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Complete Healthcare Compliance Manual 2024
Post-Acute Care: Home Health

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What Are Home Health Agencies?

Home health agencies (HHAs) provide services in the home of a patient and are covered services under the Medicare program. Many managed care insurance products also cover home health services. State Medicaid programs cover certain types of home health services but at a much lower level of reimbursement. While the premise of providing care in the home of a patient may seem like a simple concept, the Medicare regulations and guidance governing HHAs are complex, which can lead to numerous compliance issues.

Medicare has very specific requirements on how HHAs must be organized, what qualifies as a home health service, and how a patient qualifies for the provision for HHA services. Failure to meet any of these requirements can jeopardize payments made to HHAs under the Medicare program.

Covered Home Health Services

Under Medicare, HHAs are private or public organizations that:

1. Are primarily engaged in providing skilled nursing and other therapeutic services;
2. Have policies established by a group of professional personnel, including one or more physicians and registered nurses, to govern the services provided;
3. Maintain clinical records on all patients;
4. Comply with the licensure laws of states that license HHAs;
5. Have an overall plan and budget in effect; and
6. Meet the HHA Conditions of Participation (CoPs) found at 42 C.F.R. § 484.[3]

Home Health Patient Qualifications and Homebound Status

In order to qualify for home health services under Medicare, the services or items must be provided in a patient's place of residence and be:

1. Part-time or intermittent nursing care provided by or under the supervision of a registered professional nurse
2. Physical or occupational therapy or speech-language pathology services
3. Medical social services under the direction of a physician
4. Part-time or intermittent services of a home health aide who has successfully completed an approved training program

5. Medical supplies, but not drug or other biologicals except for covered osteoporosis drugs
6. Medical services provided by an intern or resident-in-training under a teaching program of the affiliated hospital (if the HHA is affiliated with a hospital)
7. Any of the foregoing items and services that are provided on an outpatient basis, under arrangement made by the HHA, at a hospital or skilled nursing facility, or at a rehabilitation center. The items and services must involve the use of equipment that cannot readily be made available in the patient's home, or that are furnished in a facility while the patient is there to receive any such item or service involving the use of the equipment. Transportation to the facility is not a covered service.[4]

In addition to the qualifying services under Medicare, there are additional qualifications that a patient must meet. These patient qualifications require the patient be:

1. Confined to home.
2. Under the care of a physician or allowed practitioner.
3. Receiving services under a plan of care established and periodically reviewed by a physician or allowed practitioner.
4. Have a continuing need for occupational therapy.[5]

Being confined to home (also called "homebound") in order to qualify for the Medicare home health benefit is not as simple as it might sound. In order to qualify as being confined to home, the patient:

1. Must either be confined to home due to illness or injury and need the aid of supportive devices such as crutches, canes, wheelchairs, and walkers; need the use of special transportation; or need the assistance of another person in order to leave the place of residence; or
2. Have a condition that makes leaving the home medically contraindicated.[6]

If the patient meets one of these two qualifications, the patient must also meet the following two additional criteria. The first criteria is that the patient must have a normal inability to leave the home. The second criteria is that leaving the home must require considerable and taxing effort. Both of these criteria must be met in order for the patient to be considered confined to home.[7] It is also important to note that a patient is not considered confined to home if the patient is residing in a Medicare-certified skilled nursing facility. A patient is considered to be confined to home if the patient is residing in an assisted living facility. While these criteria may seem superficially simple, state and federal regulators often interpret these criteria narrowly or broadly as they see fit. Therefore, it is critical that HHAs have ironclad documentation regarding whether a patient meets the homebound criteria.

The plan of care now may be established, completed, certified, and recertified by an "allowed practitioner" in addition to a physician. Allowed practitioner includes physician assistants, nurse practitioners, or clinical nurse specialists in accordance with state law in the state where the allowed practitioner provides services.[8]

The physician or allowed practitioner must also certify that the patient qualifies for Medicare home health services. The certification must be completed when the Outcome and Assessment Information Set (OASIS) start-of-care assessment is initiated. The physician or allowed practitioner must certify that:

1. "Home health services are or were needed because the patient is or was confined to the home,"

2. "The patient needs or needed skilled nursing services on an intermittent basis…, or physical therapy, or speech-language pathology services;"
3. "A plan of care has been established and is periodically reviewed by a physician *or allowed practitioner*;"
4. "The services are or were furnished while the patient is or was under the care of a physician *or allowed practitioner*;" and
5. A "face-to-face encounter [performed by the physician or allowed practitioner] occurred no more than 90 days prior to or within 30 days after the start of the home health care." (The face-to-face encounter may now be completed via telehealth.)[9]

The face-to-face encounter is considered a condition of payment under the Medicare program. Being a condition of payment means HHAs must pay close attention to the timing and documentation requirements for completing the face-to-face encounter. Failure to timely complete a face-to-face encounter can lead to significant paybacks for claims filed with a faulty face-to-face encounter.

Medicare reimbursement for HHAs is based on a prospective payment system (PPS). On January 1, 2020, Centers for Medicare & Medicaid Services (CMS) implemented a new PPS for HHAs called the Patient-Driven Groupings Model (PDGM). The goal of PDGM was to eliminate therapy as the driver for HHA reimbursement by creating a case-mix reimbursement methodology. Like other Medicare PPS reimbursement methodologies, another goal of PDGM was to create a value-over-volume model of reimbursement that focuses on the total condition of the patient.

One major shift with the implementation of PDGM was movement from 60-day episodes of care to 30-day periods of care. The 30-day period of care bundles all covered home health services, including medical supplies, and is paid on a reasonable-cost basis. The care bundled in the 30-day period of care are:

1. Skilled nursing services
2. Home health aide services
3. Physical therapy
4. Speech-language pathology services
5. Occupational therapy services
6. Medical social services[10]

Services excluded from the 30-day period of care include durable medical equipment, certain injectable osteoporosis drugs, and disposable negative pressure wound devices. These services are paid pursuant to a Medicare fee schedule or are subject to consolidated billing.[11] The 30-day payment period is subject to a case-mix adjustment based on the characteristics and needs of the patient.[12]

The first step under PDGM is to establish an admission source for the patient. Under PDGM, each 30-day period is classified as a community or institutional admission source depending on the healthcare setting used by the patient in the 14 days prior to the HHA admission. The timing of the 30-day period is either considered early or late. The first 30-day period is always considered an early admission. All subsequent 30-day periods are considered late unless there is a gap of more than 60 days between the end of one 30-day period of care and the start of another.[13]

PDGM assigns patients to clinical groups based on the principal diagnosis reported for each 30-day period. There are 12 clinical groups that describe the primary reason for the home health encounter. These clinical groups are:

1. Musculoskeletal rehabilitation
2. Neuro/stroke rehabilitation
3. Wounds, post-op wound aftercare, and skin/nonsurgical wound care
4. Behavioral health care
5. Complex nursing interventions
6. Medication management, teaching, and assessment (MMTA) surgical aftercare
7. MMTA cardiac/circulatory
8. MMTA endocrine
9. MMTA infectious disease/neoplasms/blood-forming diseases
10. MMTA gastrointestinal tract and genitourinary system
11. MMTA respiratory
12. MMTA other[14]

Each 30-day period is then assigned to one of 432 case-mix groups based on the clinical groups set forth above.[15] The 30-day period also has a labor adjustment that is based on the wage index of the geographic area in which the patient resides.[16]

PDGM assigns a functional impairment level to the patient of low, medium, or high based on responses to items on the OASIS. These OASIS items include risk for hospitalization, grooming, ability to dress upper body safely, ability to dress lower body safely, bathing, toilet transferring, and ambulation and locomotion. A comorbidity adjustment of none, low, or medium is then factored in based on certain diagnoses reported on home health claims.[17]

Enforcement and Regulation

Critical focus areas for enforcement include fines, satisfying the rigorous operational and care mandates in the federal regulations, detailed billing and claims filing requirements set forth in Medicare manual guidance, and home health eligibility for Medicare beneficiaries. HHAs have also been the target of the U.S. Department of Justice (DOJ) for instances of healthcare fraud.

CMS has the responsibility for ensuring compliance with the CoPs through surveys conducted by the state survey agencies. The state survey agencies conduct annual surveys of HHAs at least once every 36 months.[18] The state survey agencies also conduct abbreviated surveys of HHAs when there is a complaint allegation. Federal surveyors have the ability to conduct surveys in order to verify the state survey agencies are following federal survey protocols. Federal surveyors will sometimes assist the state survey agencies if the care at the HHA warrants their assistance.

HHAs must comply with the CoPs found at 42 C.F.R. § 484 and were most recently revised in 2017.[19] The interpretive guidelines to the CoPs are found in "Appendix B" of the CMS *State Operations Manual*.[20] The interpretive guidelines, which interpret the CoPs, are a valuable resource for HHAs. The interpretive guidelines are used by state and/or federal surveyors when conducting surveys of HHAs. While the interpretive guidelines can be used by state and/or federal surveyors when surveying HHAs, they do not act as a substitute for the CoPs and cannot be used as the sole basis to cite an HHA.

CMS may impose civil money penalties up to $10,000 per day for violations of the CoPs.[21] Other remedies available to CMS are denials of payment for new or all admissions, installing a temporary manager, and directed plans of correction. CMS also has the authority to terminate HHAs from the Medicare and/or Medicaid programs in as little as 23 days for an immediate jeopardy violation of the CoPs.

In addition to the regulatory authority CMS has over HHAs, many states also license HHAs. States will regulate HHAs pursuant to licensure regulations separate from the CoPs. In some states, the licensure regulations defer to the CoPs or are similar to the CoPs. In other states, the licensure regulations impose requirements that have no connection to the CoPs. HHAs must pay close attention to state licensure regulations. If an HHA loses its state license, it is also automatically terminated from the Medicare and/or Medicaid program.

Recent healthcare fraud schemes involving HHAs have been announced by the DOJ. One DOJ announcement involved a healthcare fraud scheme involving more than $150 million in fraudulent claims.[22] The owner of a home health company orchestrated the fraud by certifying patients as eligible for home health that were not eligible and falsifying medical records in order to cover up the ineligibility.[23] The scheme also provided kickbacks to physicians under the guise of medical director fees to certify patients as eligible for home health.[24]

Another elaborate scheme involved an HHA that employed more than 3,000 home health and personal care aides whereby the HHA would bill for home health aide services that the home health aides claimed to have provided but in reality did not. The DOJ was able to prove that instead of providing home health aide visits, the home health aides in question "stayed home, ran personal errands, vacationed, and socialized with family and friends."[25]

While the vast majority of HHAs provide care in compliance with all state and federal laws, the nature of providing care in the home opens the industry up to healthcare fraud schemes that are not as easy to pull off in other healthcare settings.

The implementation of PDGM has created new compliance issues for HHAs. CMS has committed to closely monitor therapy service use, payment, and quality trends in the course of billing under PDGM. It is extremely important for HHAs to understand that, while therapy is not the reimbursement driver under PDGM (as it was under the prior home health PPS), HHAs are still required to provide all therapy necessary if the resident requires therapy under PDGM. CMS has warned HHAs that "[t]he need for therapy services under PDGM remains unchanged. Therapy provision should be determined by the individual needs of the patient without restriction or limitation on the types of disciplines provided or the frequency or duration of visits."[26]

Another potential compliance issue created by PDGM addresses the request for anticipated payment (RAP). Prior to PDGM, RAPs allowed HHAs to receive a portion of their payment up front. Under PDGM, even though RAPs will be totally eliminated in 2021, HHAs will still be required to file a no-pay RAP. Failure to file a no-pay RAP will result in financial penalties, so HHAs need to address this issue in their claims filing process.

Therapy use and no-pay RAPs are just examples of two of the more significant compliance issues created by

PDGM. Given the complexity of PDGM, HHAs should review their entire claims filing process as part of their HHA compliance program.