound. The beneficiary shall be considered homebound if the following two criteria are met.

Criteria-One:

The beneficiary must either:

- Because of illness or injury, need the aid of supportive devises such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the assistance of another person in order to leave their place of residence

  OR
- Have a condition such that leaving his or her home is medically contraindicated.

Criteria-Two:

- There must exist a normal inability to leave home;

  AND
- Leaving home must require a considerable and taxing effort.

Absences from the home for health care treatment (including adult day care) or religious services are allowed, and do not negate the beneficiary's homebound status. For examples of homebound status, refer to the *Medicare Benefit Policy Manual (CMS Pub. 100-02, Ch. 7, §30.1.1)* PDF

- Place of Residence — Medicare Benefit Policy Manual (CMS Pub. 100-02, Ch. 7 §30.1.2) PDF
- Cognitive or Psychiatric Conditions
- Documentation of Homebound Status

Homebound Status

http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8444.pdf


MLN Matters®
Official Information Health Care Professionals Can Trust

RELEASED products from the Medicare Learning Network® (MLN)
"Transitional Care Management Services," Fact Sheet, ICN 908628, Hard Copy only.

MLN Matters® Number: MM8444 — Related Change Request (CR) #: CR 8444
Related CR Release Date: October 18, 2013 — Effective Date: November 19, 2013
Related CR Transmittal #: R172BP — Implementation Date: November 19, 2013

Home Health - Clarification to Benefit Policy Manual Language on "Confined to the Home" Definition

Homebound Status

MLN Matters article MM8444 (from prior page)

- Clarifies **definition** of patient being "confined to home"
- Reflects definition in Social Security Act (Section 1835(a))
- **Removes vague terms** to ensure clear and specific definition
- **Not** a change in homebound definition

Homebound Status

Two criteria are used to determine homebound status

Criteria-One:

The patient must **either**:

- Because of illness or injury, need the aid of supportive devices such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the assistance of another person in order to leave their place of residence.

OR

- Have a condition such that leaving his or her home is medically contraindicated.

Homebound Status

Two criteria are used to determine homebound status (continued)

Criteria-Two:

- There must exist a normal inability to leave home

AND

- Leaving home must require a considerable and taxing effort

Homebound Status

The patient may be considered homebound (confined to the home) if absences from the home are:

- infrequent
- for periods of relatively short duration
- for the need to receive health care treatment
- for religious services
- to attend adult daycare programs
- for other unique or infrequent events
- the patient may have more than one home
  - vacation home, home of caregiver, seasonal home

Homebound Status

- Documentation must support **homebound status** throughout
- Beware of vague descriptions:

  "taxing effort", "unable to leave home"

- Utilize **objective, measurable language**

Homebound Status

Examples of **good documentation to support homebound status**:

- "After ambulating 20 feet, patient has increased dyspnea and complains of severe lower back pain. Must sit for 4 minutes before able to continue."
- "Patient has unsteady gait, and must sit to rest for 7 minutes after 10 feet of ambulation due to uncontrolled vertigo."

Medical Necessity

Medical Necessity

http://www.cgsmedicare.com/hhh/coverage/HH_Coverage_Guidelines/1E.html

Medically Necessary and Reasonable

Medicare Benefit Policy Manual (CMS Pub. 100-02, Ch. 7 §20.1) PDF

All services billed to Medicare must meet the criteria of "medically necessary and reasonable." To determine whether a service is reasonable and necessary, the Medicare home health benefit considers each beneficiary's unique medical condition. The medical record documentation, including the Plan of Care and OASIS, provide the basis for this determination. Coverage decisions are always based upon the objective clinical evidence of the beneficiary's individual need for care.

- It is the home health agency's responsibility to provide clear documentation of the medical necessity and reasonableness. This includes: progress or lack of progress, medical condition, functional losses, and treatment goals.
- The length of time services will be covered is generally determined by the beneficiary's needs.

Impact of Caregivers on Medical Necessity

National and Local Coverage Determinations

Documenting Medical Necessity

Medical Necessity

Full denials **OR**

Partial denials, may result in Low Utilization Payment Adjustment (LUPA) or therapy downcodes

Medical Necessity

All services must be reasonable and medically necessary **related to the patient's condition.**

- Observation and assessment
- Teaching
- Therapy

Medical Necessity

Does the documentation clearly answer "why home health and why now?"

Reminder: Good documentation should address:

- Objective clinical evidence of patient's individual need for care
- Progress or lack of progress
- Medical condition
- Functional losses
- Treatment goals
- Discharge planning

Medical Necessity

Covers all disciplines

- Nursing
- Physical therapy
- Occupational therapy
- Speech-language pathology

Medical Necessity - "Do's"

Identify skilled service, and **reason** skilled service is necessary for beneficiary in objective terms

Examples of **good documentation to support medical necessity**:

- "Wound care completed per POC to left great toe. No s/s of infection, but patient remains at risk due to diabetic status."
- "Range of motion (ROM) is tolerated to lower extremities. Unsafe to teach caregiver ROM due to patient's displaced fracture."

Medical Necessity – "Do's"

Demonstrate **medical necessity** of skilled observation and assessment by documenting complexity of beneficiary's condition and co-morbidities affecting outcomes.

Examples of **good documentation**:

- "Lungs sound coarse throughout. Patient finished antibiotic therapy today for pneumonia, and seeing pulmonologist tomorrow for follow up to due to COPD and emphysema."
- "Patient able to ascend 5 steps with stand by assistance. Relies heavily upon assistance and railing. Shows fear and is anxious by need for constant reassurance and unwillingness to go further."

Medical Necessity – "Don'ts"

Skilled nursing **fables.** These are **NOT TRUE!**

- "As long as you document teaching, it is a billable visit."
- "As long as you document assessment, it is a billable visit."

Medical Necessity – "Don'ts"

The service must:

- Require the skills of a nurse or qualified therapist
  - Service is **NOT** skilled because it is performed by a nurse or qualified therapist
  - Service does **NOT** become unskilled because it is taught
- Be reasonable and necessary to treat patient's illness or injury
  - Patient's condition warrants the skilled care
  - **MUST BE evident in documentation**

Resources

Home Health Clinical Resources

CMS Hospice Benefit Policy Manual (Pub. 100-02, Chapter 7)

http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c07.pdf

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Home Health Coverage Guidelines

Medicare Benefit Policy Manual, (CMS Publication 100-02, Ch. 7) PDF

CMS Quick Reference Information: Home Health Services PDF

Medicare pays for care in a beneficiary's home, when qualifying criteria are met, and documented. It is essential for home health agencies to have a complete understanding of these criteria, as you have the right and responsibility, in collaboration with the physician, to decide if the beneficiary qualifies for your services. The agency then must understand what services are covered, and how to document these services. Refer to the following topics for more information:

- Qualifying Criteria for Home Health Services
  - Physician orders, Plan of Care and Certification
    - Face-to-Face (FTF) Encounter
    - Face-To-Face Encounter Calendar Quick Resource Tool
  - Homebound;
  - Intermittent, if Skilled Nurse; and
  - Medically Necessary and Reasonable

Medicare-Covered Home Health Services	Additional Resources
• Defining "Visits"	• Advance Beneficiary Notice of Noncoverage (ABN)
• Foot Care under the Home Health Benefit	• Expedited Determination Process

Home Health Resources

Electronic Code of Federal Regulations: Title 42 CFR 424.22; Requirements for home health services

- http://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=c86654e32a4f36f15d70fab390124c29&n=pt42.3.424&r=PART&ty=HTML#se42.3.424_122&rgn=div8

Subpart B—Certification and Plan Requirements

§424.10 Purpose and scope.
§424.11 General procedures.
§424.13 Requirements for inpatient services of hospitals other than inpatient psychiatric facilities.
§424.14 Requirements for inpatient services of inpatient psychiatric facilities.
§424.15 Requirements for inpatient CAH services.
§424.16 Timing of certification for individual admitted to a hospital before entitlement to Medicare benefits.
§424.20 Requirements for posthospital SNF care.
§424.22 Requirements for home health services.
§424.24 Requirements for medical and other health services furnished by providers under Medicare Part B.
§424.27 Requirements for comprehensive outpatient rehabilitation facility (CORF) services.

CGS HH&H Website: Educational Materials

http://www.cgsmedicare.com/hhh/education/materials/index.html

Educational Materials & Resources

Home Health and Hospice Education

- Adjustments/Cancels
  - Limitation on Recoupment (935)
- Checking Eligibility
- Comprehensive Error Rate Testing (CERT) Program
- Fiscal Intermediary Standard System (FISS) Guide
- Medicare Secondary Payer (MSP)
  - Submitting MSP Claims and Adjustments
  - Medicare Secondary Payer (MSP) Billing and Adjustments PDF Quick Resource Tool
  - Medicare Secondary Payer (MSP) Online Tool
- Resources for the Most Common Home

Home Health Education

- Claims Processing and Reimbursement for Home Health Supplies
- Home Health Claims Filing and Special Claims Filing Situations
- Home Health Coverage Guidelines
- Home Health Quick Resource Tools
- Resolving Rejected Home Health Claims Caused by Billing Errors
- Medicare Learning Network Home Health Prospective Payment System Fact Sheet PDF
- Medicare Learning Network Quick Reference Information: Home Health Services PDF

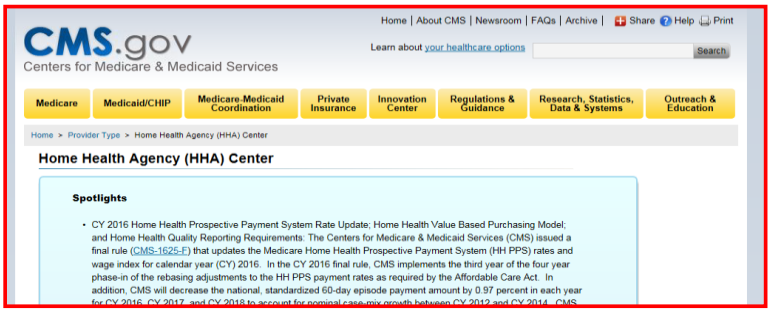
Hospice Education

- Change Request 8877
- Hospice Claims Filing and Special Claims Filing Situations
- Hospice Coverage Guidelines
- Hospice Quick Resource Tools
- Hospice Sequential Billing
- Medicare Learning Network Hospice Payment System Fact Sheet PDF

CMS Home Health Agency Center

http://www.cms.gov/Center/Provider-Type/Home-Health-Agency-HHA-Center.html

- Spotlights current events & hot topics
- Provides information regarding Open Door Forums (ODF)



CGS HH&H Website

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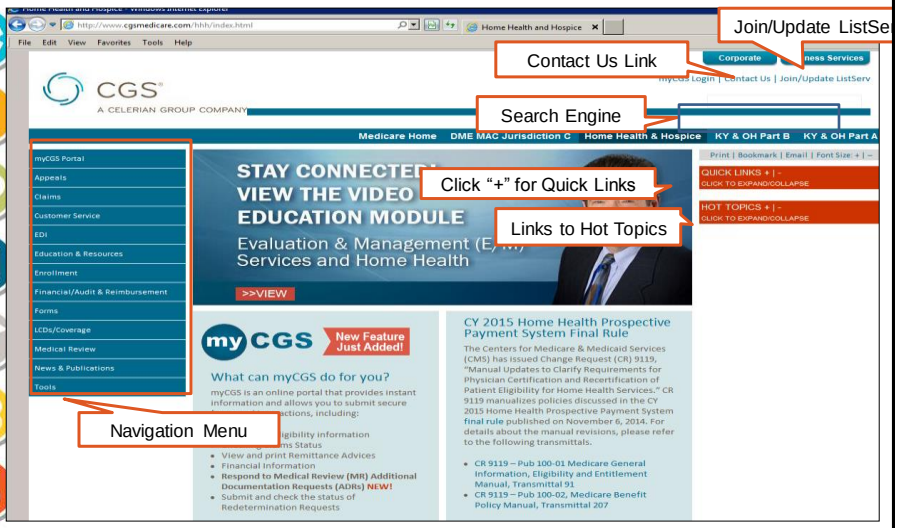
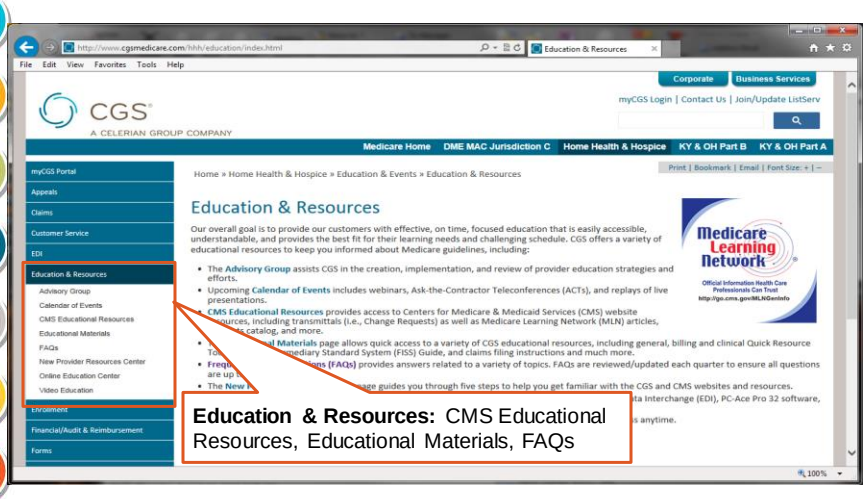


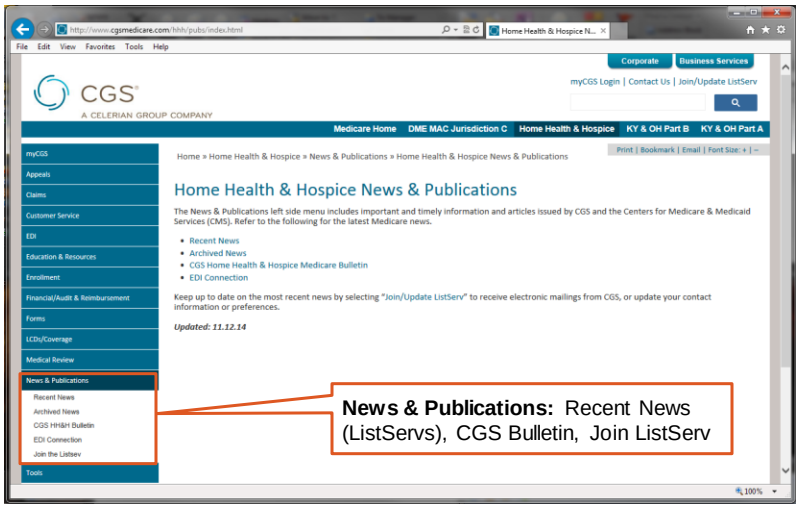
CGS HH&H Website: Education & Resources

http://www.cgsmedicare.com/hhh/education/index.html



CGS HH&H Website: News & Publications

http://www.cgsmedicare.com/hhh/pubs/index.html



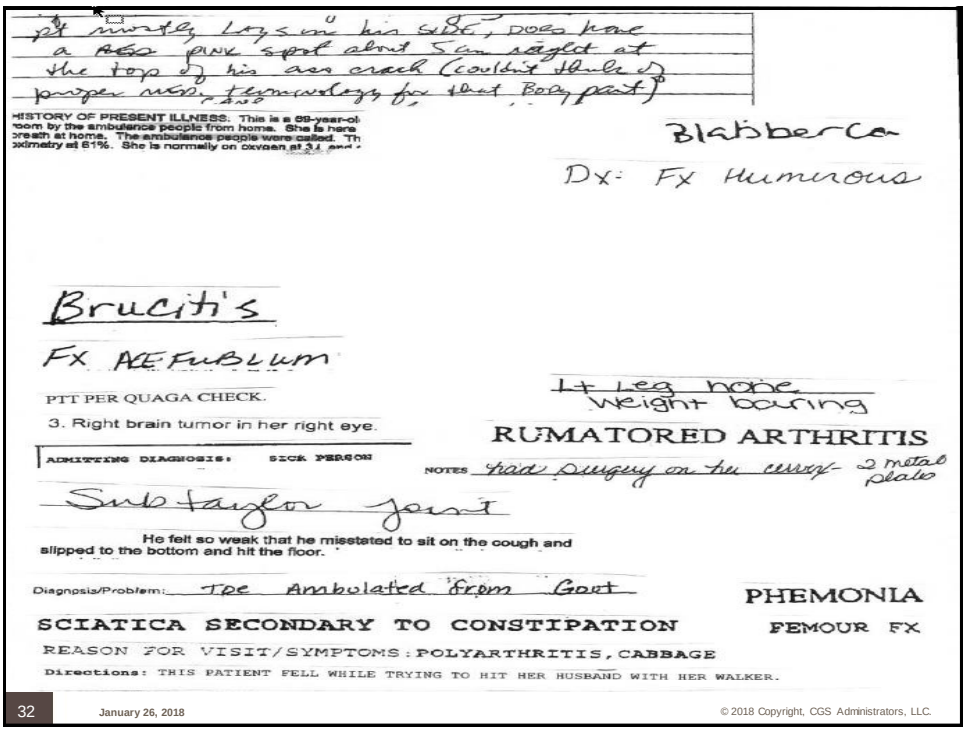
Questions?

CGS Provider Contact Center: 1.877.299.4500

Option 1: Customer Service

Twitter: http://www.twitter.com/hhhcgs

Facebook: http://www.facebook.com/hhhcgs



Documentation Examples

Supporting Documentation

Discharge Plans - Original

Patient able to resume previous lifestyle.

Supporting Documentation

Discharge Plans - Better

Patient able to resume independent level of care and live alone in private home instead of needing 24/7 caregiver. Patient able to resume previous lifestyle of doing own housework and laundry. Patient able to drive self to activities and appointments. Patient able to enjoy gardening and traveling.

Supporting Documentation

Original

M1240 – Has this patient had a formal pain assessment using a standardized, validated pain assessment tool?

Yes, and it indicates severe pain

M1242

Present pain: 4

Change in pain: No

Had knee replacement two days prior

Supporting Documentation

Better

M1240 – Has this patient had a formal pain assessment using a standardized, validated pain assessment tool?

Yes, and it indicates severe pain

M1242

Present pain: 8

Change in pain: Yes

Had knee replacement two days prior

Supporting Documentation

Original

She is no longer able to drive. Taxing effort to leave home and requires a cane and another person to do so.

Supporting Documentation

Better

She is no longer able to drive due to weakness and slow reflexes. Taxing effort to leave home and requires a cane and another person for stand by assist and assistance with doors, etc. to do so.

Supporting Documentation

Original

She is able to drive to appointments and grocery store only because there is no one else to take her.

Supporting Documentation

Original

She is able to drive to appointments and grocery store only because there is no one else to take her. Patient is not considered homebound.

Supporting Documentation

Original

The patient is not safe to drive due to her multiple medical problems and history of several automobile accidents in recent months. She cannot obtain reliable transportation.

In her current condition, she becomes significantly short of breath with even minimal physical activity. This makes travel outside the house very difficult and taxing.

Supporting Documentation

Better

The patient is not safe to drive due to her multiple medical problems and history of several automobile accidents in recent months. She cannot obtain reliable transportation due to the rural area in which she lives.

In her current condition, she becomes significantly short of breath with even minimal physical activity such as walking 10 feet or less. She is unable to navigate stairs. This makes travel outside the house very difficult and taxing.

General

Family Comments

Better

Patient has increased pain when walking on right foot as reported by her daughter, who lives with the patient as her caregiver.

Homebound

Original

Update: In the past 60 days, the patient has not had any hospitalizations or falls. The patient has completed her PT and is enjoying stable health at this time. The patient's medications have not changed in the past 60 days. The patient/caregiver is satisfied with our services and is requesting that their services continue.

Homebound

Better

Patient discharged after meeting therapy goals. Home Exercise Plan (HEP) understood and demonstrated. Medication regime is unchanged and understood by patient.

Multiple Concerns

Original:

(Name) unable to walk with FWW more than 10 feet without needing to rest due to SOB. Lives with elderly spouse. Newly diagnosed diabetic with expected medication changes before glucose levels remain stabile. Poor short term memory. Patient very thin and frail due to poor nutrition.

Multiple Concerns

Better

(Name) unable to walk with FWW more than 10 feet without needing to rest due to SOB. Lives with elderly spouse with own health concerns. Newly diagnosed diabetic with expected medication changes before glucose levels remain stabile. Poor short term memory. Patient very thin and frail due to poor nutrition.

Contacted physician to report current situation. Physician will talk with patient and spouse to recommend assisted living facility. Son of patient contacted (permission to speak with son information in patient's file from original intake).

Progression

Great:

Patient denies fall, but has bruises on elbows and knees with slight abrasions. More shaky today with standing. Patient unable to demonstrate filling insulin syringes after 2 prior teachings. Called physical therapist to relay today's findings. Educated patient on correct filling of insulin syringes. Patient able to fill syringe correctly.

2 visits later

Patient's family has removed all throw rugs in house. Able to stand unassisted. Patient successfully demonstrated correct procedure to fill syringes and administer insulin.

Activities of Daily Living

Original:

M1810 Able to get clothes out of closets and drawers, put them on and remove them from the upper body without assistance.

M1820 Able to obtain, put on, and remove clothing without assistance.

M1830 Able to bathe self in shower or tub independently, including getting in and out of tub/shower.

M1840 Able to get to and from the toilet and transfer independently with or without a device.

M1850 Able to independently transfer

M1860 Able to independently walk on even and uneven surfaces and negotiate stairs with or without railings

Homebound

Activities of Daily Living

Better:

M1810 Able to get clothes out of closets and drawers, put them on and remove them from the upper body without assistance.

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M1850 Able to independently transfer

M1860 Able to independently walk on even and uneven surfaces and negotiate stairs with or without railings

NOT Homebound

Changes

Good!!

Patient appeared more tired than usual. Did not answer door herself.

Only ate half of breakfast aide prepared for her.

New wound noted on buttocks. Reported to nurse

Outings

Good!

Patient said her daughter took her to her grandson's birthday party on Tuesday. Hasn't been able to watch her favorite TV shows without falling asleep since then.

Be Observant

Mr. Smith had not changed his clothes since the last time I was here. Didn't want to talk. His dog is at his son's house.

Therapy

Good!!

PT Summary of Care

Patient started physical therapy on (date) due to a TKA.

On her initial evaluation her ROM measured 12 degrees extension and 70 degrees flexion. Pain was 8/10 at worst and gait was limited to 150' with 3WW.

Upon discharge from home health services, patient's ROM measured 4 degrees extension and 103 degrees flexion. She was ambulating x 250' without an AD with SBA. Her pain was persistent throughout her plan of care and remained 8/10 at worst at discharge.

Patient remained in her home as it was difficult and taxing to leave her home for treatment due to knee stiffness, weakness, and persistent pain.

Therapy

Good!

Documented clinical findings included muscular atrophy, frailty, weakness in all extremities and mild cognitive impairment. The FTF also attested to (name's) homebound status and cited her need for an assistive device and the assistance of another to leave home.

Dr. (name) noted (name) was having issues with balance, poor strength/endurance, a declining ability to perform ADLs (activities of daily living), bilateral lower extremity (BLE) weakness, fear of falls, pain all over, and edema to BLE. She needed a home safety evaluation. Notably, (name) also had problems with hypertension, fibromyalgia, post-polio syndrome, weakness, and limited mobility.

Therapy

Original

PT

Patient very confused today and hard to keep on task.

Therapy

Better

PT

Patient more confused today than usual. Did not recognize this therapist today, even though she usually calls therapist by name. Could not follow simple commands such as getting up out of her chair without repeated instructions. Became easily distracted by people walking past her door.

This behavior is unusual for this patient. Usually alert and oriented. Will report to nurse.

Therapy

Excellent!

Patient requires frequent rest breaks after 50-60' and then 2-3 hours to recover after outings

Patient requires supervision and frequent rest breaks with ambulation due to CHF and gait instability after 70-80 feet and then 2-3 hours to recover after extended outings

Patient requires frequent rest breaks due to CHF after 50-60' and supervision due to gait instability to leave home, then 2-3 hours to recover after outings

Considerable and taxing effort to leave home, taking 1-2 hours to recover due to decreased independence with gait transfers and balance.

Therapy

Original:

Goal: Patient will ambulate 300 feet x 2 with walker and SBA x 2 on various surfaces

Therapy

Better

Goal: Patient will ambulate 300 feet x 2 with walker and SBA of two people on various surfaces, such as linoleum, carpeting, sidewalk and gravel driveway

Therapy

Original

February 18th

Patient's family cancelled the therapy appointment due to falling twice in the last 24 hours. Patient was rescheduled for Monday the 23rd.

Therapy

Better

February 18th

Patient's family cancelled the therapy appointment due to falling twice in the last 24 hours. Nurse advised family that she needed to see patient this morning to check for injuries. Appointment set for 9:00 this morning to see patient. Will call physician to report after examination.

Therapy

Original

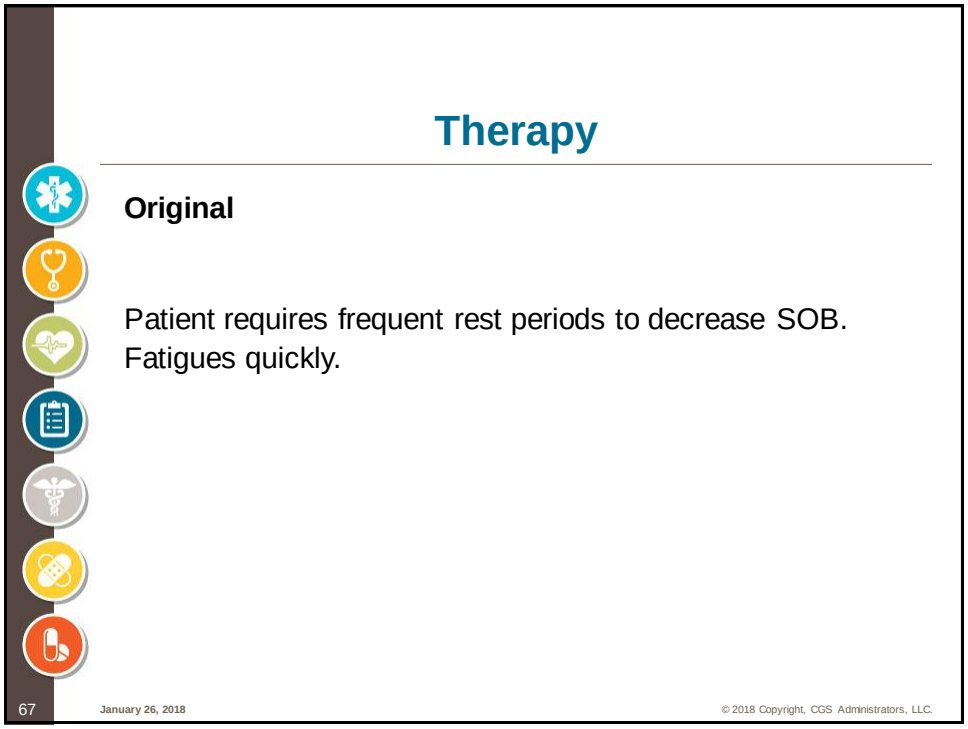
Patient called and cancelled appointment because his bike broke down yesterday and he had to walk it home for a very long distance.

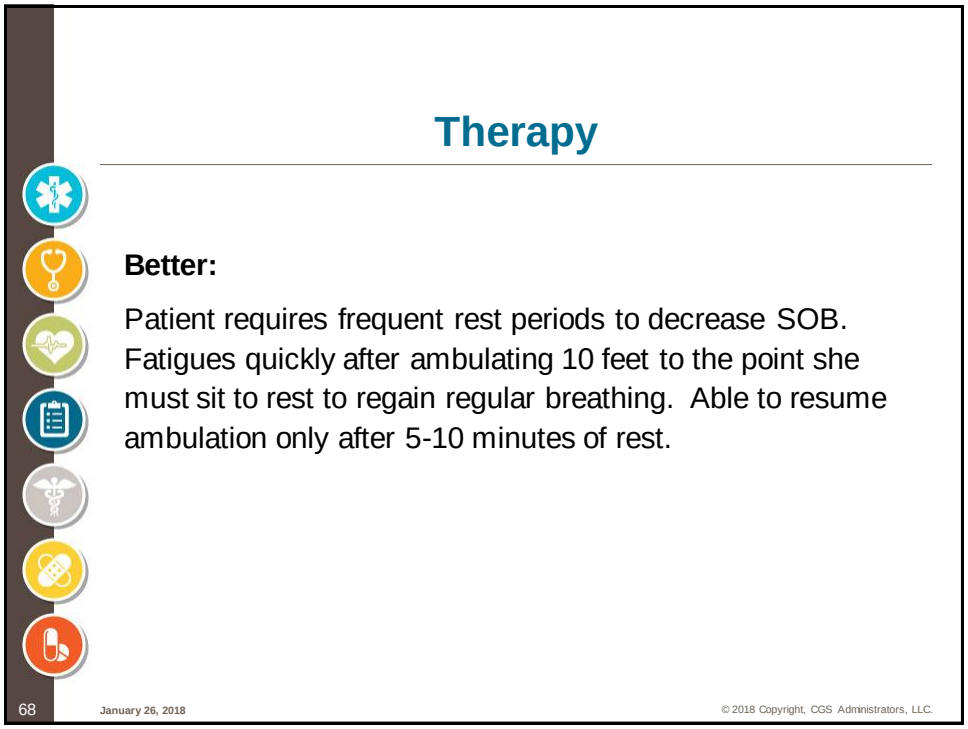
Happened more than once!

Therapy

Better

Patient discharged. Able to ride bicycle and ambulate for long distances.





Therapy

Original

Patient lives alone.

Patient unable to ambulate without assist of at least one person.

Therapy

Better

Patient recently moved to assisted living until able to return to private home. Unable to ambulate without assist of at least one person.

Therapy

Good:

Initial Finding: Patient able to gait train 0' feet with max assistance in transfers and FWW for balance and stability

Goal: To gait train 600 feet with or without AD and independent transfers on level/uneven surfaces to allow patient to get into and out of doctor office and exit home in case of emergency.

Therapy

Original

Patient reported she doesn't understand why she needs to do therapy. She doesn't want to walk around. Lacks ability to stand independently. Patient lives temporarily with sister. She is frustrated she isn't able to go back to her home immediately.

Therapy

Better

Patient reported she doesn't understand why she needs to do therapy. She doesn't want to walk around. Lacks ability to stand independently. Patient lives temporarily with sister. She is frustrated she isn't able to go back to her home immediately.

Included sister in training. Demonstrated to patient what therapy will help her do. HEP initiated. Patient agreed to try it. Short term goals set in place for patient to see progress.

Therapy

Original

Facility nurse (name) requested in service for facility staff for transfer training. Will coordinate with OT to schedule. Patient scheduled for PT discharge next week, but will be extended.

Therapy

Better

Facility nurse (name) requested in service for facility staff for transfer training. Informed facility nurse that Medicare does not cover training of facility staff.

Therapy

Original

Patient is able to ambulate and transfer, but it is a taxing effort. Patient is able to do most ADLs, but accepts help if available.

Therapy

Better

Patient is able to ambulate and transfer, but it is a taxing effort. Patient is able to do most ADLs, but accepts help if available.

HEP plan has been in place for patient to increase strength and confidence without skilled services. Patient understands and agrees with HEP.

Therapy

Original

(Name) sitting at table upon arrival. She had HEP in front of her and stated she had just completed exercises. Was able to verbalize correctly everything she had done. No sign of SOB. Patient denied pain.

Therapy

Better

(Name) sitting at table upon arrival. She had HEP in front of her and stated she had just completed exercises. Was able to verbalize correctly everything she had done. No sign of SOB. Patient denied pain.

This therapist requested patient repeat HEP. Patient was able to verbalize what should be done, but was unable to physically perform the exercises. Was out of breath after 5 minutes and complained of pain at 5 out of 10.

Adjusted HEP to a more gradual increase in activity. Patient able to perform at new level and understood how to increase activity in a safe manner.

Therapy

Original:

Goal: Patient will be able to ambulate 900 feet on even and uneven surfaces without assistive device. Patient will be able to climb 50+ steps without unsteadiness or shortness of breath.

Patient is 88 years old.

Therapy

Better:

Goal: Patient will be able to ambulate 900 feet on even and uneven surfaces without assistive device. Patient will be able to climb 50+ steps without unsteadiness or shortness of breath.

Patient is 88 years old and active. Wants to be able to continue attending college football games as he has done for the past 60 years.

Resources

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Quick Resource Tools (QRT)

http://www.cgsmedicare.com/hhh/education/materials/hh_qrt.html

Home Health Quick Resource Tools

General	Billing	Clinical
• Face-To-Face (FTF) Encounters for Home Health Certification PDF • Home Health 60-Day Episode Calendar Schedule PDF • Home Health 60-Day Episode: 2016 Calendar Schedule PDF • Medical Review Additional Development Request (MR ADR) Tool PDF • Success with Medical Record Requests PDF • Understanding Home Health Prospective Payment System (HH PPS) Health Insurance Prospective Payment System (HIPPS) Code Changes ◦ For "through" dates prior to 1/1/2015 PDF ◦ For "through" dates on or after 1/1/2015 and prior to 1/1/2016 PDF ◦ For "through" dates on or after 1/1/2016 and prior to 1/1/2017 PDF ◦ For "through" dates on or after 1/1/2017 PDF	• Avoiding Billing Errors Caused By Overlapping Home Health Episodes PDF • Avoiding Reason Code 38107 PDF • Demand Billing Information Sheet for Home Health Providers PDF • ELGA and ELGH Overview of Key Fields PDF • Home Health Medicare Billing Codes Sheet PDF • Home Health Pre-Claim Review (PCR) Demonstration Fact Sheet - **Temporarily Unavailable** • Medicare Resources for New Billers PDF • Medicare Secondary Payer (MSP) Billing & Adjustments PDF • Ordering/Referring Checklist for Home Health Agencies PDF • Special Billing Situations Under HH PPS PDF • Treatment Authorization Code Structure PDF	• 2016 Leap Year Home Health Face-To-Face Encounter Calendar PDF • Advance Beneficiary Notice (ABN) vs Home Health Change of Care Notice (HHCCN) PDF • Face-To-Face Encounter Calendar PDF • Home Health Qualifying Criteria for Intermittent Care PDF • Home Health Wound Care Flow Sheet PDF • Medicare Resources for New Clinicians PDF • Signature Guidelines for Home Health & Hospice Medical Review PDF • Home Health Denial Fact Sheets ◦ 5HC01 – Missing / Incomplete / Untimely Face-to-Face Encounter PDF ◦ 5HH01 – Homebound status PDF ◦ 5HN01 – Medical necessity PDF ◦ 5HS01 – No OASIS PDF ◦ Denial Reason: Missing/Incomplete/ Untimely Plan of Care or Certification PDF

Updated: 01.09.17

Homebound Criteria

http://www.cgsmedicare.com/hhh/coverage/HH_Coverage_Guidelines/1C.html

Homebound

Medicare Benefit Policy Manual (CMS Pub. 100-02, Ch. 7 §30.1, §30.1.1) PDF

One of Medicare's qualifying criteria for home health care is that the beneficiary is homebound and that the physician certifies that he or she believes the beneficiary is homebound. The beneficiary shall be considered homebound if the following two criteria are met.

Criteria-One:

The beneficiary must either:

- Because of illness or injury, need the aid of supportive devises such as crutches, canes, wheelchairs, and walkers; the use of special transportation; the assistance of another person in order to leave their place of residence

  OR
- Have a condition such that leaving his or her home is medically contraindicated.

Criteria-Two:

- There must exist a normal inability to leave home;

Resources

http://www.cgsmedicare.com/hhh/education/faqs/index.html

Frequently Asked Questions (FAQs)

- Additional Development Request (ADR)/Medical Review
- Adjustments/Cancel
- Appeals
- Ask-the-Contractor Teleconference (ACT) Questions and Answers
- Beneficiary Eligibility Information
- Checking Claim Status
- Comprehensive Error Rate Testing (CERT) Program
- Cost Report
- Cost Report Reopening
- EDI
- Home Health Billing
- Home Health Clinical – Medical Review
- Hospice Billing
  - Change Request 8358
  - Change Request 8877
  - Change Request 8877: Updates from CGS on Timely Filing of NOEs and Exception Requests Ask-the-Contractor Teleconference (ACT), February 18, 2015
  - Change Request 8877 Ask-the-Contractor Teleconference (ACT), September 24, 2014
- Hospice Clinical
- Hospice Face-to-Face (FTF) Encounters
- Hospice Physician Billing
- ICD-10-CM/PCS
- Medicare Secondary Payer (MSP)

Questions?

CGS Provider Contact Center: 1.877.299.4500

Option 1: Customer Service
Option 2: Electronic Data Interchange (EDI)
Option 3: Provider Enrollment
Option 4: Overpayment Recovery (OPR)

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