
Program Memorandum

Intermediaries

Department of Health and
Human Services (DHHS)
HEALTH CARE FINANCING
ADMINISTRATION (HCFA)

Transmittal A-00-71

Date: OCTOBER 2, 2000

CHANGE REQUEST 1356

SUBJECT: Medical Review (MR) of Home Health Services--For Regional Home Health Intermediaries (RHHIs) Only-Action

A. GENERAL INFORMATION.--To qualify for Medicare coverage of home health services, a beneficiary must be under the care of a physician who establishes the plan of care (POC). The POC must contain specific items as listed in 42 CFR 484.18(a). The POC must be signed and dated by a physician who meets the certification and re-certification requirements and must be signed by the physician before billing for services. The home health agency (HHA) may provide services prior to obtaining the physician's written POC based on documented verbal orders. If care continues beyond the certification period, the HHA must obtain a re-certification from the physician.

1. HCFA Form-485--Home Health Certification and Plan of Care Data Elements

Standardized data collection facilitates accurate coverage decisions, helps to ensure correct payment for covered services and promotes compliance with federal laws and regulations. The HCFA Form-485 (the Home Health Certification and Plan of Care) meets regulatory and national survey requirements for the physician's POC, certification and recertification. HCFA Form-485 provides a convenient way to submit a signed and dated POC, however, HHAs may submit any document that is signed and dated by the physician that contains all of the required components of the POC as described below. The signed POC is maintained in the beneficiary's medical record at the HHA with a copy of the signed POC available upon request when needed for MR. Providers may submit the POC electronically if acceptable to the (RHHI). HHAs are required to obtain a signed POC as soon as practical after the start of care and prior to submitting the claim.

The following items are contained on the HCFA Form-485:

No.	Data Element	Description:
1	Patient's HICN	The HICN (numeric plus alpha indicator(s)) as shown on the patient's health insurance card, certificate award, utilization notice, temporary eligibility notice, or as reported by the SSO.
2	Start of Care (SOC) Date	The HHA enters the month, day, year on which covered home health services began, i.e., MMDDYYYY (03012000). The SOC date is the first Medicare billable visit. This date remains the same on subsequent plans of care until the patient is discharged. Home health may be suspended and later resumed under the same SOC date in accordance with the HHA's internal procedures.

HCFA-Pub. 60A

- 3 Certification Period
- a. For Dates of Service before the effective date of the home health prospective payment system (HHPPS) (October 1, 2000): The
 - b. HHA enters the month, day, year, e.g., MMDDYYYY that identifies the period covered by the physician's POC. The "From" date for the initial certification must match the SOC date. The "To" date can be up to, but never exceed 2 calendar months and, mathematically, never exceed 62 days. The "To" date is repeated on a subsequent re-certification as the next sequential "From" date. Services delivered on the "To" date are covered in the next certification period.

EXAMPLE: Initial certification "From" date 03012000; Initial certification "To" date 05012000; Re-certification "From" date 05012000; Re-certification "To" date 07012000.

- c. For Dates of Service on or after the effective date of HH PPS (October 1, 2000): The HHA enters the month, day, year, e.g., MMDDYYYY that identifies the period covered by the physician's POC. The "From" date for the initial certification must match the SOC date. The "To" date is up to and including the last day of the episode which is not the first day of the subsequent episode. The "To" date can be up to, but never exceed a total of 60 days that includes the SOC date plus 59 days.

EXAMPLE: Initial certification "From" date 10012000; Initial certification "To" date 11292000; Re-certification "From" date 11302000; Re-certification "To" date 01282001.

NOTE: Services delivered on 11292000 are covered in the initial certification episode.

- 4 Medical Record No. This is the patient's medical record number that is assigned by the HHA and is an optional item. If not applicable, the agency enters "N/A."
- 5 Provider No. This is the 6 digit number issued by Medicare to the HHA. It contains 2 digits, a hyphen, and 4 digits (e.g., 00-7000).
- 6 Patient's Name and Address The HHA enters the patient's last name, first name, and middle initial as shown on the health insurance card and the street address, city, State, and ZIP code.
- 7 Provider's Name, Address and The HHA enters its name and/or branch office (if appropriate), street address (or other legal address), city, State and ZIP code and

	Telephone No	telephone number.
8	Date of Birth	The patient's date of birth (month, day, year) in numbers, i.e., MMDDYYYY (04031920) is entered.
9	Sex	The patient's sex is checked in the appropriate box.
10	Medications: Dose, Frequency, Route	The physician's orders for all medications including the dosage, frequency and route of administration for each drug must be listed.
11	Principal Diagnosis, ICD-9-CM Code and Date of Onset, Exacerbation	The principal diagnosis is the diagnosis most related to the current POC. The diagnosis may or may not be related to the patient's most recent hospital stay, but must relate to the services rendered by the HHA. If more than one diagnosis is treated concurrently, the diagnosis that represents the most acute condition and requires the most intensive services should be entered. The ICD-9-CM guidelines dictate that certain specific principle diagnoses are only to be used when a specific secondary diagnosis is present.

Using the ICD-9-CM coding guidelines, the HHA enters the appropriate ICD-9-CM code for the principal diagnosis in the space provided. The code is the full ICD-9-CM diagnosis code including all digits. Prior to the effective date of HHPPS, V codes are acceptable as principle and secondary diagnoses. In many instances, the V code more accurately reflects the care provided. However, the V code should not be used when the acute diagnosis code is more specific to the exact nature of the patient's condition. After the implementation of HHPPS, the principle diagnosis must match on the physician certified POC, the Outcome and Assessment Information Set (OASIS) and the Uniform Billing Form-92 (UB-92). In addition, V codes are NOT acceptable as principle or first secondary diagnoses but could be recorded in item 21 entitled Orders for Discipline and Treatments. The ICD-9-CM coding guidelines should be followed in assigning an appropriate V code.

EXAMPLES: (Prior to the effective date of HHPPS) 1) Patient is surgically treated for a subtrochanteric fracture (code 820.22). Admission to home care is for rehabilitation services (V57.1). The HHA uses 820.22 as the principle diagnosis since V57.1 does not specify the type or location of the fracture.

2) Patient is surgically treated for a malignant neoplasm of the descending colon (code 153.2) with exteriorization of the colon. Admission to home care is for instruction in care of colostomy (V55.3). The HHA uses V55.3 as the primary diagnosis since it is more specific to the nature of the proposed services.

EXAMPLES: (After the effective date of HHPPS) 1) Patient is surgically treated for a subtrochanteric fracture (code 820.22). Admission to home care is for rehabilitation

services (V57.1). The HHA uses 820.22 as the primary diagnosis and may enter V57.1 as a second secondary diagnosis or in field 21.

2) Patient is surgically treated for a malignant neoplasm of the descending colon (code 153.2) with exteriorization of the colon. Admission to home care is for instruction in care of colostomy (V55.3). Even though V55.3 is more specific to the nature of the proposed service, the HHA must use code 153.2 as the principle diagnosis and may use V55.3 as a second secondary diagnosis or in field 21.

The principal diagnosis may change on subsequent forms only if the patient develops an acute condition or an exacerbation of a secondary diagnosis requiring intensive services different than those on the established POC.

The medical diagnostic term is listed next to the ICD-9-CM code. The date reflects either the date of onset, if it is a new diagnosis, or the date of the most recent exacerbation of a previous diagnosis. If the exact day is not known, the HHA uses 00 for the day.

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| 12 | Surgical Procedure, Date, ICD-9-CM Code | The surgical procedure relevant to the care being rendered is entered. For example, if the diagnosis in Item 11 is "Fractured Left Hip," the ICD-9-CM Code, the surgical procedure and date are noted (e.g., 81.52, Partial Hip Replacement, 060998). |
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If a surgical procedure was not performed or is not relevant to the POC, N/A is inserted. The addendum is used for additional relevant surgical procedures. At a minimum, the month and year must be present for date of surgery.

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| 13 | Other Pertinent Diagnoses: Dates of Onset/ Exacerbation, ICD-9-CM Code | Enter all pertinent diagnoses, both narrative and ICD-9-CM codes, relevant to the care rendered. Other pertinent diagnoses are all conditions that coexisted at the time the POC was established, or which developed subsequently, or that affect the treatment of care. Exclude diagnoses that relate to an earlier episode which have no bearing on this POC. |
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These diagnoses can be changed to reflect changes in the patient's condition however, they must match the diagnoses listed on the OASIS and the UB-92 and conform with the ICD-9-CM coding guidelines.

In listing the diagnoses, place them in order to best reflect the seriousness of the patient's condition and to justify the disciplines and services provided. However, there may be exceptions to this rule, dictated by ICD-9-CM coding sequencing requirements. For example, if a principle diagnosis exists which dictates the utilization of a specific secondary diagnosis, then the agency should list this secondary diagnosis first in the list of "other pertinent diagnoses". If there are more than four pertinent secondary diagnoses, use an addendum to list them. Enter N/A if there are no pertinent diagnoses.

The date reflects either the date of onset if it is a new diagnosis or the date of the most recent exacerbation of a previous diagnosis. Note that the date of onset or exacerbation must be as close to the actual date as possible. If the date is unknown, note the year and place 00s in the month or day if not known.

- 14 DME and Supplies All non-routine supplies must be specifically ordered by the physician or the physician's order for services must require use of the specific supplies. The HHA enters in this item non-routine supplies that are not specifically required by the order for services. For example, an order for foley insertion requires specific supplies, i.e., foley, catheter tray. Therefore, these supplies are not required to be listed. Conversely, an order for wound care may require use of non-routine supplies which would vary by patient. Therefore, the non-routine supplies would be listed.

If the HHA lists a commonly used commercially packaged kit, it is not required to list the individual components. However, if there is a question of cost or content, the RHHI can request a breakdown of kit components.

RHHIs should reference the HIM 11, §206.4 for a definition of non-routine supplies.

The HHA also lists DME ordered by the physician that will be billed to Medicare. The HHA enters N/A if no supplies or DME are billed.

- 15 Safety Measures The physician's instructions for safety measures are listed.
- 16 Nutritional Requirements The HHA enters the physician's orders for the diet. This includes specific therapeutic diets and/or any specific dietary requirements. Fluid needs or restrictions are recorded. Total parenteral nutrition (TPN) can be listed under this item or under medications if more space is needed.
- 17 Allergies Medications to which the patient is allergic are listed. In addition, other allergies the patient experiences (e.g., foods, adhesive tape, iodine) are included.
- 18A Functional Limitations All items that describe the patient's current limitations as assessed by the physician and the agency are indicated.
- 18B Activities Permitted The activity(ies) that the physician allows and/or for which physician orders are present are indicated.

If "Other" is checked under Item 18A or 18B, a narrative explanation is required.

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| 19 | Mental Status | The block(s) most appropriate to describe the patient's mental status is checked. If "Other" is checked, the patient's condition is specified here. |
| 20 | Prognosis | A check is placed in the box which specifies the most appropriate prognosis for the patient; poor, guarded, fair, good or excellent. |

NOTE: The number or letter adjacent to the blocks in Items 18 through 20 correspond to the codes for EMC transmission only.

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| 21 | Orders for Discipline and Treatments (Specify Amount, Frequency, Duration) | The physician must specify the frequency and the expected duration of the visits for each discipline. The duties/treatments to be performed by each discipline must be stated. A discipline may be one or more of the following: SN, PT, ST, OT, MSS, or AIDE. |
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Orders must include all disciplines and treatments, even if they are not billable to Medicare. In general, the narrative explanation for applicable treatment codes is acceptable as the order when that narrative is sufficiently descriptive of the services to be furnished. However, additional explanation is required in this item to describe specific services, i.e., A1, A4, A5, A6, A7, A22, A23, A28, A29, A32, B15, C9, D11, E4, E6, and F15. Additional explanation is also required where the physician has ordered specific treatment, medications, or supplies. When aide services are needed to furnish personal care, an order for "personal care" is sufficient. See example of orders below.

Frequency denotes the number of visits per discipline to be rendered, stated in days, weeks, or months. Duration identifies the length of time the services are to be rendered and may be expressed in days, weeks, or months.

A range of visits may be reflected in the frequency (e.g., 2 to 4 visits per week). When a range is used, consider the upper limit of the range the specific frequency. An agency may use ranges if acceptable to the physician without regard to diagnosis or other limits.

Example of Physician's Orders: Certification period is from 03012000 - 05012000:

OT- Eval., Activities of Daily Living (ADL) training, fine motor coordination 3x/wk x 6wks

ST- Eval., speech articulation disorder treatment 3x/wk x 4wks

SN- Skilled observation and assessment of C/P and neuro status instruct meds and diet/hydration 3x/wk x 2wks

MSS-Assessment of emotional and social factors 1x/mo x 2mos

AIDE-Assist with personal care, catheter care 3x/wk x 9wks

Specific services rendered by physical, speech, and occupational therapists may involve different modalities. The "AMOUNT" is necessary when a discipline is providing a specific modality for therapy. Modalities usually mentioned are heat, sound, cold, and electronic stimulation.

EXAMPLE: PT - To apply hot packs to the C5-C6 x 10 minutes 3x/wk x 2wks.

PRN visits may be ordered on a POC only where they are qualified in a manner that is specific to the patient's potential needs. Both the nature of the services and the number of PRN visits to be permitted for each type of service is specified in the POC. Open-ended, unqualified PRN visits do not constitute physician orders for patient care since neither the nature, nor the frequency of the service is specified.

EXAMPLE: Skilled nursing visits 1xm x 2m for Foley change and PRN x 2 for emergency Foley irrigation and/or changes.

22	Goals and Rehabilitation Potential/ Discharge Plans	This reflects the physician's description of the achievable goals and the patient's ability to meet them as well as plans for care after discharge.
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Examples of realistic goals:

- Independence in transfers and ambulating with walker;
- Healing of leg ulcer(s);
- Maintain patency of Foley catheter. Decrease risk of urinary infection;
- Achieve optimal level of cardiovascular status. Medication and diet compliance; and
- Ability to demonstrate correct insulin preparation/administration.

Rehabilitation potential addresses the patient's ability to attain the goals and an estimate of the time needed to achieve them. This information should be pertinent to the nature of the patient's condition and ability to respond. The words "Fair" or "Poor" alone, are not acceptable. Instead, descriptors must be added:

EXAMPLE: Rehabilitation potential is good for partial return to previous level of care, but patient will probably not be able to perform ADL independently.

Where daily care has been ordered, the agency must be specific as to the goals and when the need for daily care is expected to end. Discharge plans include a statement of where or how the patient will be cared for once home health services are no longer provided.

- 23 Nurse's Signature and Date of Verbal SOC This verifies for surveyors, HCFA's representatives, and the RHHI that a registered nurse, qualified therapist (i.e., physical therapist, speech-language pathologist, occupational therapist, or medical social worker), or any health professional responsible for furnishing or supervising the patient's care, spoke to the attending physician and received verbal authorization to visit the patient. This date may precede the SOC date in Item 2 and may precede the "From" date in Item 3.

This field may be used to document receipt of verbal orders when services are furnished prior to the physician's written orders on SOC or re-certification. If this field is used, the order must be written on HCFA Form-485 and signed and dated with the date of receipt by the nurse, therapist, social worker, or qualified health professional to begin or modify care or continue care at re-certification.

This item is signed by the nurse, qualified therapist, social worker, or health professional responsible for the completion of HCFA Form-485, or by non-clerical personnel authorized to do so by applicable State and Federal laws and regulation, as well as by the HHA's internal policies. The HHA enters N/A if the physician has signed and dated HCFA Form-485 on or before the SOC or re-certification date, or has submitted a written order to start, modify, or continue care on a document other than HCFA Form-485.

- 24 Physician's Name and Address The agency prints the physician's name and address. The attending physician is the physician who established the POC and who certifies and re-certifies the medical necessity of the home health visits and/or services. Supplemental physicians involved in a patient's care are mentioned on the addendum only. The physician must be qualified to sign the certification and POC in accordance with 42 CFR 424 Subpart B. Physicians who have significant ownership interest in, or a significant financial or contractual relationship with an HHA may not establish or review a plan of treatment or certify or re-certify the need for home health services.
- 25 Date HHA Received Signed POC The date the agency received the signed POC from the attending/referring physician is entered. It is required only if the physician does not date Item 27. The agency enters N/A if Item 27 date is completed.
- 26 Physician Certification This statement serves to verify that the physician has reviewed the POC and certifies to the need for the services.
- 27 Attending Physician's Signature and Date The attending physician signs and dates the POC/certification prior to the claim being submitted for payment; rubber signature stamps are not acceptable. The form may be signed by another physician

who is authorized by the attending physician to care for his/her patients in his/her absence. While the regulations specify that documents must be signed, they do not prohibit the transmission of the POC or oral order via facsimile machine. The HHA is not required to have the original signature on file. However, the HHA is responsible for obtaining original signatures if an issue surfaces that would require verification of an original signature. HHAs which maintain patient records by computer rather than hard copy may use electronic signatures. However, all such entries must be appropriately authenticated and dated. Authentication must include signatures, written initials, or computer secure entry by a unique identifier of a primary author who has reviewed and approved the entry. The HHA must have safeguards to prevent unauthorized access to the records and a process for reconstruction of the records upon request from the intermediary, state surveyor, or other authorized personnel, or in the event of a system breakdown.

The agency should not predate the orders for the physician, nor write the date in this field. If the physician left it blank, the agency should enter the date it received the signed POC under Item 25. An unsigned copy is submitted to you with the signed copy retained in the agency's files.

28 Penalty Statement This statement specifies the penalties imposed for misrepresentation, falsification, or concealment of essential information on the HCFA Form-485.

2. Addendum to HCFA Form-485--Plan of Care

When additional space is needed to complete HCFA Form-485 fields, HHAs use an addendum signed by the physician.

3. MR of Home Health Claims with Dates of Service before October 1, 2000

In reviewing the POC and/or other medical information, the RHHI makes a MR determination on the entire certification period or beyond if services are continued. If the RHHI determines that services are non-covered from the SOC or at some point during the billing period, the RHHI must ensure the appropriate controls are in place so that subsequent claims are suspended for appropriate action.

RHHIs may deny visits/services based upon information provided on the POC. However, additional information or a copy of the medical record must be requested when objective clinical evidence needed to support a decision is not clearly present. (See MIM §3116.1.) RHHIs do not deny claims because a field on the HCFA Form-485 has not been completed. If the missing information is needed to make a coverage determination, it must be requested. When requesting additional documentation

for MR purposes, notify providers that the requested documentation is to be submitted to the RHHI within 30 days of the request. However, if the documentation needed to make a MR determination is not received within 45 days from the date of the documentation request, make a MR determination based on the available medical documentation. Do not return the claim to the provider. If the claim is denied, deny payment or collect the overpayment. Follow the procedures below when conducting MR.

- Missing or Incomplete Physician's Orders
 - Visits for a discipline are billed but there is no physician order, or the physician order is present but is not specific, or there is no frequency. RHHIs request a copy of the physician's order for the services. RHHIs accept a documented verbal order or signed written order (see below for acceptable verbal orders). Do not accept orders signed after the service(s) is rendered unless there is evidence of a pre-existing verbal order. If the agency is furnishing services without a physician's order, deny the services. RHHIs advise the HHA that the findings will be reported for possible referral to the State survey office.
- Physician's order for discipline and frequency is present but there is no duration of visits.
 - RHHIs make a medical necessity determination on the duration billed.
- Agency provides fewer visits than the physician orders.
 - RHHIs do not deny claims because the agency provides fewer visits than ordered. The agency should be reporting decreases in visits to the physician. Where an agency is consistently decreasing visits without reporting to the physician, notify the RO so that the State survey office can be advised.
- Documentation of physician's verbal orders. Accept any of the following:
 - Receipt of verbal orders is identified by the signature of a registered nurse, qualified therapist (i.e., physical therapist, speech language pathologist, occupational therapist, or medical social worker), or any other health professional responsible for furnishing or supervising the patient's care and the date in Item 23 of HCFA Form-485, and the form is signed by the physician;
 - The POC is signed by the physician and contains the verbal order(s) which has been written, signed, and dated in the clinical record;
 - The form on which the verbal order is written, signed, and dated by agency staff is countersigned by the physician; or
 - A document signed by the physician contains the written, signed, and dated verbal order in the clinical record.

There are no required forms or format for documentation or confirmation of verbal orders. In the absence of documentation of verbal orders, RHHIs accept a notarized statement from the physician that he/she gave verbal orders before the services were rendered.

4. Medical Review of HH PPS Claims (Date of Service on or After 10/1/2000)

a. General--RHHIs are to conduct MR of Medicare HHPPS claims focusing efforts at areas that affect payment. Once it is established that the episode met Medicare coverage requirements and was billed appropriately, it may not be necessary to continue review of the record. The goal of MR is to determine whether services provided are reasonable and necessary, delivered and coded correctly, and appropriately documented. Some of the terminology used to describe MR will change with the HHPPS. For example, in a cost-based system, prepayment MR means MR conducted prior to making a payment. Postpayment MR means MR conducted after making a payment. Under the HHPPS, most MR will be conducted after an initial payment is made (e.g. request for anticipated payment (RAP)) but before payment of the claim. MR will not be conducted on the RAPs. RHHIs must follow the prescribed workload requirements found in the annual budget performance requirements (BPRs).

b. Types of Review--Review conducted prior to payment of the claim is called "pre-claim review." Medical review may also be conducted following payment of the claim. This type of review is called "post-claim review". For fiscal year 2001, MR will be conducted primarily on a pre-claim targeted basis. Targeted review may also be conducted on a post-claim basis if data analysis supports review. HCFA recognizes the value of random review in identifying normal practice patterns, aberrancies, and potential vulnerabilities under the PPS. Random MR of HHPPS claims should be conducted primarily on a post-claim basis until implementation of the Comprehensive Error Rate Testing (CERT) program or until further instructions are issued by HCFA.

c. MR Process--MR should be conducted after validating provider/service specific billing errors. Consider the principles of Progressive Corrective Action (PCA) when conducting MR (see Change Request 1285 "Medical Review--Progressive Corrective Action" dated August 7, 2000).

d. Claim Selection--Targeted review should focus on specific program vulnerabilities inherent in the PPS until data analysis identifies provider/service specific problems. Providers with high error rates, newly participating providers, referrals from state survey agencies, other HCFA reviews, etc. may also be targeted for medical review. It may be appropriate to flag subsequent claims when full or partial denials of previous beneficiary specific episodes have been made.

e. Record Request--RHHIs must request documentation necessary to make a MR determination. The requested documentation may include, but is not limited to, physician

orders and progress notes; patient care plans; the comprehensive assessment; the OASIS; nursing and rehabilitation therapy notes; treatment and flow charts and vital sign records, weight charts and medication records; discharge summary notice; and other home health medical record documentation. We expect that review of the bill (UB-92) alone would not provide sufficient information to make a MR determination. When requesting additional documentation for MR purposes, notify providers that the requested documentation is to be submitted to the contractor within 30 days of the request.

f. Record Review--For all selected claims, review medical documentation and determine whether the services provided were covered. Concentrate review of the record on the reason why the claim was selected for review. For example, if data analysis indicates a provider is aberrant (as compared to peers) in billing a particular home health resource group (HHRG), MR may be limited to ensuring the correct HHRG is billed. If data analysis indicates a provider consistently provides just enough visits during the 60 day episode to meet or exceed the low utilization payment adjustment (LUPA) or therapy thresholds, MR should focus review efforts on these areas. More extensive review of the claim may not be an efficient use of MR resources. If the documentation needed to make a MR determination is not received within 45 days from the date of the documentation request, make a MR determination based on the available medical documentation. Do not return the claim to the provider (RTP).

In order to be covered, a service must meet all three of the following criteria:

- Beneficiaries must continue to meet the home health eligibility requirements as described in MIM §3117 (e.g., whether the beneficiary is under a POC established and approved by a physician, under the care of a physician, confined to the home, and in need of skilled intermittent services).
- The services must not be statutorily excluded. Determine whether the services are excluded from coverage under any provision in §1862(a) of The Act other than §1862(a)(1)(A).
- Services are Reasonable and Necessary. Determine whether the services are reasonable and necessary under §1862(a)(1) of The Act.

NOTE: Once it is established that the episode met Medicare coverage requirements and was billed appropriately, it may not be necessary to continue review of the record.

g. Outcome of Review--If MR determines that the coverage criteria were not met at the beginning of the episode, deny the entire episode. If MR determines a beneficiary or services provided do not meet the coverage criteria at some point during the episode, disallow the services provided once the coverage criteria are not met. If by disallowing those services, the LUPA or therapy thresholds are not met, adjust the claim accordingly.

When data analysis indicates a need to look closely at the HHRG billed, review the OASIS information and other medical documentation in the beneficiary's medical record. If

documentation in the medical record conflicts with any OASIS data elements that impact the payment rate (e.g., diagnosis on OASIS and UB-92 are not supported by the POC or other medical record documentation) change the conflicting OASIS data elements. If a new HHRG is assigned, adjust the claim with the new HHRG for correct payment. If as a result of MR, the payment made is less than the payment billed, the difference is considered a partial denial.

If during a review it is determined that a HHA does not comply with the conditions of participation, do not deny payment solely for this reason. Refer to the applicable state survey agency.

If it is determined that services are provided without physician orders, disallow the services, adjust the claim if the disallowed services affect the LUPA or therapy thresholds, and refer any under-service issues to the applicable state survey agency.

If it is determined that any of the services billed were not furnished, disallow the services that were not furnished. If when disallowed, the claim results in classification to a lower HHRG category or LUPA, adjust the claim accordingly. If fraudulent billing practices are suspected, refer to your Fraud Unit. See Chapter 4 of the Program Integrity Manual (PIM) regarding actions to be taken when there is suspected fraudulent billing.

h. Data Analysis--Use data analysis as a tool in identifying target areas for MR according to the guidelines in Chapter 2 of the PIM. RHHIs should conduct data analysis of PPS claims, consider data from other sources (PROs, carriers, Medicaid) and referrals from internal or external sources (e.g., provider audit, fraud and abuse units, beneficiary or other complaints) to ensure efficient targeting of MR efforts where there is the greatest risk to the Medicare trust funds.

5. Medicare Integrity Program – Provider Education and Training (MIP-PET)

The HHPPS is a new payment methodology. Education is key to ensure proper billing. As billing problems are identified, RHHIs should not only educate the individual providers of problems, but also the home health community about the common billing problems identified through MR. This education should be as interactive as possible. RHHIs should be proactive in using the results of MR to educate providers and prevent future errors. The costs associated with these activities are to be budgeted and charged to the MIP-PET CAFM2 code 24001.

6. Medical Review of Skilled Nursing and Home Health Aide Hours for Determining Part-Time or Intermittent Care

The RHHI requests medical documentation when it suspects that care is not part-time or intermittent care and makes decisions based on the documentation. They:

- Request entrance and exit times of SN and aide visits;
- Review hours spent in the home in accordance with MIM §3119.7;

- For part-time care, approve medically necessary visits beginning before the 35th hour a week and before the 8th hour a day;
- For intermittent care, approve medically necessary visits beginning before the 35th hour of a week or approve medically necessary daily full-time care, up to and including 8 hours per day for finite and predictable periods. The 8 hours a day limit does not apply if the RHHI is approving less than daily care.
- Do not make a decision that covered care could be accomplished in fewer hours if visits are determined to be covered and services are part-time or intermittent.

7. Treatment Codes for Home Health Services

The agency may use the narrative explanation for the treatment codes which represent the services to be furnished. The narrative is entered in Item 21 of the HCFA Form-485. Additional narrative is required under Item 21 of the HCFA Form-485 to describe specific services, e.g., A1, A4, A5, A6, A7, A22, A23, A28, A29, A32, B15, C9, D11, E4, E6, and F15. (See asterisked items/services as follows). Non-asterisked items/services do not require additional narrative unless the physician has ordered specific treatment and/or use of prescription medications and/or non-routine supplies. Listing of a code for a particular service is not intended to imply coverage. The codes are to ease identification of services ordered by the physician whether or not these services are payable individually by Medicare. Physician's orders reflect a narrative description of treatment and services to be furnished.

A--Skilled Nursing

These represent the services to be performed by the nurse. Services performed by the patient or other person in the home without the teaching or supervision of the nurse are not coded. The following is a further explanation for each service:

A1 *	Skilled Observation and Assessment (Inc. V.S., Response to Med., etc)	Includes all skilled observation and assessment of the patient where the physician determines that the patient's condition is such that a reasonable probability exists that significant changes may occur which require the skills of a licensed nurse to supplement the physician's personal contacts with the patient. (See §3117.4.A.)
A2	Foley Insertion	Insertion and/or removal of the Foley catheter by nurse.
A3	Bladder Instillation	Instilling medications into the bladder.
A4*	Open Wound Care/Dressing	Includes irrigation of open, postsurgical wounds, application of medication and/or dressing changes. Does not include decubitus care. Describe dimension of

		wound (size and amount and type of drainage) on an addendum when necessary. See A28 for observation uncomplicated surgical incision.
A5*	Decubitus Care (Partial tissue loss with signs of infection or full thickness tissue loss, etc.)	Includes irrigation, application of medication and/or dressing changes to decubitus. The agency describes size (depth and width) and appearance on an addendum when necessary. Use this code only if the decubitus being treated presents the following characteristics: 1 -- Partial tissue loss with signs of infection such as foul odor or purulent drainage; 2 -- Full thickness tissue loss that involves exposure of fat or invasion of other tissue such as muscle or bone. For care of decubitus not meeting this definition, see A29.
A6*	Venipuncture	The HHA specifies the test and frequency to be performed under physician's orders.
A7*	Restorative Nursing	Includes exercises, transfer training, carrying out of restorative program ordered by the physician. This may or may not be established by a physical therapist. This code is not used to describe non-skilled services (e.g., routine range of motion exercises).
A8	Post Cataract Care	Includes observation, dressings, teaching, etc., of the immediate postoperative cataract patient. (See MIM §3117.4.A.)
A9	Bowel/Bladder Training	Includes training of patients who have neurological or muscular problems or other conditions where the need for bowel or bladder training is clearly identified. (See MIM §3114.4.E.1.)
A10	Chest Physio (Inc. postural drainage)	Includes breathing exercises, postural drainage, chest percussion, conservation techniques, etc.
A11	Adm. Of Vitamin B/12	Administration of vitamin B-12 preparation by injection for conditions identified in Medicare guidelines. (See MIM §3117.4.)
A12	Adm. Insulin	Preparation of insulin syringes for

A13	Adm. Other IM/Subq	administration by the patient or other person, or the administration by the nurse. Administration of any injection other than vitamin B/12 or insulin ordered by the physician.
A14	Adm. IVs/ Clysis	Administration of intravenous fluids or clysis or intravenous medications.
A15	Teach Ostomy or Ileo conduit care	Teaching the patient or other person to care for a colostomy, ileostomy or ileoconduit or nephrostomy.
A16	Teach Nasogastric Feeding	Teaching the patient or other person to administer nasogastric feedings. Includes teaching care of equipment and preparation of feedings.
A17	Reinsertion Nasogastric	Includes changing the tube by the nurse.
A18	Teach Gastrostomy Feeding	Teaching the patient or other person to care for gastrostomy and administer feedings. Includes teaching care of equipment and preparation of feedings.
A19	Teach Parenteral Nutrition	Teaching the patient and/or family to administer parenteral nutrition. Includes teaching aseptic technique for dressing changes to catheter site. Agency documentation must specify that this service is necessary and does not duplicate other teaching.
A20	Teach Care of Trach	Teaching the patient or other person to care for a tracheostomy. This includes care of equipment.
A21	Adm. Care of Trach	Administration of tracheostomy care by the nurse, including changing the tracheostomy tube and care of the equipment.
A22	Teach Inhalation Rx.	Teaching patient or other person to administer therapy and care for equipment.
A23*	Adm. Inhalation Rx	Administration of inhalation treatment and care of equipment by the nurse.
A24	Teach Adm. of Injection	Teaching patient or other person to administer an injection. Does not include the administration of the injection by the nurse (see A11, A13) or the teaching/administration of insulin. (See A12, A25.)

A25	Teach Diabetic Care	Includes all teaching of the diabetic patient (i.e., diet, skin care, administration of insulin, urine testing).
A26	Disimpaction/F.U. Enema	Includes nursing services associated with removal of an impaction. Enema administration in the absence of an impaction only if a complex condition exists - e.g., immediate postoperative rectal surgery.
A27*	Other (Spec. under Orders)	Includes any SN or teaching ordered by the physician and not identified above. The agency specifies what is being taught in Item 21 (HCFA Form-485).
A28*	Wound Care/Dressing – Closed Incision/Suture Line	Skilled observation and care of surgical incision/suture line including application of DSD. (See A4.)
A29*	Decubitus Care	Includes irrigation, application of medication and/or dressing changes to decubitus/other skin ulcer or lesion, other than that described in A5. The HHA describes size (depth and width) and appearance on the addendum.
A30	Teach Care of Any Indwelling Catheter	Teaching patient or other person to care for indwelling catheter.
A31	Management and Evaluation of Patient Care Plan	The complexity of necessary unskilled services require skilled management of a registered nurse to ensure that these services achieve their purpose, and to promote the beneficiary's recovery and medical safety.
A32*	Teaching and Training (other) (spec. under Orders)	Specify under physician orders.

* Code which requires a more extensive descriptive narrative for physician's orders.

B--Physical Therapy (PT)

These codes represent all services to be performed by the physical therapist. If services are provided by a nurse, they are included under A7. The following is a further explanation of each service:

B1	Evaluation	Visit(s) made to determine the patient's condition, physical therapy plans and rehabilitation potential; to evaluate the home environment to eliminate structural
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				barriers and to improve safety to increase functional independence (ramps, adaptive wheelchair, bathroom aides).
B2	Therapeutic Exercise			Exercises designed to restore function. Specific exercise techniques (e.g. Rood, Proprioceptive Neuromuscular Facilitation (PNF), Codman's, William's, Brunstrom, are specified. The exercise treatment is listed in the medical record specific to the patient's condition, manual therapy techniques which include soft tissue and joint mobilization to reduce joint deformity and increase functional range of motion.
B3	Transfer Training			To evaluate and instruct safe transfers (bed, bath, toilet, sofa, chair, commode) using appropriate body mechanics, and equipment (sliding board, Hoyer lift, trapeze, bath bench, wheelchair). Instruct patient, family and care-givers in appropriate transfer techniques.
B4	Establish or Upgrade Program	Home		To improve the patient's functional level by instruction to the patient and responsible individuals in exercise which may be used as an adjunct to PT programs.
B5	Gait Training			Includes gait evaluation and ambulation training of a patient whose ability to walk has been impaired. Gait training is the selection and instruction in use of various assistive devices (orthotic appliances, crutches, walker, cane, etc.).
B6	Pulmonary Physical Therapy			Includes breathing exercises, postural drainage, etc., for patients with acute or severe pulmonary dysfunction.
B7	Ultra Sound			Mechanism to produce heat or micro-massage in deep tissues for conditions in which relief of pain, increase in circulation and increase in local metabolic activity are desirable.
B8	Electro Therapy			Includes treatment for neuromuscular dysfunction and pain through use of electrotherapeutic devices (biofeedback, electromuscular stimulation, TENS,

		Functional Electrical Stimulation (FES), High Voltage Galvanic Stimulation (HVGS), etc.).
B9	Prosthetic Training	Includes stump conditioning, (shrinking, shaping, etc.), range of motion, muscle strengthening and gait training with or without the prosthesis and appropriate assistive devices.
B10	Fabrication Temporary Devices	Includes fabrication of temporary prostheses, braces, splints, and slings.
B11	Muscle Reeducation	Includes therapy designed to restore function due to illness, disease, or surgery affecting neuromuscular function.
B12	Management and Evaluation of a Patient Care Plan	The complexity of necessary unskilled services require skilled management by a qualified physical therapist to ensure that these services achieve their purpose, and to promote the beneficiary's recovery and medical safety.
B13	Reserved	
B14	Reserved	
B15	Other (Spec. under Orders)	Includes all PT services not identified above. Specific therapy services are identified under physician's orders (HCFA Form-485 Item 21).

* Code which requires a more extensive descriptive narrative for physician's orders.

C--Speech Therapy (ST)

These codes represent the services to be performed by the speech therapist. The following is a further explanation of each service.

C1	Evaluation	Visit made to determine the type, severity and prognosis of a communication disorder, whether speech therapy is reasonable and necessary and to establish the goals, treatment plan, and estimated frequency and duration of treatment.
C2	Voice Disorders Treatments	Procedures and treatment for patients with an absence or impairment of voice caused by neurologic impairment, structural abnormality, or surgical procedures affecting the muscles of voice production.

C3	Speech Articulation Disorders Treatments	Procedures and treatment for patients with impaired intelligibility (clarity) of speech - usually referred to as anarthria or dysarthria and/or impaired ability to initiate, inhibit, and/or sequence speech sound muscle movements – usually referred to as apraxia/dyspraxia.
C4	Dysphagia Treatments	Includes procedures designed to facilitate and restore a functional swallow.
C5	Language Disorders Treatments	Includes procedures and treatment for patients with receptive and/or expressive aphasia/dysphasia, impaired reading comprehension, written language expression, and/or arithmetical processes.
C6	Aural Rehabilitation	Procedures and treatments designed for patients with communication problems related to impaired hearing acuity.
C7	Reserved	
C8	Non-oral Communications	Includes any procedures designed to establish a non-oral or augmentive communication system
C9*	Other (Spec. Under Orders)	Speech therapy services not included above. Specify service to be rendered under physician's orders (HCFA Form-485 Item 21).

* Code which requires a more extensive descriptive narrative for physician's orders.

D--Occupational Therapy

These codes represent the services to be rendered by the occupational therapist. The following is a further explanation of each service:

D1	Evaluation	Visit made to determine occupational therapy needs of the patient at the home. Includes physical and psychosocial testings, establishment of plan of care, rehabilitation goals, and evaluating the home environment for accessibility and safety and recommending modifications.
D2	Independent Living/Daily Living Skills (ADL training)	Refers to the skills and performance of physical cognitive and psychological/emotional self care, work, and play/leisure activities to a level of

		independence appropriate to age, life-space, and disability
D3	Muscle Re-education	Includes therapy designed to restore function lost due to disease or surgical intervention.
D4	Reserved	
D5	Perceptual Motor Training	Refers to enhancing skills necessary to interpret sensory information so that the individual can interact normally with the environment. Training designed to enhance perceptual motor function usually involves activities which stimulate visual and kinesthetic channels to increase awareness of the body and its movement.
D6	Fine Motor Coordination	Refers to the skills and the performance in fine motor and dexterity activities.
D7	Neurodevelopmental Treatment	Refers to enhancing the skills and the performance of movement through eliciting and/or inhibiting stereotyped, patterned, and/or involuntary responses which are coordinated at subcortical and cortical levels.
D8	Sensory Treatment	Refers to enhancing the skills and performance in perceiving and differentiating external and internal stimuli such as tactile awareness, stereognosis, kinesthesia, proprioceptive awareness, ocular control, vestibular awareness, auditory awareness, gustatory awareness, and factory awareness necessary to increase function.
D9	Orthotics Splinting	Refers to the provision of dynamic and static splints, braces, and slings for relieving pain, maintaining joint alignment, protecting joint integrity, improving function, and/or decreasing deformity.
D10	Adaptive Equipment (fabrication and training)	Refers to the provision of special devices that increase independent functions.
D11*	Other	Occupational therapy services not quantified above.

* Code which requires a more extensive descriptive narrative for physician's orders.

E--Medical Social Services (MSS)

These codes represent the services to be rendered by the medical social service worker. The following is a further explanation of each service:

E1	Assessment of Social and Emotional Factors	Skilled assessment of social and emotional factors related to the patient's illness, need for care, response to treatment and adjustment to care; followed by care plan development.
E2	Counseling for Long-Range Planning and Decision making	Assessment of patient's needs for long term care including: evaluation of home and family situation; enabling patient/family to develop an in-home care system; exploring alternatives to in-home care; arrangement for placement.
E3	Community Resource Planning	The promotion of community centered services(s) including education, advocacy, referral and linkage.
E4*	Short Term Therapy	Goal oriented intervention directed toward management of terminal illness; reaction/adjustment to illness; strengthening family/support system; conflict resolution related to chronicity of illness.
E5	Reserved	
E6*	Other (Specify Under Orders)	Includes other medical social services related to the patient's illness and need for care. Problem resolution associated with high risk indicators endangering patient's mental and physical health including: abuse/neglect, inadequate food/medical supplies; high suicide potential. The service to be performed must be written under doctor's orders (HCFA Form-485 Item 21).

* Code which requires a more extensive descriptive narrative for physician's orders.

F--Home Health Aide

These codes represent the services to be rendered by the home health aide. Specific personal care services to be provided by the home health aide must be determined by a registered professional

nurse. Services are given under the supervision of the nurse, and if appropriate, a physical, speech or occupational therapist. The following is a further explanation of each service:

F1	Tub/Shower Bath	Assistance with tub or shower bathing.
F2	Partial/Complete Bed Bath	Bathing or assisting the patient with bed bath.
F3	Reserved	
F4	Personal Care	Includes shaving of patient or shampooing the hair.
F5	Reserved	
F6	Catheter Care	Care of catheter site and/or irrigations under nursing supervision.
F7	Reserved	
F8	Assist with Ambulation	Assisting the patient with ambulation as determined necessary by the nurse care plan.
F9	Reserved	
F10	Exercises	Assisting the patient with exercises in accordance with the plan of care.
F11	Prepare Meal	May be furnished by the aide during a visit for personal care.
F12	Grocery Shop	May be furnished as an adjunct to a visit for personal care to meet the patient's nutritional needs in order to prevent or postpone the patient's institutionalization.
F13	Wash Clothes	This service may be provided as it relates to the comfort and cleanliness of the patient and the immediate environment.
F14	Housekeeping	Household services incidental to care and which do not substantially increase the time spent by the home health aide.
F15*	Other (Specify Under Orders)	Includes other home health aide services in accordance with determination made by a registered professional nurse. Specified in Item 21 HCFA Form-485.

* Code which requires a more extensive descriptive narrative for physician's orders.

8. Effectuating Favorable Final Appellate Decisions That a Beneficiary is "Confined to Home"

a. **General** -- RHHIs are instructed to do the following when a favorable final appellate decision that a beneficiary is "confined to home" is rendered on or after July 1, 2000.

NOTE: For the purposes of this manual section: A favorable decision is a decision that is favorable to the beneficiary. A final appellate decision is a decision at any level of the appeals process where the Regional Office (RO) has finally determined that no further appeals will be taken, or where no appeal has been taken and all time for taking an appeal has lapsed.

- Promptly pay the claim that was the subject of the favorable final appellate decision.
- Promptly pay or review based on the review criteria below:
 - all claims that have been denied that are properly pending in any stage of the appeals process
 - all claims that have been denied where the time to appeal has not lapsed
 - all future claims submitted for this beneficiary
- For favorable final appellate decisions issued during a one year grace period starting on July 1, 2000 and ending June 30, 2001, reopen all denied claims that are subject to the 12 month reopening provision. Promptly pay or review, based on the review criteria below, these reopened claims.
- Establish procedures to ensure that medical review of a beneficiary's claim, after the receipt by that beneficiary of a favorable final appellate decision related to "confined to home," is reviewed based on the review criteria below.
- Notify the beneficiary and the affected home health agency that the favorable final appellate decision related to "confined to home" will be given "great weight" in evaluating if the beneficiary is "confined to home." Inform them of what steps should be taken if they believe a claim has been denied in error.
- Maintain records containing information on the beneficiaries receiving favorable final appellate decision related to "confined to home." These records should include at a minimum the Beneficiary's name, HCIN number, service date of the claim that received the favorable final appellate decision and the date of this decision. This information should be made available to HCFA upon request.

b. Review Criteria--Afford the favorable final appellate decision that a beneficiary is "confined to home" great weight in evaluating whether the Beneficiary is confined to the home when reviewing services rendered after the service date of the claim addressed in the favorable final appellate decision *unless* there has been a change in facts (such as medical improvement or an advance in medical technology) that has improved the Beneficiary's ability to leave the home. All medical review that is done on claims for services performed after the service date of the claim that is addressed in the favorable final appellate decision should determine if (a) there has been a change in facts (as noted above) that affects the beneficiary's ability to leave the home and (b) if the services provided meet all other criteria for Home Health care. If there

have been no changes in facts that affect the beneficiary's ability to leave the home and if all other criteria for home health services are met, the claim would ordinarily be paid. Medical review staff should generally adhere to the following examples, if applicable, in effectuating this review:

Example 1

A quadriplegic beneficiary receives a favorable final appellate decision that he is confined to the home even though he leaves home several times a week for personal reasons. This decision would ordinarily be given "great weight" in future medical review determinations, with the result that the Beneficiary would therefore be treated as "confined to the home" in those determinations.

Example 2

A diabetic beneficiary with a severely broken leg that is not healing well receives a favorable final appellate decision that he is confined to the home, even though he leaves home several times a week for personal reasons. This decision would ordinarily be given "great weight," with the result that the Beneficiary would therefore be treated as "confined to the home" for subsequent medical review decisions. However, if upon review, evidence showed that the Beneficiary's medical condition had changed and the ability to leave the home had improved then the favorable final appellate decision would no longer be given "great weight" in determining if the patient was "confined to home." Medical review of these cases should be done periodically to determine if there are changes in facts that have improved the Beneficiary's ability to leave the home.

9. Reporting--The Program Integrity Management Reports (PIMR) system (when operational) will extract data electronically from existing systems (e.g. your standard system, CAFM, CROWD, etc.) to meet all medical review savings, workload and cost reporting requirements. However, post-payment reviews will still need to be reported manually.

The *effective date* for this Program Memorandum (PM) is October 1, 2000.

The *implementation date* for this PM is October 30, 2000.

These instructions should be implemented within your current operating budget.

This PM may be discarded after October 30, 2001.

If you have any questions, contact Gina Perantoni at (410) 786-3219 or Jill Nicolaisen at (410) 786-5873.