PPS: The Big Picture

Fall Conference, 2012

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Industrial Revolution
Urbanization
Disappearance of ‘extended’ family
Increased life expectancy
The Great Depression

Social Security 1935

This 1968 poster informs seniors about the Medicare program that was added to Social Security in 1965 (first benefits payable in 1966).
Medicare: Conditions of Participation: Regulations setting minimum health and safety standards for Medicare providers

Hospital Prospective Payment System: DRG discharged patients to post acute “sicker & quicker”

Home Health Agency Growth and Related Events

1950’s

Postwar (WWII) technology and the notion that health care was cheaper and easier to provide in hospitals.

1965

1,753 HHA

24 visits per patient

1965

5,983 HHAs

1985

20 visits per patient

1990

10,000 HHAs

45 visits per patient

1950’s
Medicare as Regulator

Conditions of Participation

Medicare as Payer

Conditions for Coverage

Cost Based Reimbursement

\[
\text{Total Costs} \div \text{Visits} = \text{Visit Cost}
\]

Financial Incentive: to keep visit cost down

Total Costs \div \text{Visits} = \text{Visit Cost}

Financial incentive a natural fit with nurturing nature of caregivers

Maximize visits

Cheapest visit to maximize?

Continued need for personal care

Increased need for duration

Continued need for services

Personal care encouraged

Continued coverage

Skilled need/homebound

Dependent on services

$.4 billion in 1965

$20 billion in 1992
Medicare
Medicaid
DRGs
ORT
BBA
IPS

Cost Based Reimbursed

Prospective Payment

1996
$4,666 per patient
74 visits per patient
Anti Fraud & Abuse Efforts

Operation Restore Trust
$188 Million owed to Federal Government

BBA of 1997 & HH IPS

1999
$2,892 per patient
41 visits per patient

Medicare
Medicaid
DRGs
ORT
BBA
IPS
OASIS
OBQI

Cost Based Reimbursed

Prospective Payment

PPS

HH Covered Services
Outpt. Therapy
HH Non-routine Supplies
Ostomy supplies
Consolidated
Some osteoporosis drugs
Vaccines
**Low Utilization Payment Adjustment**
- Less than 5 visits
- Per visit rate based on discipline & location of service

**Partial Episode Payment Adjustment**
- Patient transfer to another agency
- Discharge & readmit within 60 day episode
- Pro-rated payment

**Outlier Payment Adjustment**
- Paid when estimated costs exceed outlier threshold
- Subject to 10% payment cap

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### 60 Day PPS Episode Payment

<table>
<thead>
<tr>
<th>Dimension</th>
<th>HHRRG Code</th>
<th>Early Episodes</th>
<th>Late Episodes</th>
<th>All Episodes</th>
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<td>C3</td>
<td>9 or more</td>
<td>15 or more</td>
<td>6 or more</td>
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<td></td>
<td>F3</td>
<td>7 or more</td>
<td>10 or more</td>
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<td>Service utilization</td>
<td>S1</td>
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<td>S4</td>
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<td>10</td>
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<td></td>
<td>S5</td>
<td>11 to 13</td>
<td>d</td>
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**SOC Episode**
- 1st skilled visit
- Ends day 60
- 60% RAP
- Adjusted balance

**Recert Episode**
- Day 61
- Ends day 120
- 50% RAP
- Adjusted balance

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**60 Day PPS Episode Payment**
Data Set

Core Items of a comprehensive assessment

Measuring patient outcomes for OBQI

Rigorous & systematic measurement of patient outcomes

Used for quality monitoring and improvement program
Medicare as Regulator

Conditions of Participation

Medicare as Payer

Conditions for Coverage

Medicare as Quality Monitor

OBQI

Majority of medical errors do not result from individual recklessness or the actions of a particular group.

More commonly, errors are caused by faulty systems, processes, and conditions that lead people to make mistakes or fail to prevent them.

Institute of Medicine, 1999

Strategy for Reinventing the System

Fostering innovation and improving the delivery of care

Institute of Medicine, 2001
Care System

Supportive payment & regulatory environment

Organizations that facilitate the work of patient-centered teams

High performing patient-centered teams

Outcomes:• Safe• Effective• Efficient• Personalized• Timely• Equitable

REDESIGN IMPERATIVES: CHALLENGES
• Reengineered care processes
• Effective use of information technologies
• Knowledge and skills management
• Development of effective teams
• Coordination of care across patient conditions, services, sites of care over time

10 Rules for Redesign...

Ten Rules for Redesign (IOM)

1. Care is based on continuous healing relationships.
   Patients should receive care whenever they need it and in many forms, not just face-to-face visits. This implies that the health care system must be responsive at all times, and access to care should be provided over the Internet, by telephone, and by other means in addition to in-person visits.

2. Care is customized according to patient needs, values.
   The system should be designed to meet the most common types of needs, but should have the capability to respond to individual patient choices and preferences.

Ten Rules for Redesign (IOM)

3. The patient is the source of control.
   Patients should be given the necessary information and opportunity to exercise the degree of control they choose over health care decisions that affect them. The system should be able to accommodate differences in patient preferences and encourage shared decision making.

4. Knowledge is shared and information flows freely.
   Patients should have unfettered access to their own medical information and to clinical knowledge. Clinicians and patients should communicate effectively and share information.

Ten Rules for Redesign (IOM)

5. Decision making is evidence-based.
   Patients should receive care based on the best available scientific knowledge. Care should not vary illogically from clinician to clinician or from place to place.

6. Safety is a system property.
   Patients should be safe from injury caused by the care system. Reducing risk and ensuring safety require greater attention to systems that help prevent and mitigate errors.

7. Transparency is necessary.
   The system should make available to patients and their families information that enables them to make informed decisions .... This should include information describing the system's performance on safety, evidence-based practice, and patient satisfaction.
Ten Rules for Redesign (IOM)

8. **Needs are anticipated.**
   The system should anticipate patient needs, rather than simply react to events.

9. **Waste is continuously decreased.**
   The system should not waste resources or patient time.

10. **Cooperation among clinicians is a priority.**
    Clinicians and institutions should actively collaborate and communicate to ensure an appropriate exchange of information and coordination of care.

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**HHCAHPS**

- To produce comparable data on the patient’s perspective that allows objective and meaningful comparisons between home health agencies on domains that are important to consumers.
- Public reporting of survey results will create incentives for agencies to improve their quality of care.
- Public reporting will enhance public accountability in health care by increasing the transparency of the quality of care provided in return for public investment.
- To receive 2013 annual payment update (APU), survey data must be submitted quarterly.

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**Home Health Time Line**

- **Cost Based Reimbursed**
- **Prospective Payment**

<table>
<thead>
<tr>
<th>Year</th>
<th>Medicare</th>
<th>Medicaid</th>
<th>DRGs</th>
<th>ORT</th>
<th>BBA</th>
<th>IPS</th>
<th>OASIS</th>
<th>OBQI</th>
<th>PPS</th>
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</table>

**Medicare**
- HHQI
- ACH

**Medicaid**
- ORT
- BBA
- IPS
- OASIS
- OBQI

**Cost Based Reimbursed**
- 1965

**Prospective Payment**
- 1985
- 1992
- 1997
- 1998
- 2000
- 2003
- 2007

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**HHCAHPS**

- **To produce comparable data on the patient’s perspective that allows objective and meaningful comparisons between home health agencies on domains that are important to consumers.**
- **Public reporting of survey results will create incentives for agencies to improve their quality of care.**
- **Public reporting will enhance public accountability in health care by increasing the transparency of the quality of care provided in return for public investment.**
- **To receive 2013 annual payment update (APU), survey data must be submitted quarterly.**
Since 2007, sought to “unite the home care community under the shared vision of reducing avoidable hospitalizations to improve patient quality of care.”

**Medicare FFS 2010**

<table>
<thead>
<tr>
<th></th>
<th>Persons Served (in millions)</th>
<th>Program Payments (in billions)</th>
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<tr>
<td>Inpatient Hospital</td>
<td>7.5</td>
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<tr>
<td>Skilled Nursing Facility</td>
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<td>$27.3</td>
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<tr>
<td>Home Health Agency</td>
<td>1.7</td>
<td>$7.3</td>
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<tr>
<td>Hospice</td>
<td>1.2</td>
<td>$7.3</td>
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**HH Provision After PPS**

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<th>2001</th>
<th>2010</th>
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<tr>
<td>Number of visits (in millions)</td>
<td>258</td>
<td>74</td>
<td>125</td>
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<tr>
<td>Visit Type (percent of total)</td>
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<tr>
<td>Home Health Aide</td>
<td>48%</td>
<td>25%</td>
<td>16%</td>
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<tr>
<td>Skilled Nursing</td>
<td>41%</td>
<td>50%</td>
<td>52%</td>
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<tr>
<td>Therapy</td>
<td>10%</td>
<td>24%</td>
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<tr>
<td>Visits per home health patient</td>
<td>73</td>
<td>33</td>
<td>36</td>
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Contemporary America

Home Health Time Line

- Medicare
- Medicaid
- DRGs
- ORT
- BBA
- IPS
- OASIS
- OBQI
- HHQI
- ACH
- PPS
- VBP
- P4P
- PPS Updates
- PPS Refinement

Cost Based Reimbursed
Prospective Payment


2008 Update
- Therapy Threshold changes

2010 Update
- OASIS-C

2011 Update
- Rate Updates
- FTF
- Therapy assessments
- HTN codes
- Non-CAHP

2012 Update
- Rate Updates
- FTF
- Therapy assessments

2013 Final rule

- $2,137.73 rate change
  - Up 3% for rural
  - Down 2% for those who fail to submit quality data

- 2.3% MBI
  - 1 point reduction in MBI under HCR
  - 1.32% case mix creep adjustment (left over from 2012)

- Outlier
  - Loss share remains at .80
  - Fixed Dollar Loss ratio lowered from .67 to .45

- CBSA Wage Indices changes
2013 Final Rule (cont.)

FTF Adjustment
- Inpatient NPP may do FTF
- Pass info through inpatient physician to certifying physician

Therapy Assessments
- Coverage resumes with visit of late assessment
- Non-coverage limited to discipline with late assessment
- Multiple discipline assessments must occur on visits 11, 12, 13 or 17, 18, 19, unless not feasible, then can be ‘close to’

Timing Noncompliance
- If FTF encounter does not occur by day 30
  - Medicare benefit requirements not met
  - Episode cannot be billed
    - Requires corrective OASIS & billing actions
  - Decision must be made
    - Discharge patient?
    - Continue services?
  - How to communicate to patient?

Timing Noncompliance
- If agency chooses to discharge patient
  - Must issue Home Health Advance Beneficiary Notice (HHABN)
    - To notify patient due to lack of qualifying encounter
    - Must use HHABN Option Box 2
  - Cannot hold patient financially responsible for services received at time of discharge
    - Change of care notice
    - Discharge for administrative reasons
  - May deliver in advance of actual discharge date to allow time to meet requirement

HHABN
- Notify patient of discharge due to lack of FTF encounter
  - Must use new HHABN effective April 1, 2011, Option Box 2
  - Change of care notice with no bearing on financial liability
- Patient not financially liable for lack of qualifying encounter
  - May deliver in advance of actual discharge date to allow patient additional time to meet requirement
  - Color code and pre-print language on this HHABN

https://www.cms.gov/BNI/03_HHABN.asp
– Prior versions of HHABNs issued on and after April 1, 2011, for any purpose considered invalid
Timing Noncompliance

• If agency chooses to continue services
  – Considered change in pay source
  – All OASIS assessments & billing transactions for original episode must be deleted & canceled
  – New SOC date required

Timing Noncompliance – New SOC

- All services prior to new SOC date noncovered & cannot be billed or paid
- Considered change in pay source
- All OASIS assessments & billing transactions for original episode must be deleted & canceled
- New SOC date required
- Repeat: All OASIS assessments completed prior to new SOC date must be deleted

"You have not had a face-to-face visit with your physician within 30 days of your admission to this home health agency, as is required by Medicare."
Timing Noncompliance – New SOC

• OASIS assessment originally completed closest to new SOC date forms basis of new SOC OASIS assessment
  • Any type of OASIS assessment(s)
  • Copy scoring from OASIS assessment(s) completed closest new SOC date
  • Cannot “create” new OASIS responses
  • May be necessary to copy scoring from multiple assessments in order to fully complete one SOC assessment

Timing Noncompliance – New SOC

• Must update some OASIS items rather than copying from previously completed assessment(s)
  – M0030 should be updated for new SOC date
  – M0090 should be updated for actual date new assessment is generated which would be sometime on or after FTF encounter date
  – M0102 date physician ordered SOC should be “NA”
  – M0104 date of referral should be day prior to new SOC
  – M2200 should be updated to reflect actual/estimated therapy utilization in new episode period

New SOC Example

• 01/01/12 date of first skilled visit
• 03/11/12 (day 70) date of FTF encounter
• 02/10/12 date of Medicare eligibility
  – 30 days prior to FTF encounter date
• 02/12/12 date of new SOC
  – First visit date after FTF encounter date
• All services provided between 01/01/12 – 02/11/12 noncovered
• 02/13/12 assessment date on new OASIS
  – Date new assessment completed

Documentation

• Must be separate & distinctly identifiable section of certification or addendum
• Must be clearly titled
  – 2013 proposed rules clarify that physician does not have to title documentation; can be titled by home health personnel
• Must be signed & dated by qualified certifying physician
• Must include patient name and qualifying FTF encounter date
### Documentation

- **Qualified certifying physician:**
  - Community physician who conducts the FTF encounter, establishes & signs the POC & will follow the patient
  - Inpatient physician who conducts the FTF encounter, establishes & signs the POC & will follow the patient
  - Inpatient physician who conducts the FTF encounter, initiates orders for home health services, but will ‘hand off’ to community physician establishing & signing POC

- **Narrative clinical findings**
  - *Composed by qualified certifying physician*
  - Physicists may compose after date of encounter using medical record entries from FTF encounter
  - Physician may dictate to support personnel
  - May *not* dictate to home health agency personnel
  - Physician may utilize own electronic medical records’ prepared descriptive language
  - Use of home health agency standardized language not permitted
  - Physician may utilize support personnel to compile narrative

- **Support personnel**
  - Those that work with or for physician on regular basis & regularly perform documentation, take dictation from physician &/or extract support documentation from physician’s medical records
  - Can compile narrative by extracting information from physician’s medical record entries documented during qualifying FTF encounter
  - NPPs *do not* meet support personnel criteria
    - *Cannot* compose home health qualifying encounter certification documentation even if NPP performed FTF encounter
    - Must document & communicate clinical findings to qualified certifying physician

- **Must include narrative clinical findings**
  - *Composed by qualified certifying physician*
  - Reflect clinical condition of patient *as seen during qualifying FTF encounter*
  - Explain how findings support
    - Encounter related to primary reason for home health
    - Patient needs intermittent skilled nursing &/or therapy
    - Patient is homebound
  - CMS does not plan to verify with physician record
Documentation

- Inpatient Physicians or Inpatient NPP performing encounter during inpatient stay can communicate findings from medical record to community physician
  - May be compiled by inpatient support staff
  - Compiled documentation must be titled FTF
  - Inpatient physician or NPP need not sign
  - Inpatient physician documentation must be signed/dated by community physician

2013 Rule
- Allows NPP in acute or post-acute facility to perform FTF encounter in collaboration with or under supervision of inpatient physician
- Inpatient physician could then inform certifying physician of patient’s homebound status & need for skilled services

Documentation

- Attachments can satisfy narrative requirement
  - May utilize copies of physician’s documentation on orders, acute/post-acute discharge summaries, or other documentation if
    - Reflects clinical condition of patient as seen during encounter & supports need for intermittent skilled nursing &/or therapy services & that patient is homebound
    - Were drafted by physician or compiled by physician’s support personnel
    - Clearly signed & dated by qualified certifying physician
    - Clearly attached as part of the certification/addendum

Documentation Considerations

- Home health agencies may not alter, transcribe, compile or create FTF documentation
- Standardized language may not be used for physicians to select
- However, a certification addendum that includes checkboxes that was created by a physician’s office is permissible
- FTF sample documentation is allowed but may not be patient specific
Effective Clinical Management

- Balance
- Define & Communicate
- Objective
- Concurrent

Effective Clinical Management

- Quality, Compliance, Cost
- Key Performance Indicators
- Measures of Performance
- Accountability
Define Indicators
- Quantify Measures
- Set Standards
- Communicate Expectations
  - Countable
  - Achievable
  - Reasonable
  - Reachable
  - Evidence based
  - In advance

Measure Objectively
- Benchmark
- Avoid challenges
- Allow self-monitoring
  - Internal patterns
  - Industry performance
  - Perceptions & definitions of quality by staff
  - Encourage self-improvement

Concurrent Accountability
- Monitor elements at the same time
  - Clinical outcomes
  - Utilization
  - Performance standards
- Monitor while still influence of control
  - Impact the outcome before it happens

Key Performance Measures
- Quality Examples
  - ACH Rate
  - Targeted OBQI indicators
  - Process Measures
- Compliance Examples
  - Quarterly record review percent
  - Process Performance
- Cost Examples
  - Visits per episode
  - Hours per visit
  - Caseload productivity standard
Quality

► **Objective Measures, Standards** - Know who is getting what outcomes
► **Concurrent Accountability**
  Select charts for Process of Care Investigation based on episodes that need managing and staff that need managing
► **Communicate Expectations**
  Develop an OBQI Plan of Action to improve outcomes based on available evidence

Compliance

► **Set Standards** – Communicate an expected percentage
► **Objective Measures** – Quantify percentage achieved during Quarterly Record Review
► **Accountability** – For those pesky process performance measures
► **Bonus** – Charts chosen for OBQI Process of Care Investigation should have a compliance review while the chart is open

Cost

► **Set Standards** - Using industry benchmarks or internal patterns
► **Measure Objectively**
  Identify sources for data extraction and format for recording and reporting to staff
► **Key Indicators** - Direct cost productivity should not be contradictory to episodic payment structure – *make the measure meaningful*

Caseload Productivity Rationale

Who is your only revenue producer?
What is your greatest cost to the episode?
Visits per episode
Hours per visit
Caseload productivity standard
### Effective Clinical Management

- **Balance Quality, Compliance, Cost**
- **Define Key Performance Indicators**
- **Objective Measures of Performance**
- **Concurrent Accountability**

### Performance Data

<table>
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<th>Performance Measures</th>
<th>Performance Category</th>
<th>Expected Minimum Performance Measures</th>
<th>Expected Performance Cost</th>
<th>Optimal Performance Cost</th>
<th>Actual Performance Costs</th>
<th>Actual Performance Results</th>
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<td>Documentation timely and complete</td>
<td>Compliance</td>
<td>65.0%</td>
<td>65.0%</td>
<td>90.0%</td>
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<td>Hospitalization rate</td>
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<td>25.0%</td>
<td>35.0%</td>
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<td>Improved medication management</td>
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**Employee Information**

- **Name:** Nellie Nurse
- **Position:** Clinical personal
- **ID No.:** 1000
- **Hire Date:** 1/1/1997
Medicare home health eligibility requires that a face-to-face encounter with you be documented for this patient before you complete and sign the attached home health certification. This encounter must have taken place within 90 days prior to or 30 days after the start of home health services.

If you work in collaboration with a nurse practitioner or a clinical nurse specialist, or supervise a physician’s assistant, the face-to-face encounter may be carried out by that nonphysician practitioner, who must in turn document their clinical findings and communicate those findings to you. However, only you as the certifying physician may order home health services, certify that the face-to-face encounter occurred, and certify that other eligibility criteria are met.

The following summarizes our understanding of why this patient has been referred for Medicare home health services, including the homebound status of the patient, and is based on the information we received from the referral source.

**Please complete, sign, date, and return the attached face-to-face encounter certification form**
Addendum to Medicare Home Health Certification
Physician Face-to-Face Encounter Documentation

<table>
<thead>
<tr>
<th>Patient name</th>
<th>Home health start date</th>
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</table>

**Encounter Date and Reason for Encounter**

I certify that I, or a qualified nonphysician practitioner working with me, had a face-to-face encounter with this patient on the date indicated below relating to the primary reason the patient requires home health services.

Encounter date _________________

**Need for Home Health Services**

I certify that based on my findings:

a. home health services are medically necessary for this patient, including either intermittent skilled nursing and/or therapy, and

b. this patient is homebound in that absences from home require considerable and taxing effort, are infrequent or of short duration, or are attributable to the need to receive health care.

My clinical findings support the need for these services because:

[Blank space for clinical findings]

I certify that I, as the certifying physician, composed the above information based on my clinical judgement relating to this patient’s medical condition.

Certifying physician signature ___________________________ Date _______________
Inpatient Physician Face-to-Face Encounter Documentation and Medicare Home Health Certification

I certify that I, or a qualified nonphysician practitioner working with me, had a face-to-face encounter with this patient on the date indicated below relating to the primary reason the patient requires home health services.

Encounter date

I certify that based on my findings:

a. home health services are medically necessary for this patient, including either intermittent skilled nursing and/or therapy, and

b. this patient is homebound in that absences from home require considerable and taxing effort, are infrequent or of short duration, or are due to the need to receive health care.

My clinical findings support the need for these services because:

Based on the above findings, I certify that this patient is homebound and needs intermittent skilled nursing care, physical therapy, and/or speech therapy or continues to need occupational therapy. The patient is under my care, and I have initiated the plan of care. This patient will be followed by a physician who will periodically review the plan or care.

Physician signature ___________________________ Date __________

Physician printed name: ___________________________