# C2C PHONE DEMO

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## Summary of April Results

This month, a total of **two (2) claims** were included in March's review. After a telephone conference was conducted and verbal testimony was provided, 50% of the claims were overturned (favorable) and 50% were upheld (unfavorable).

**One (1) home health claim** was included in this month's telephone demonstration. That claim denied because the orders were insufficient to cover all dates of service.

**One (1) hospice claim** was included in the telephone demonstration and was denied because of an untimely NOE submission.

****Percentages are based on the total home health or hospice claims.****

| | |
|---|---|
| **TOTAL CLAIMS** | **2** |
| Favorable (Overturned) | 1 |
| Unfavorable (Upheld) | 1 |
| **Home Health** | **1** |
| Orders - Missing/Incomplete/Invalid | 1 |
| **Hospice** | **1** |
| NOE Invalid/Missing/Untimely | 1 |

## HOME HEALTH BREAKDOWN OF RESULTS

*****Percentage is based on the total number of home health claims*****

1. **Home Health - No valid orders (100%)**

   The orders on the plan of care must indicate the type of services to be provided to the patient, both with respect to the professional who will provide them and the nature of the individual services, as well as the frequency of the services. Orders for care may indicate a specific range in the frequency of visits to ensure that the most appropriate level of services is provided to home health patients under a home health plan of care. When a range of visits is ordered, the upper limit of the range is considered the specific frequency. Orders for services to be furnished "as needed" or "PRN" must be accompanied by a description of the patient's medical signs and symptoms that would occasion a visit and a specific limit on the number of those visits to be made under the order before an additional physician order would have to be obtained **(§30.2.2)**.

### Use of Oral (Verbal) Orders

The Home Health Agency (HHA) must be acting upon a physician plan of care that meets the requirements for HHA services to be covered. For HHA services to be covered, the individualized plan of care must specify the services necessary to meet the patient-specific needs identified in the comprehensive assessment. In addition, the plan of care must include the identification of the responsible discipline(s) and the frequency and duration of all visits as well as those items listed in 42 Code of Federal Regulations (CFR) 484.60(a) that establish the need for such services. All care provided must be in accordance with the plan of care. The orders on the plan of care must include the type of services to be provided, who will provide the service, the nature of the service, and the frequency of the services. The plan of care must be signed and dated by a physician before the final claim is submitted for payment. Any changes in the plan of care must also be signed and dated by a physician prior to submission of the final claim.

When services are rendered based on the physician's verbal orders, the orders must be accepted and put into writing by personnel authorized to so under State and Federal laws and regulations as well as by any internal policies set forth by the HHA. The verbal orders must be signed and dated with the date the orders were received. This can be done by a registered nurse or qualified therapist (physical therapist, speech-language pathologist, occupational therapist, or licensed medical social worker). Rendering of services will not be delayed without supervising registered nurse or therapist signature; however, verbal orders must be signed and dated by the physician prior to the submission of the final bill.

If the services are furnished based on a **physician's oral order**, the orders may be accepted and put in writing by personnel authorized to do so by applicable State and Federal laws and

## DISCLAIMER

This information was prepared as a tool to assist providers and is not intended to grant rights or impose obligations. Although every reasonable effort has been made to assure the accuracy of the information within these pages, the ultimate responsibility or the correct submission of claims and response to any remittance advice lies with the provider of services.

This publication is a general summary that explains certain aspects of the Medicare Program, but is not a legal document. The official Medicare Program provisions are contained in the relevant laws, regulations, and rulings. Medicare policy changes frequently, and links to the source documents have been provided within the document for your reference.

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regulations as well as by the HHA's internal policies. The **orders must be signed and dated** with the **date of receipt** by the registered nurse or qualified therapist (i.e., physical therapist, speech-language pathologist, occupational therapist, or medical social worker) responsible for furnishing or supervising the ordered services. The orders may be signed by the supervising registered nurse or qualified therapist after the services have been rendered, if HHA personnel who receive the oral orders notify that nurse or therapist before the service is rendered. Thus, the rendering of a service that is based on an oral order would not be delayed pending signature of the supervising nurse or therapist. Oral orders must be countersigned and dated by the physician before the HHA bills for the care in the same way as the plan of care.

Services which are provided from the beginning of the 60-day certification period based on a request for anticipated payment and before the physician signs the plan of care are considered to be provided under a plan of care established and approved by the physician where there is an oral order for the care prior to rendering the services which is documented in the medical record and where the services are included in a signed plan of care.

Services that are provided in the subsequent 60-day certification period are considered provided under the plan of care of the subsequent 60-day episode where there is an oral order before the services provided in the subsequent period are furnished and the order is reflected in the medical record. However, services that are provided after the expiration of the plan of care, but before the acquisition of an oral order or a signed plan of care are not considered provided under a plan of care **(§30.2.5)**.

**Suggestion:** Documentation submitted should include valid physician orders for the services to be rendered. A valid order should include the service to be provided to the patient (who will provide them and the nature of the services) and the frequency of the services. The frequency of visits may be stated as a specific range to ensure the appropriate level of care is provided. If a range is indicated, the upper limit of the range will be considered the frequency. If PRN orders are included, signs and symptoms that initiate the visit must be included in addition to the limit on the number of PRN visits.

**Guidelines:** CMS IOM Pub. 100-02, Medicare Benefit Policy Manual (MBPM), Chapter 7 - Home Health Services - https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c07.pdf

- **Section 30.2** - Services Are Provided Under a Plan of Care Established and Approved by a Physician
- **Section 30.2.2** - Specificity of Orders
- **Section 30.2.5** - Use of Oral (Verbal) Orders
- **Section 30.3** - Under the Care of a Physician

## HOSPICE BREAKDOWN RESULTS

*****Percentage is based on the total number of hospice claims*****

**1. Hospice – Notice of Election Untimely or Invalid (100%)**

When a beneficiary elects hospice services, a valid Notice of Election (NOE) must be submitted timely. Timely-filed NOEs shall be filed within 5 calendar days after the date of the hospice admission. The election statement must include the effective date of the election, which may be the first date of hospice care or a later date but may be no earlier than the date of the election statement. An individual may not designate an effective date that is retroactive.

Documentation must support the reason an exception is needed. If the documentation is insufficient to support the exception, the claim will be denied.

**Chapter 9, § 20.2.1.3- Hospice Notice of Election reads:**

> There may be some circumstances that may be beyond the control of the hospice where it may not be possible to timely-file the NOE within 5 calendar days after the effective date of election or timely-file the Notice of Termination or Revocation (NOTR) (see section 20.2.4 - Hospice Notice of Termination or Revocation) within 5 calendar days after the effective date of a beneficiary's discharge or revocation. Therefore, the regulations do allow for exceptions. There are four circumstances that may qualify the hospice for an exception to the consequences of filing the NOE more than 5 calendar days after the effective date of election. These exceptional circumstances are as follows:
>
> 1. Fires, floods, earthquakes, or other unusual events that inflict extensive damage to the hospice's ability to operate;
> 2. An event that produces a data filing problem due to a CMS or Medicare contractor systems issue that is beyond the control of the hospice;
> 3. A newly Medicare-certified hospice that is notified of certification after the Medicare certification date, or is awaiting its user ID from its Medicare contractor; or,
> 4. Other circumstances determined by CMS to be beyond the control of the hospice.
>
> If one of the four circumstances described above prevents a hospice from timely-filing its NOE, the hospice must document the circumstance to support a request for an exception, which would waive the consequences of filing the NOE late. Using that documentation, the hospice's Medicare contractor will determine if a circumstance encountered by a hospice qualifies for an exception to the consequences for filing an NOE more than 5 calendar days after the effective date of election. If the request for an exception is denied, the Medicare contractor will retain the decision of the denial. Hospices retain their usual appeal rights on the claim for payment.

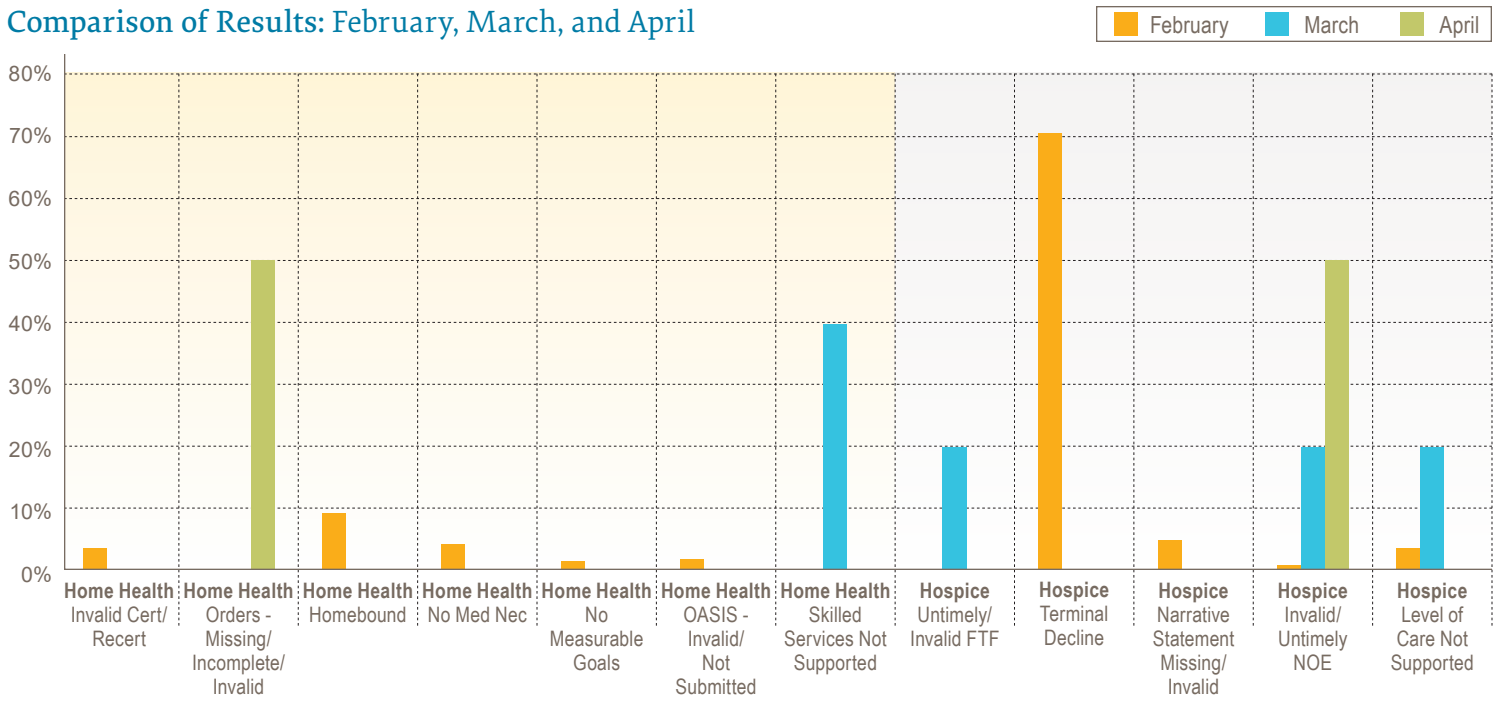
**Suggestion:** To avoid delays with the submission of the NOE, all information should be carefully entered. The election date cannot be retroactive, and the submission should be within the 5-day timeframe requirement. If any exceptions exist, providing careful documentation of the reason for the delay should be submitted in accordance with the guidelines.

**Guidelines:** CMS IOM, Pub. 100-02, Medicare Benefit Policy Manual (MBPM), Chapter 9, Coverage of Hospice Services Under Hospital Insurance - https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c09.pdf

- **Section 20.2.1.3** - Hospice Notice of Election

## Comparison of Results: February, March, and April

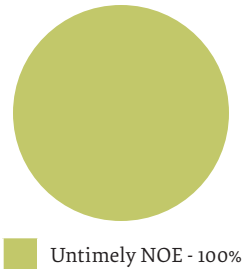



This graph shows the data from February, March, and April denials for a visual comparison.

## Distribution of Results: April 2021 - Home Health

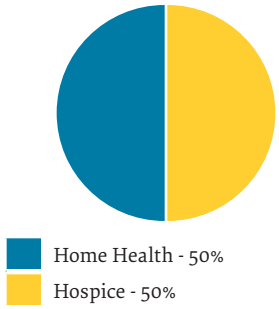

This pie chart illustrates the percentage of each home health denial, allowing for a visual comparison of home health denial reasons.

## Distribution of Results: April 2021 - Hospice




This pie chart illustrates the percentage of each hospice denial, allowing for a visual comparison of the denial reasons.

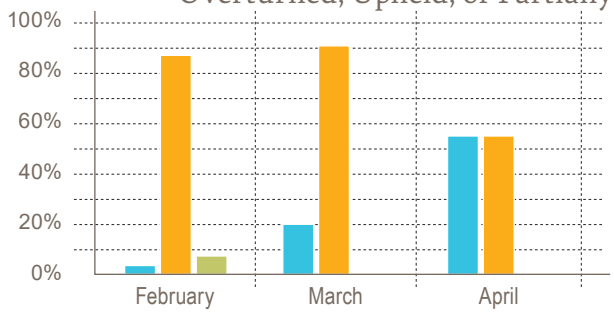
## Dispositions Overturned or Upheld by QIC: April 2021

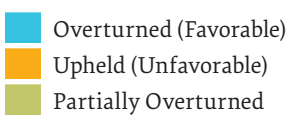



The pie chart provides a visual comparison of decisions that were either overturned (favorable) or upheld (unfavorable).

## Dispositions: February - April

### Overturned, Upheld, or Partially Overturned




The bar graph is a comparison of decisions for the months of December, January and February that were either overturned (favorable), upheld (unfavorable), or partially favorable.