Home Health Services

Medical Review Criteria

Associated Hospital Service

Overview

- Homebound
- Certified Plan of Care
- Skilled intermittent services
- Reasonable and necessary treatment

Home Health Eligibility

The beneficiary must meet all four qualifying criteria…

- Homebound
- Intermittent Skilled Need
- Physician established plan of care
- Medicare participating Home Health Agency

Reference Eligibility Sections 1814 and 1835 of the Social Security Act

MD Certification of Homebound

For home health services to be covered
the law requires that the physician
certify the patient is confined to his/her home

Reference: CMS Manual 100-2 Medicare Benefit Policy Manual, CH.7 §30.1.1 and 30.5.1

Homebound

- Place of residence
- Normal inability to leave home
- Leaving takes a considerable and taxing effort
- Absences are for an infrequent and short duration or to receive healthcare treatment
- Can attend State certified/licensed or accredited day care program and religious services

Reference: CMS Manual 100-2 Medicare Benefit Policy Manual, CH.7 §30.1

Place of Residence

CAN Be:

- House/Apartment
- Assisted living facility
- Group home
- Relatives home

Reference: CMS Manual 100-2 Medicare Benefit Policy Manual, CH.7 §30.1.2

Normal Inability To Leave Home

- Medically contraindicated
- Requires a supportive device or support of another
- Taxing effort to leave the home

Reference: CMS Manual 100-2 Medicare Benefit Policy Manual, CH. 7 §30.1.1

Absences Shall Be Infrequent Or Of Relatively Short Duration

Such as, but not limited to:

- Attendance at a religious service
- Occasional trip to barber
- Family reunion, funeral, graduation, or other infrequent or unique event

- Reference: CMS Manual 100-2 Medicare Benefit Policy Manual, CH. 7 §30.1.1

Documentation Guidelines for Homebound Status

- Homebound is a qualifying criteria for Medicare coverage and should be evaluated on admission and throughout the episode.

- Clearly document homebound status in the clinical record

Documentation Continued

Notes should:

- describe the “Taxing Effort” as a result of the patient’s medical condition (i.e., shortness of breath, dyspnea on exertion, weakness, etc.).
- reflect the need for assistance of another individual or the assistive device required to leave home..
- reflect the frequency, duration, and purpose of absences.

Skilled Need

The beneficiary must need:

- Intermittent skilled nursing (other than solely venipuncture) or
- Physical therapy or
- Speech language pathology or
- Continue to need Occupational therapy

Reference Eligibility Sections 1814 and 1835 of the Social Security Act

Intermittency

- A medically predictable recurring need for skilled nursing services at least once every 60 -90 days.

- Reference: CMS Manual 100-2 Medicare Benefit Policy Manual, CH. 7 §30.4, 40.1.3

Intermittency Requirements

- The Plan of Care for daily skilled nursing services must indicate a finite and predictable end period (a specific date) when care will no longer be necessary on a daily basis

- The intermittent skilled need must also be met for eligibility

Reference: CMS Manual 100-2 Medicare Benefit Policy Manual, CH. 7 §30.4, 40.1.3 Eligibility Sections 1814 and 1835 of the Social Security Act

Skilled Services

Skilled nursing, physical therapy, speech-language pathology, and occupational therapy on an ongoing basis

- Reasonable and Necessary
- Management and Evaluation
- Observation and Assessment
- Teaching and Training

Reference: CMS Manual -2 Medicare Benefit Policy Manual, CH. 7§40.1-40.2

The key to success is

DOCUMENTATION

Resources

- www.cms.hhs.gov/manuals
- www.cms.hhs.gov/medlearn/matters/
- www.oasistraining.org
- www.ahsmedicare.com