CMS Manual System

Pub. 100-01 Medicare General Information, Eligibility, and Entitlement

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 19 **Date: MARCH 11, 2005**

Change Request 3698

SUBJECT: Revisions to Chapter 5, Section 50 of Publication 100-01 in the IOM to Clarify Current Policy

I. SUMMARY OF CHANGES: Revisions are being made to correct information that was omitted during the transition of the paper-based manual to the internet only manual (IOM).

NEW/REVISED MATERIAL - EFFECTIVE DATE*: N/A
IMPLEMENTATION DATE: N/A

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (*N/A if manual not updated.*)
(R = REVISED, N = NEW, D = DELETED) – (*Only One Per Row.*)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	5/50/Home Health Agency Defined
R	5/50/50.2/Arrangements by Home Health Agencies
R	5/50/50.5/Rehabilitation Centers

III. FUNDING: No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2005 operating budgets.

IV. ATTACHMENTS:

	Business Requirements
X	**Manual Instruction**
	Confidential Requirements
	One-Time Notification
	Recurring Update Notification

***Unless otherwise specified, the effective date is the date of service.**

50 - Home Health Agency Defined

(Rev.19, Issued: 03-11-05, Effective/Implementation: N/A)

A home health agency is a public agency or private organization, or a subdivision of such an agency or organization, which meets the following requirements:

- It is primarily engaged in providing skilled nursing services and other therapeutic services, such as physical therapy, speech language pathology services, or occupational therapy, medical social services, and home health aide services.

    1. *The law governing the Medicare home health prospective payment system (PPS) requires that all payments be made to the home health agency for any services and medical supplies (as described in subsection 1861 (m)(5) of the Social Security Act (except for durable medical equipment (DME)) that are furnished to an individual during the time the individual is under a home health plan of care. This applies without regard to whether or not the item or service was furnished by the agency, by others under contract or arrangement with the agency, or otherwise.*
    2. *Under the consolidated billing requirement governing home health PPS, we require that the HHA submit all Medicare claims for all services except DME while the eligible beneficiary is under a home health plan of care (see subsection 201 for consolidated billing details). HHAs may provide the covered home health services (except DME) either directly or under arrangement.*
    3. *An HHA must furnish at least one of the qualifying services directly through agency employees on a visiting basis in a place of residence used as a patient's home, but may furnish the second qualifying service and additional services under arrangement with another HHA or organization.*

- It has policies established by a professional group associated with the agency or organization (including at least one physician and at least one registered nurse) to govern the services, and provides for supervision of such services by a physician or a registered nurse;
- It maintains clinical records on all patients;
- It is licensed in accordance with State or local law or is approved by the State or local licensing agency as meeting the licensing standards (where State or local law provides for the licensing of such agencies or organizations); and

- It meets other conditions found by the Secretary of the Department of Health and Human Services to be necessary for health and safety.

A private organization which is not exempt from Federal income taxation under section 501 of the Internal Revenue Code of 1954 (sometimes referred to as a "proprietary" organization) must be licensed pursuant to State law. If the State has no licensing law for such organizations, a proprietary agency cannot participate in the health insurance program.

For services under hospital insurance, the term "home health agency" does not include any agency or organization which is primarily for the care and treatment of mental disease.

50.2 - Arrangements by Home Health Agencies

(Rev.19, Issued: 03-11-05, Effective/Implementation: N/A)

A. A home health agency (HHA) may have others furnish covered items or services through arrangements under which receipt of payment by the HHA for the services discharges the liability of the patient or any other person to pay for the services. Whether the items and services are provided by the HHA itself or by another agency under arrangement, both must agree not to charge the patient for covered items and services and must also agree to return money incorrectly collected.

In permitting HHAs to furnish services under arrangements, it was not intended that the agency merely serve as a billing mechanism for the other party. Accordingly, for services provided under arrangements to be covered, the agency must exercise professional responsibility over the arranged-for services *and ensure compliance with the home health conditions of participation.*

The agency's professional supervision over arranged-for services requires application of many of the same quality controls as are applied to services furnished by salaried employees. The agency must accept the patient for treatment in accordance with its *administration* policies, maintain a complete and timely clinical record of the patient that includes diagnosis, medical history, physician's orders, and progress *notes* relating to all services received; maintain liaison with the attending physician with regard to the progress of the patient and to assure that the required plan of treatment is periodically reviewed by the physician; secure from the physician the required certifications and recertifications; and ensure that the medical necessity of such services is reviewed on a sample basis by the agency's staff or an outside review group.

There are three situations in which an HHA may have arrangements with another health organization or person to provide home health services to patients:

- Where an agency or organization, in order to be approved to participate in the program, makes arrangements with another organization or individual to provide the nursing or other therapeutic services that it cannot provide directly;

- Where an agency that is already approved for participation, makes arrangements with others to provide services or items it does not provide directly; and
- Where an agency that is already approved for participation makes arrangements with a hospital, skilled nursing facility, or rehabilitation center for services on an outpatient basis because the services involve the use of equipment that cannot be made available to the patient in his/her place of residence.

B. If an agency's subdivision (acting in its capacity as an HHA) makes an arrangement with its parent agency for the provision of certain items or services, there need not be a contract or formal agreement. If, however, the arrangement is made between the HHA and another provider participating in the health insurance program (hospital, skilled nursing facility, or HHA, and, in the case of physical therapy, occupational therapy, or speech-language pathology services, clinics, rehabilitation agencies, and public health agencies), there must be a written statement regarding the services to be provided and the financial arrangements.

C. If the arrangements are with an agency or organization that is not a qualified provider of services, there must be a written contract that includes all of the following:

1. *A description of the services to be provided.*
2. *The duration of the agreement and how frequently it is to be reviewed.*
3. *A description of how personnel will be supervised.*
4. *A statement that the contracting organization will provide services in accordance with the plan of care established by the patient's physician in conjunction with the HHA's staff.*
5. *A description of the contracting organization's standards for personnel, including qualifications, functions, supervision, and inservice training.*
6. *A description of the method of determining reasonable costs and reimbursement by the HHA for the specific services to be provided by the contracting organization.*
7. *An assurance that the contracting organization will comply with title VI of the Civil Rights Act.*

D. If an HHA notifies a beneficiary of noncoverage of services that another party has been furnishing under arrangements entered into by the agency, the initial notice, in and of itself, does not negate the contract between the agency and the other party. Unless the evidence shows that the contract has been formally terminated, the beneficiary is still considered to be the agency's patient and the other party to be the representative of the agency. Consequently, if upon initial notice that a service is no longer covered the other party continues to provide services to the patient, the other party is considered to be furnishing the services under arrangements with the home health agency, absent evidence to the contrary. Thus, if a beneficiary appeals the noncoverage of any or all of the arranged for services furnished after the notice, and a ruling is made in favor of the beneficiary, those

services ruled on favorably would be reimbursable since they would constitute services furnished under arrangements by a certified HHA. If the denial is sustained, however, the other party cannot bill the beneficiary for the denied services since the HHA, not the other party, is responsible for the care rendered.

50.5 - Rehabilitation Centers

(Rev.19, Issued: 03-11-05, Effective/Implementation: N/A)

When the services are of such a nature that they cannot be administered at the patient's residence and are administered at a rehabilitation center which is not participating in the program as a hospital, skilled nursing facility, or home health agency, the rehabilitation center must meet certain standards. The physical plant and equipment of such a rehabilitation center must meet all applicable State and local legal requirements for construction, safety, health, and design, including safety, sanitation and fire regulations, building codes, and ordinances. *Given the statutory definition, a community mental health center is not considered a rehabilitation center.*