The Office of Inspector General (OIG) 2017 Work Plan targets home visits conducted by physicians and mid-level providers for claims review. Here's what you need to know to ensure your home visit claims meet Medicare billing requirements.

Changes to Medicare regulations and a reimbursement increase in 1998 resulted in the number of claims for home visits increasing from 1.4 million in 1999 to 2.3 million in 2009. Continued increases in recent years, along with the Centers for Medicare & Medicaid Services (CMS) also expressing concerns about medical necessity, led the OIG to add home visits to its 2016 and 2017 Work Plans.

Home Services Must Be Necessary, Not a Convenience

Like all services, home visits must be medically necessary to be covered. According to Medicare.gov, "medically necessary" is defined as "health-care services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms and that meet accepted standards of medicine." The services cannot be for the convenience of the patient, the patient's family, or the physician.

The provider must be able to prove that the home visit was based on the patient's inability to come to the office either this one time, or on an ongoing basis, due to physical or mental issues and not due to financial or other personal reasons. Physicians also cannot provide home services at their convenience (for example, visiting senior independent living facilities on a routine basis, without requests for or by patients).

Medicare rules (Medicare Claims Processing Manual, Chapter 12, Section 30.6.14.1.B) further define homebound status:

Under the home health benefit the beneficiary must be confined to the home for services to be covered. For home services provided by a physician using these codes, the beneficiary does not need to be confined to the home. The medical record must document the medical necessity of the home visit made in lieu of an office or outpatient visit.

Document Medical Necessity for Home Services

Providers must document clearly the reason for all E/M visits. For home visits, documentation must include how the visit was initiated (patient request, family or other source) and should detail the patient's conditions that prevented him or her from traveling to the provider's place of service. As with any E/M service, documentation must include a chief complaint; history of presenting illness (HPI); review of systems; and past, family, social history elements that are the key to making any note support medical necessity.

History provides the "why" of the note, and supports the level of exam to be performed and the complexity of the patient. If there is a clear description of the patient and his or her conditions in the

HPI, medically necessity will be supported. The plan of care should also provide an indication of the need for future visits, and the expectation of whether the patient will be able travel to the physician's office.

Don't Skip Patient Demographics, Business Forms

The home visit with a new patient has the same business requirements as a visit to the office, so providers need to gather the necessary demographic and insurance information, and provide patients with the appropriate forms. Maintaining a complete and accurate medical record for each patient is critical. Forms should include:

- Notice of Privacy Practices
- General consent for treatment
- New patient intake form
- History form
- Financial policies

2017 OIG Work Plan: Physician Home Visits – Reasonableness of Services

A home visit is when a physician provides evaluation and management (E/M) services in a patient's home. From January 2013 through December 2015, Medicare provided $718 million in payments for physician home visits. Physicians are required to document the medical necessity of a home visit in lieu of an office or outpatient visit. Medicare will not pay for items or services that are not "reasonable and necessary" (SSA § 1862(a) (1) (A)). The OIG will determine whether Medicare payments to physicians for E/M home visits were reasonable and made in accordance with Medicare requirements.

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