CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-01 Medicare General Information, Eligibility, and Entitlement	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 68	**Date: April 22, 2011**
	Change Request 7377

SUBJECT: Physician Certification and Recertification of Services Manual Changes

I. SUMMARY OF CHANGES: This manual update includes a face-to-face encounter requirement for home health and hospice certifications.

EFFECTIVE DATE: January 1, 2011
IMPLEMENTATION DATE: May 12, 2011

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. 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 is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	4/30.1/ Content of the Physician's Certification
R	4/60/Certification and Recertification by Physicians for Hospice Care

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

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

Attachment - Business Requirements

Pub. 100-01	Transmittal: 68	Date: April 22, 2011	Change Request: 7377

SUBJECT: Physician Certification and Recertification of Services Manual Changes

EFFECTIVE DATE: January 1, 2011

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I. GENERAL INFORMATION

A. Background: CMS is including the following clarifications to Chapter 4, Physician Certification and Recertification of Services, of Pub. 100-01, the Medicare General Information, Eligibility, and Entitlement Manual:

Due to new provisions mandated by passage of the Affordable Care Act, there are new statutory requirements regarding face-to-face encounters for certifications applicable to the home health and hospice programs that must be updated in Chapter 4.

B. Policy: Sections 6407 and 3132 of the Affordable Care Act require these face-to-face encounters with a physician for home health and hospice certifications. Details of the policy are provided in the above-mentioned chapter.

II. BUSINESS REQUIREMENTS TABLE

Use"Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7377.1	Medicare contractors shall make providers aware of the clarifications provided in Pub. 100-01, Medicare General Information, Eligibility, and Entitlement Manual, Chapter 4, Sections 30.1 and 60, regarding face-to-face encounters with a physician, including posting this entire instruction or providing a direct link to this instruction on their web site, and include information about it in a listserv message.	X		X		X					

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7377.2	Contractors shall post this entire instruction, or a direct link to this instruction, on their Web sites and include information about it in a listserv message within 1 week of the release of this instruction. In addition, the entire instruction must be included in the Contractors next regularly scheduled bulletin. Contractors are free to supplement it with localized information that would benefit their provider community in billing and administering the Medicare program correctly. Please note that a provider education article related to this instruction is available at http://www.cms.gov/MLNMattersArticles/downloads/SE1038.pdf. Notification of the article has also been released via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their web site and include information about it in a listserv message.	X		X		X					

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below:
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
CR 7329	Clarifications for Home Health Face-to-Face Encounter Provisions

Section B: For all other recommendations and supporting information, use this space:
N/A

V. CONTACTS

Pre-Implementation Contact(s): Kelly M. Horney, 410-786-0558, kelly.horney1@cms.hhs.gov

Post-Implementation Contact(s): Kelly M. Horney, 410-786-0558, kelly.horney1@cms.hhs.gov or contact your Contracting Officer's Technical Representative (COTR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: *For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),* and/or *Carriers*:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: *For Medicare Administrative Contractors (MACs)*:

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

30.1 - Content of the Physician's Certification

(Rev.68, Issued: 04-22-11, Effective: 01-01-11, Implementation: 05-12-11)

Under both the hospital insurance and the supplementary medical insurance programs, no payment can be made for covered home health services that a home health agency provides unless a physician certifies that:

- The home health services are because the individual is confined to his/her home and needs intermittent skilled nursing care, physical therapy and/or speech-language pathology services, or continues to need occupational therapy;

- A plan for furnishing such services to the individual has been established and is periodically reviewed by a physician; and

- The services are or were furnished while the individual was under the care of a physician.

Certifications must be obtained at the time the plan of care is established or as soon thereafter as possible.

Effective January 1, 2011, as a requirement for payment, the certifying physician must document that he or she, or an allowed non-physician practitioner (NPP) working in collaboration with the certifying physician, had a face-to-face encounter with the patient in accordance with Pub. 100-02, the Medicare Benefit Policy Manual, Chapter 7 manual guidance, Section 30.5.1.1.

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 Home Health Agency (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.

The 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, in the event of a system breakdown.

See §10.1 for the effects of failure to certify or recertify.

60 - Certification and Recertification by Physicians for Hospice Care

(Rev. 68, Issued: 04-22-11, Effective: 01-01-11, Implementation: 05-12-11))

The hospice must obtain written certification of terminal illness for each period of hospice care received by an individual. For the initial 90-day period, the hospice must obtain written certification statements from the medical director of the hospice or the physician member of the hospice interdisciplinary group, and the individual's attending physician (if the individual has one). The certification must specify that the individual's prognosis is for a life expectancy of 6 months or less if the terminal illness runs its normal course. Recertification for subsequent periods only requires the written certification by the hospice medical director or the physician member of the hospice interdisciplinary group. Certification*s and recertifications* must be dated and signed by the physician *and must include the benefit periods to which they apply. Certifications and recertifications must include a brief narrative explanation of the clinical findings that supports a life expectancy of 6 months or less.*

If written certification is not obtained within 2 calendar days of the initiation of hospice care, a verbal certification must be obtained within the 2 days. A written certification from the medical director of the hospice or the physician member of the interdisciplinary group must be on file in the beneficiary's record prior to the submission of a claim to the *Medicare Contractor*. If these requirements are not met, no payment may be made for the days prior to certification. Instead payment will begin with the day certification is obtained, i.e., the date verbal certification is obtained.

Certifications and recertifications may be completed up to 15 days before the next benefit period begins.

For recertifications on or after January 1, 2011, a hospice physician or hospice nurse practitioner must have a face-to-face encounter with each hospice patient prior to the beginning of the patient's third benefit period, and prior to each subsequent benefit period. Failure to meet the face-to-face encounter requirements results in a failure by the hospice to meet the patient's recertification of terminal illness eligibility requirement. The patient would cease to be eligible for the benefit. See Pub. 100-02, Medicare Benefit Policy Manual, Chapter 9, Section 20.1, Timing and Content of Certification