NGS Medicare Home Health Updates: Key Insights and Compliance Essentials for 2025

Michigan Home Care & Hospice Association

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Objective

This session aims to equip home health providers with updates on Medicare regulations for 2025, focusing on minimizing claim denials, understanding Medical Review trends, and ensuring compliance with documentation and the TPE process.

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Agenda

1. Documentation & Best Practices
2. Additional Documentation Request (ADR)
3. Targeted Probe & Educate (TPE)
4. Medical Review Trends
5. Resource Access

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Documentation Best Practices
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Plan of Care Components
The Plan of Care (POC) must contain ALL the following components:
Certification Statement
Documentation of Homebound Status
Skilled Services
Frequency and Duration
Physician Orders
Medications
Goals and Prognosis
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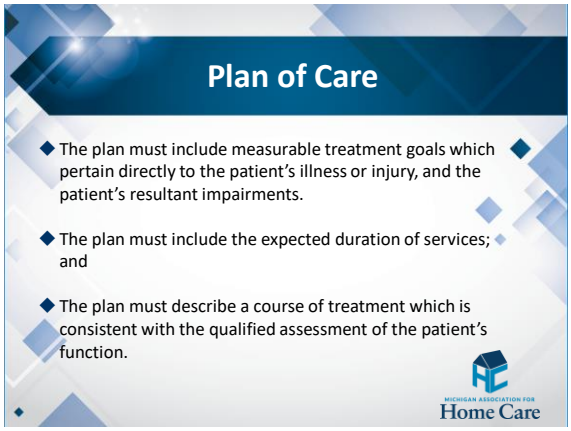
Plan of Care
The plan must include measurable treatment goals which pertain directly to the patient's illness or injury, and the patient's resultant impairments.
The plan must include the expected duration of services; and
The plan must describe a course of treatment which is consistent with the qualified assessment of the patient's function.
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Certification

- The physician/NPP should complete the certification when the plan of care is established, or as soon as possible thereafter.
- The certification must be complete prior to when a HHA bills Medicare for reimbursement.
- It is not acceptable for HHAs to wait until the end of the 60-day episode of care to obtain a completed certification.

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Example Certification Statement

I certify that this patient is under my care and that I, or a nurse practitioner, clinical nurse specialist, or physician assistant working with me, had a face-to-face encounter with this patient on [Date], which was related to the primary reason the patient requires home health services.

Patient Name:
Medicare Number:
Date of Birth:

Based on my findings, I certify that:

1. The patient is confined to the home (homebound).
2. The patient needs intermittent skilled nursing care, physical therapy, and/or speech-language pathology services.
3. A plan of care has been established and will be periodically reviewed by me.
4. The services required will be furnished while the patient is under my care.

Detailed Reasons for Homebound Status: [Include specific reasons why the patient is considered homebound, such as difficulty walking, use of a wheelchair, or the need for assistance to leave home.]

Skilled Services Required: [Detail the specific skilled services needed, such as wound care, IV therapy, physical therapy, etc.]

Physician's Name:
Physician's Signature:
Date:

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Homebound Status Criteria

Criteria One:

The patient must either:

A. 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 to leave their place of residence

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

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Homebound Status Criteria

If the patient meets one of the criterion one conditions, then the patient must ALSO meet two additional requirements:

Criteria Two:

1. There must exist a normal inability to leave home;
2. AND - Leaving home must require a considerable and taxing effort

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Homebound Status

If the patient does in fact leave the home, the patient may nevertheless be considered homebound if the absences from the home are infrequent or for periods of relatively short duration, or are attributable to the need to receive health care treatment.

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Homebound Status

Absences attributable to the need to receive health care treatment include, but are not limited to:

- Attendance at adult day centers to receive medical care;
- Ongoing receipt of outpatient kidney dialysis; or
- The receipt of outpatient chemotherapy or radiation therapy.

CMS Internet Only Manual, Pub. 100-02, Ch. 7 – Home Health Services

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Skilled Services

1. Specific Skilled Services:
   Clearly outline what skilled nursing, therapy, or other professional services are needed. This could include wound care, administration of injections, physical therapy exercises, or complex patient education.

2. Medical Necessity:
   Justify why each skilled service is necessary based on the patient's medical condition or treatment requirements. This helps meet Medicare guidelines and ensures that the services are aligned with the patient's health needs.

3. Plan Details:
   Include the frequency, duration, and goals of the skilled services being provided. This helps set expectations for care delivery and outcomes.

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Skilled Services

4. Qualifying Criteria:
   Ensure that the plan of care reflects CMS guidelines and aligns with the patient's homebound status and need for intermittent skilled care.

5. Coordination with Physician Orders:
   The plan of care should be consistent with the physician's orders and clearly document any changes in the treatment regimen as they occur.

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Documentation Tips

1. Include specific documentation regarding the patient's prior level of function including the acuity of the change in function.
   - Record this in objective, measurable and functional terms.
   - This is a key piece of information used for establishing potential, prognosis and realistic functional goals.

2. Provide an objective description of the changes in function that make skilled services necessary at the time.

3. Describe the skilled nature of the treatment provided
   - Descriptions of the skilled treatment.
   - Changes made to the treatment due to the assessment of the patient's needs on a particular visit.
   - Modifications of the treatments to the next, more complex or difficult task.

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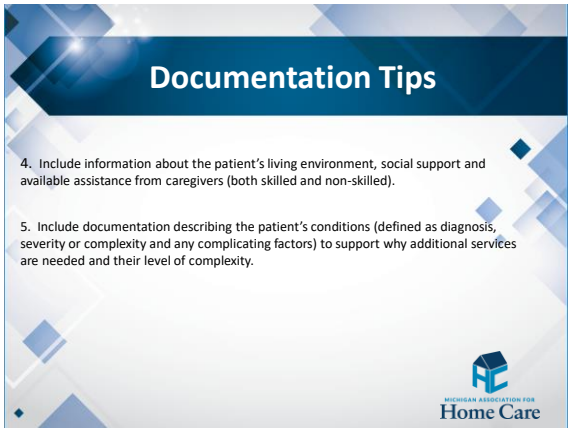
Documentation Tips
4. Include information about the patient's living environment, social support and available assistance from caregivers (both skilled and non-skilled).
5. Include documentation describing the patient's conditions (defined as diagnosis, severity or complexity and any complicating factors) to support why additional services are needed and their level of complexity.
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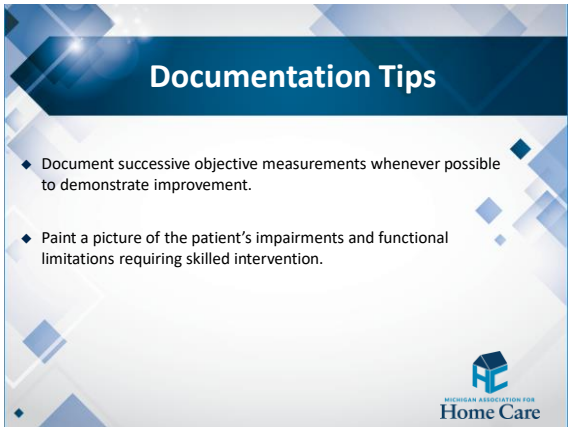
Documentation Tips
Document successive objective measurements whenever possible to demonstrate improvement.
Paint a picture of the patient's impairments and functional limitations requiring skilled intervention.
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Additional Documentation Request (ADR)
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What is ADR?

Generated when documentation is necessary to support a Medicare claim to:

- ✓Support payment of items or services reported on the claim
- ✓Ensure compliance with Medicare's coverage, coding, payment and billing policies

Additional Documentation Request (ADR) Quick Reference Guide (ngsmedicare.com)

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ADR Best Practice Tips

- Check for ADRs daily.
- Ensure all contact information is correct within Provider Enrollment, Chain, and Ownership System (PECOS)
  - Report a Change of Information in PECOS
  - Resolving PECOS Common Errors and Warnings
- Respond timely.
  - ADR Timeline Calculator

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ADR Best Practice Tips

- Utilize all Free NGS self-service resources:
  - NGSConnex
  - NGSMedicare.com
  - ADR Letters Guide
  - Home Health Documentation Checklist
- Start conversations with your internal staff / patient care team and ensure everyone is involved, and aware. Review policy checklist items.

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Targeted Probe & Educate (TPE)

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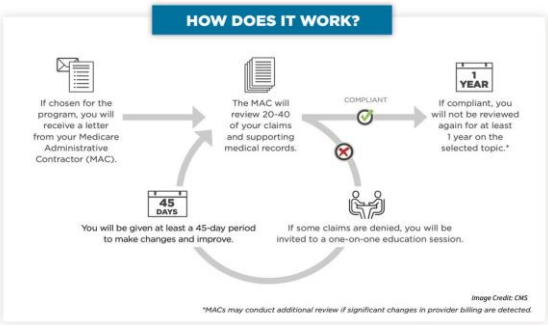
TPE Process



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Getting Started with TPE

- Utilize NGSMedicare.com for information on TPE letters and resources.
- Monitor review topics, denial trends, and FAQs for J6 Home Health.
- Ensure address accuracy in PECOS; follow instructions to update if needed.
- Utilize NGS Connex to find and respond to ADRs, check claim status, and verify beneficiary eligibility.

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Notification Letter

- Respond promptly with a point of contact for Medical Review team communication.
- Provide phone and email for effective intra-probe communication and scheduling post-probe education.
- Engage relevant teams (patient care, compliance, billing) in the review process.

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During the Review Process

- Ask questions early; contact the CMT via email: J6ACaseManagement@ElevanceHealth.com
- Utilize Provider Contact Center for assistance with claims, Medicare info, billing questions, and website guidance.

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TPE Results Letter

- Contact Case Management (CMT) within seven days of receiving Results Letter to schedule education.
- Educational session tailored to your needs to identify improvement areas.
- Failure to schedule education may result in the next round of review within 45 days.
- Results Letter Information

If error rate is over 15% and you do not seek education, it will be marked as a refusal

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Prepare for Post Probe Education

- Monitor appeal deadlines; submit appeals promptly, even before education.
- Ensure key staff are available for educational calls; share Results Letter for preparation.
- Review denial rationales thoroughly; reach out to CMT if challenges arise.

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Referral to CMS

Referrals to CMS may result in:

- Additional rounds of TPE
- Referral for revocation
- Corrective action
- Extrapolation
- Referral to Unified Program Integrity Contractor (UPIC)
- Referral to the Recovery Auditor (RA)
- 100% Pre-pay review

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Medical Review Trends

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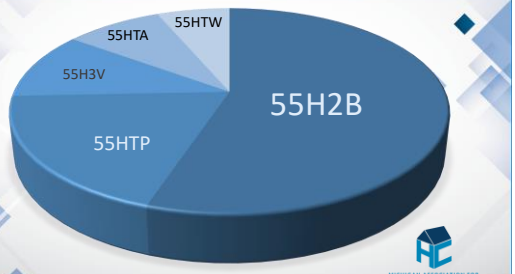
Top J6 Medical Review Denials



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55H2B

55H2B – The documentation submitted does not support homebound status.

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Tips for Avoiding 55H2B

1. Understand Homebound Status
   - Patient needs considerable & taxing effort to leave home, & absences are infrequent, of short duration, or attributable to the need to receive health care treatment.
2. Comprehensive Documentation
   - Clearly document why patient is considered homebound with specific examples. This may include the physical, mental, or environmental conditions that contribute to the homebound status.
3. Include Supporting Evidence
   - Provide assessments and notes from physicians and therapist that corroborate the homebound status. Document any recent changes in the patient's condition that contribute to being homebound.
4. Timely and Consistent Record Keeping
   - Maintain up-to-date records that consistently reflect the homebound status over time. Regular updates capture any ongoing or developing issues that impact the patient's mobility.
5. Regular Reassessment
   - Conduct & document assessments regularly to reaffirm their homebound status & ongoing need for home health services.

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55H2B Best Practices

1. Use Structured Templates:
   - Develop standardized templates for documenting homebound status to ensure that all necessary details are captured uniformly.
2. Engage in Multi-Disciplinary Collaboration:
   - Collaborate with physicians, nurses, and therapists to ensure comprehensive documentation is cohesive and accurate.
3. Regular Review and Feedback:
   - Implement a process for regular review of documentation with feedback provided to staff members for continued improvement.
4. Patient and Family Education:
   - Educate patients and their families about what constitutes homebound status to ensure accurate reporting of any changes in mobility or capability.
5. Stay Updated on Policies:
   - Stay informed about any changes in Medicare policies regarding home health services and homebound status through CMS updates and bulletins.

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55HTP

55HTP – The initial certification was missing/incomplete/invalid; therefore, the recertification episode was denied.

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Tips for Avoiding 55HTP

1. Ensure Complete Initial Certification:
   - Verify that the initial certification is complete and includes all necessary elements: patient's homebound status, need for skilled services, and a face-to-face encounter with a physician or allowed non-physician practitioner related to the primary reason for home health care.
2. Timely Initial Certification:
   - The initial certification must be obtained and signed by the physician before the start of home health services. Ensure that this certification is on file as it supports future recertifications.
3. Initial Certification Documentation:
   - Documentation should include a clear narrative explaining the medical necessity for home health services.
   - Ensure that the certification is legible and includes the date, provider signature, and all required content.
4. Verify Physician Involvement:
   - The certification must be completed by a physician or NPP, and the required face-to-face encounter must occur within 90 days prior to or 30 days after the start of the home health care.

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55HTP Best Practices
1. Checklist for Certification Requirements:
Use a checklist that covers all elements of the initial certification to verify that nothing is overlooked, ensuring completeness and accuracy.
2. Communication with Physicians:
Establish clear communication channels with certifying physicians to facilitate timely completion and submission of required certifications.
3. Staff Training:
Train home health staff on the importance of initial certifications, what they must include, and the impact of missing or invalid certifications on subsequent episodes.
4. Implement Tracking Systems:
Use electronic systems to track certification status and ensure that initial certifications are completed and filed before the start of home health services. Alerts can help notify staff of upcoming deadlines.
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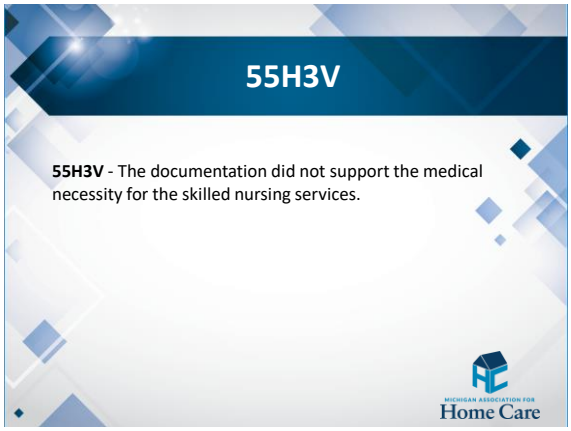
55H3V
55H3V - The documentation did not support the medical necessity for the skilled nursing services.
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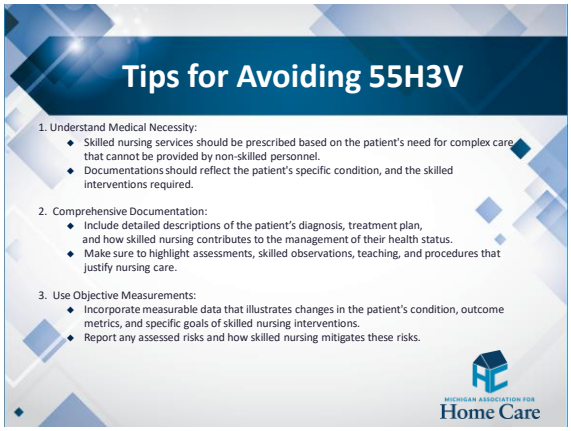
Tips for Avoiding 55H3V
1. Understand Medical Necessity:
Skilled nursing services should be prescribed based on the patient's need for complex care that cannot be provided by non-skilled personnel.
Documentations should reflect the patient's specific condition, and the skilled interventions required.
2. Comprehensive Documentation:
Include detailed descriptions of the patient's diagnosis, treatment plan, and how skilled nursing contributes to the management of their health status.
Make sure to highlight assessments, skilled observations, teaching, and procedures that justify nursing care.
3. Use Objective Measurements:
Incorporate measurable data that illustrates changes in the patient's condition, outcome metrics, and specific goals of skilled nursing interventions.
Report any assessed risks and how skilled nursing mitigates these risks.
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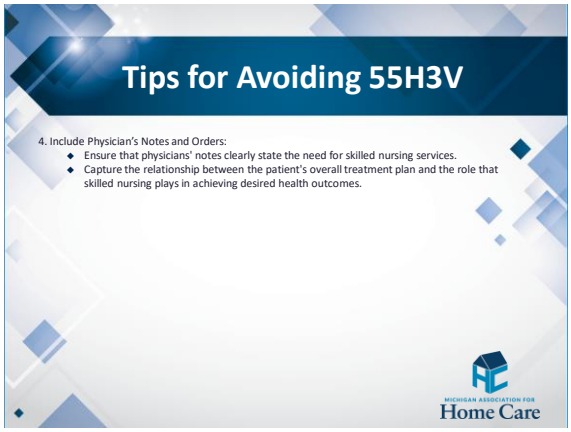
Tips for Avoiding 55H3V
4. Include Physician's Notes and Orders:
Ensure that physicians' notes clearly state the need for skilled nursing services.
Capture the relationship between the patient's overall treatment plan and the role that skilled nursing plays in achieving desired health outcomes.
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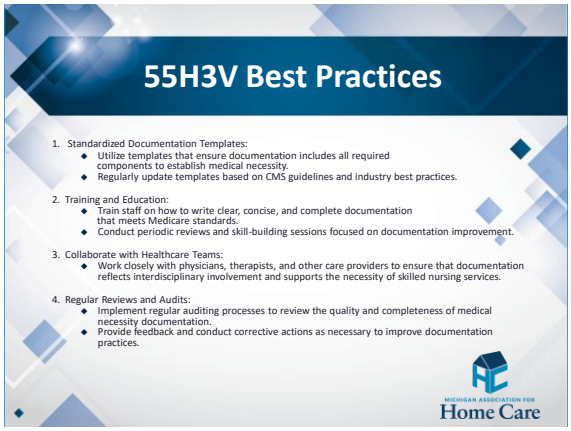
55H3V Best Practices
1. Standardized Documentation Templates:
Utilize templates that ensure documentation includes all required components to establish medical necessity.
Regularly update templates based on CMS guidelines and industry best practices.
2. Training and Education:
Train staff on how to write clear, concise, and complete documentation that meets Medicare standards.
Conduct periodic reviews and skill-building sessions focused on documentation improvement.
3. Collaborate with Healthcare Teams:
Work closely with physicians, therapists, and other care providers to ensure that documentation reflects interdisciplinary involvement and supports the necessity of skilled nursing services.
4. Regular Reviews and Audits:
Implement regular auditing processes to review the quality and completeness of medical necessity documentation.
Provide feedback and conduct corrective actions as necessary to improve documentation practices.
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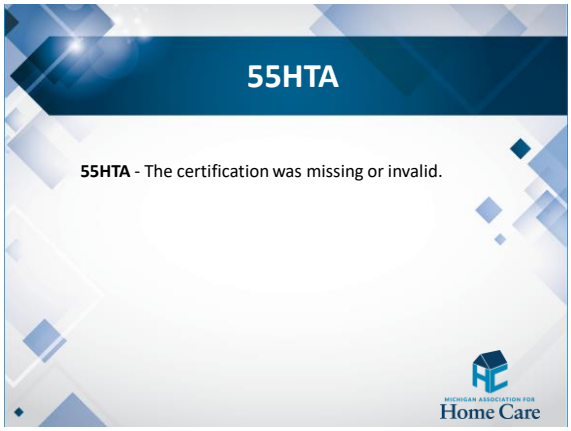
55HTA
55HTA - The certification was missing or invalid.
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55HTA Best Practices

1. Training and Education:
   - Regularly train your staff and collaborating physicians on certification requirements to ensure everyone involved understands what is needed for compliance.
2. Implement Review Processes:
   - Establish an internal review process to check that certifications are complete, signed, and accurate before submitting claims.

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55HTW

55HTW - The physician certification was invalid since the required face-to-face encounter was missing/incomplete/untimely.

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55HTW Best Practices

1. Establish Clear Protocols:
   - Develop and standardize protocols within your agency to track, schedule, and follow up on necessary face-to-face encounters.
   - Implement checklists to verify all required components of the encounter documentation are completed.
2. Staff Training:
   - Regularly train staff on the requirements for valid physician certifications, including the importance of face-to-face encounters.
   - Conduct training sessions for collaborating physicians and NPPs to reinforce their role in completing these encounter requirements.
3. Regular Audits and Feedback:
   - Conduct regular audits on patient records to ensure face-to-face encounters are documented correctly and timely.
   - Provide feedback and re-train staff as necessary to maintain high compliance standards.
4. Streamlined Communication:
   - Set up direct lines of communication between the home health agency, physicians, and hospital discharge planners to ensure all parties are informed of the requirements.
5. Review and Update Processes:
   - Regularly review internal processes in line with any updates from CMS regarding face-to-face encounter requirements.

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Resource Access
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Resources
CMS Internet Only Manual (IOM) Pub. 100-02, Medicare Benefit Policy Manual Chapter 7 – Home Health Services
NGSMedicare.com
NGSConnex
ADR Timeline Calculator
ADR Letters Guide
ADR Quick Reference Guide
Results Letter Information
Provider Contact Center
PECOS Enrollment Chain
Michigan Association for Home Care

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References
CMS Internet Only Manual (IOM) Pub. 100-02, Medicare Benefit Policy Manual Chapter 7 – Home Health Services
42 Code of Federal Regulations (CFR) Section 484 - Home Health Services
Home Health Agency (HHA) Center | CMS
NGSMedicare.com - Job Aids, Webinars, Medicare University Computer Based Training (CBT)
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