Program Memorandum
Carriers

Department of Health and Human Services (DHHS)

HEALTH CARE FINANCING ADMINISTRATION (HCFA)

Transmittal B-00-16 **Date: APRIL 2000**

CHANGE REQUEST 1088

SUBJECT: Provider Education Article: Role of Physicians in the Home Health Prospective Payment System

The purpose of this Program Memorandum (PM) is to alert the physician community of the proposed changes in the home health payment system and to inform them of their responsibilities within the system. The proposed regulation sets forth the methodology for the national prospective payment system applicable to all covered Medicare home health services. The system outlined in the proposed rule would replace the current retrospective reasonable-cost-based system. This PM supplements the regulation and is not meant to circumvent the normal rule making process. We attached an article for publication in a special bulletin, which will inform physicians of the following:

The proposed regulation;

Physician responsibilities;

Home health certification;

Plan of care certification;

Payment approach.

You must publish this article in your next regularly scheduled bulletin and post it within two weeks after receipt of this PM on any Internet sites or bulletin boards you maintain. You are encouraged to provide in your bulletin additional information to supplement or complement the article, including the requested information where indicated.

Within 30 days of publication of the article, forward a copy to the central office at this address:

Yerado Abrahamian
HCFA/CHPP/PBEG/DPET
C4-10-07
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Baltimore, Maryland 21244-1850

The effective date for this PM is April 1, 2000.

The implementation date for this PM is April 1, 2000.

These instructions should be implemented within your current operating budget.

This PM may be discarded after July 1, 2000.

If you have any questions, contact Yerado Abrahamian on (410) 786-9372.

Attachment

HCFA-Pub. 60B

Role of the Physician in the Home Health Prospective Payment System

Currently, home health agencies (HHAs) receive payment under a cost-based reimbursement system subject to limits referred to as the interim payment system. The Balanced Budget Act of 1997 (BBA '97) mandated the creation of a prospective payment system (PPS) for home health services. A proposed rule codifying the provision may be found at 64 FR 58134 (October 28, 1999). The final regulation governing this section of the BBA '97 is scheduled for July 2000 publication with a planned effective date of October 1, 2000.

While the entire proposed regulation deserves attention, this article supplements the regulation and is not meant to circumvent the normal rule making process. The purpose of this article is to alert the physician community of the proposed changes in the home health payment system and to inform them of their responsibilities within the system. This bulletin is the first in a series of bulletins. A forthcoming bulletin will provide further detail regarding Outcome Assessment Information Set (OASIS)--the home care assessment system. It is recommended that billing offices forward this bulletin to their physicians.

I. The Proposed Regulation

This proposed rule sets forth the methodology for the national PPS applicable to all covered Medicare home health services. It incorporates a national 60-day episode payment, adjusted for patient condition and area wage costs, for all services furnished to an eligible beneficiary under a Medicare home health Plan of Care. The PPS will affect the existing billing and payment practices. Payment for services will remain specific to the individual beneficiary (who is homebound and under a physician's Plan of Care) and to the site of the services delivered.

The basic vehicle for home health claims will remain the UB-92 (HCFA-1450) claim form. The claims will continue to be processed by the current Regional Home Health Intermediaries (RHHIs). RHHIs will also continue to conduct audits of providers' records, as needed, to assure that payments are appropriate for care provided. Treatment must follow a written Plan of Care established and reviewed by the attending physician at least every 60 days.

II. Physician Responsibilities

The fundamental physician responsibility in the PPS is to be the determiner of the patient's health care needs and advocate for the services required to meet those needs. In order to perform this role efficiently, certifying physicians must utilize their intimate knowledge of the patient's medical condition. As such, physicians have two specific responsibilities:

- Certify that the patient is confined to his home and is in need of home health care.
- Develop, certify, and re-certify the Plan of Care, including key aspects of the patients' condition.

III. HCFA-485

Form HCFA-485 is used for Home Health and Plan of Care Certification and re-certification.

A. Home Health Certification

The beneficiary's physician is responsible for signing the Home Health Certification form HCFA-485 upon the initiation of any Plan of Care. Section 1824(a)2 of the Social Security Act states that home health services are required when an individual is confined to his home and needs skilled nursing care on an

intermittent basis or physical or speech therapy. If an individual who has been furnished home health services based on such a need and who no longer has such a need for such care or therapy, continues to need occupational therapy; a plan for furnishing such services has to be established by the beneficiary's physician, furnished under the care of the beneficiary's physician,

and periodically reviewed by the beneficiary's physician. Upon the completion of every 60-day episode, if the patient is receiving continuous home health care from the same home health agency, the beneficiary's physician is responsible for Home Health re-certification.

B. Plan of Care Certification

The PPS does not introduce change to the Plan of Care. It remains the beneficiary's physician's responsibility to develop a Plan of Care based on his/her intimate knowledge of the medical condition of the home health patient. The Plan of Care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, and safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items.

The beneficiary's physician's orders for services in the Plan of Care must specify the medical treatments to be furnished as well as the type of home health discipline that will furnish the ordered services and at what frequency the services will be furnished. The Plan of Care must be signed and dated by the beneficiary's physician ***before*** the agency can submit a claim. Any changes in the plan must be signed and dated by the beneficiary's physician. If any services are furnished based on the beneficiary's physician's oral orders, the orders must be put in writing and signed and dated with the date of receipt by the registered nurse or qualified therapist responsible for furnishing or supervising the ordered services. Upon the completion of every 60-day episode, if the patient is receiving continuous home health care from the same home health agency, the beneficiary's physician is responsible for re-certification of the Plan of Care.

IV. Payment Approach

A. 60-Day Episode Payment

An episode, 60 days in length, is the unit of payment for proposed home health PPS. The episode payment is specific to an individual beneficiary. A 60-day episode begins with the first Medicare billable visit as day 1 and ends on and includes the 60th day from the start-of-care date. The next continuous episode re-certification period begins on day 61 and ends on and includes day 120. The 60-day episode payment covers one individual for 60 days of care regardless of the number of visits actually furnished during the 60-day period unless there is an intervening event (to be discussed in Paragraph IV.B.).

The 60 day episode payment amount will be case-mix adjusted for each patient using the OASIS developed by HCFA as part of the required home care assessment. The system was developed combining 20 data elements to measure case-mix across three domains: clinical severity factors, functional status factors and service utilization factors. Key data elements and their respective values were identified for each dimension to create a case-mix system that included 80 severity categories, or home health resource groups (HHRGs). HHRGs are a case-mix classification system in which patient characteristics and health status information gathered from the OASIS assessment in conjunction with projected therapy use during the 60-day episode are used to determine payment. After obtaining the physician's signature on the Plan of Care, the HHA will submit an initial claim and receive 50 percent of the estimated case-mix adjusted episode payment. Each initial claim must be based on a current OASIS-based case-mix.

At the end of the 60-day episode, the HHA submits a final claim for the beneficiary and normally receives the remaining 50 percent of the estimated case-mix adjusted episode payment. Each final claim must represent the actual utilization over the utilization period, in line item detail. An initial and final bill must be

submitted for each episode period.

An episode may end before the 60th day in the case of a transfer or discharge, and readmission. Such cases call for partial episode payment adjustments (PEP Adjustments) to be described later.

B. Partial Episode Payment (PEP) Adjustment

PEP Adjustments provide a simplified approach to the episode definition that takes into account key intervening events in a patient's care defined as: a beneficiary-elected transfer to a different agency; or a discharge and return to the same HHA. In such situations, a new 60-day episode clock begins for purposes of payment. When a new 60-day episode begins, the original 60-day episode payment is proportionally adjusted to reflect the length of time the beneficiary remained under the agency's care before the intervening event. The prorated payment is the PEP Adjustment. The new 60-day episode interrupting the original episode requires an OASIS assessment and physician's certification signature of the Plan of Care.

C. Significant Change in Condition Adjustment (SCIC Adjustment)

If a patient experiences an unanticipated change in condition during a 60-day episode and the change is significant enough to justify a different payment level or change in the Plan of Care, the episode payment may be adjusted. In such situations, the early part of the episode would be proportionally paid at one rate and the latter part at an adjusted rate. Physicians would continue to be required to provide and sign change orders in the Plan of Care to accommodate the patient's significant change in condition. The SCIC Adjustment does not restart the 60-day episode clock. The SCIC Adjustment occurs within a given 60-day episode.

Under PPS, an agency is paid for a 60-day period of care, in general, without regard to the amount of services it provides in a 60-day period. Similar to hospital DRG payments, the agency has incentive to provide care efficiently by using as little resources as possible to provide care for the patient. Thus, as a physician, your development and certification of the Plan of Care is critical to assuring both that the patient requires Medicare covered home health services ***and*** that the appropriate amount has been prescribed. Agencies must secure physician approval to changes in the Plan of Care prior to reducing, increasing or otherwise altering the original Plan of Care the physician authorized. Because payment is based not on the number of visits provided, but the agency's characterization of the patient's condition, your intimate knowledge of the patient's condition is an important validator of the case-mix payment level.

Physicians have played, and will continue to play, a regular role in helping to assure that Medicare home health patients receive appropriate care. While Medicare's medical review and program integrity staff will be monitoring the new PPS system, we continue to rely on physicians as the pivotal profession in health care delivery to help assure the fiscal and clinical validity of the Medicare home health system.

If you have questions regarding this article or the home health prospective payment system, contact [*enter local carrier*] at [*enter local carrier phone number*].