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Summary of August's Results

This month, a total of **28 telephone conferences** were conducted with home health/hospice agency representatives. After a telephone conference was conducted and verbal testimony was provided, 64% of the claims were overturned (favorable)and 46% were upheld (unfavorable).

Sixteen (16) home health claims were included in this month's telephone demonstration. The denials resulted from documentation that did not support the need for skilled services (7); documentation that did not support the beneficiary met the criteria to support homebound (5); missing, incomplete or invalid orders (3); and face-to-face encounters that were missing, incomplete or invalid (1).

The most common issues were related to documentation to adequately support the need for skilled services. The face-to-face encounter, in conjunction with the medical record in its entirety, must substantiate the beneficiary's need for home health services [see Centers for Medicare and Medicaid Services (CMS), Internet-Only Manual (IOM), Publication 100-02, Medicare Benefit Policy Manual (MBPM) Chapter 7, Section 30.5.1.1 – Face-to-Face Encounter and Section 30.5.1.2 -Supporting Documentation Requirements]. Additionally, documentation must support that the patient is confined to the home. In the face-to-face encounter note, the provider must provide evidence to support the patient meets both criteria outlined in the guidelines for homebound as do the clinical notes (CMS IOM, Publication 100-02, MBPM, Chapter 7, Section 30.1.1 - Confined to Home).

Again, the medical record will be reviewed in its entirety to determine whether the documentation does support a need and that the beneficiary meets the criteria for homebound. Ensuring thorough, consistent documentation encounter is reviewed for evidence will often circumvent this error and provide enough support for the skilled services.

Twelve (12) hospice claims were included in the telephone demonstration. Ten (10) of the denials were due to documentation that did not sufficiently support the beneficiary's terminal status and two (2) denials were related the lack of support for the level of care billed (CMS Pub. 100-02, MBPM, Ch. 9 §40.1.5, 40.2.1, and 40.2.2 and CMS Pub. 100-04, Medicare Claims Processing Manual (MCPM), Ch. 11 §30.1).

TOTAL CLAIMS	**28**
Favorable	10
Unfavorable	18
Home Health Claims	**16**
Need for skilled services not supported	7
Homebound not supported	5
Orders missing/incomplete/invalid	3
FTF missing/incomplete/untimely	1
Hospice	**12**
Terminal prognosis not supported	10
Level of care not supported	2

Guidelines

Medicare Benefit Policy Manual, Chapter 7 - Home Health Services - https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c07.pdf

Medicare Claims Processing Manual, Chapter 11 - Processing Hospice Claims - https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c11.pdf

BREAKDOWN OF AUGUST HOME HEALTH RESULTS

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

1. **Home Health - Documentation did not support the need for skilled services (43.75%)**

   For any home health services to be covered by Medicare, the patient must meet the qualifying criteria as specified in **§30**, including having a need for skilled nursing care on an intermittent basis (**§40.1, §40.1.1**), physical therapy, speech-language pathology services, or a continuing need for occupational therapy as defined in **§40.2** and **§40.2.1**. Skilled nursing services are necessary only when (a) the particular patient's special medical complications require the skills of a registered nurse or, when provided by regulation, a licensed practical nurse to perform a type of service that would otherwise be considered non-skilled; or (b) the needed services are of such complexity that the skills of a registered nurse or, when provided by regulation, a licensed practical nurse are required to furnish the services. The service must be so inherently complex that it can be safely and effectively performed only by, or under the supervision of, professional or technical personnel as provided by regulation, including **42 C.F.R. 409.32**. A patient's overall medical condition, without regard to whether the illness or injury is acute, chronic, terminal, or expected to extend over a long period of time, should be considered in deciding whether skilled services are needed. A patient's

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diagnosis should never be the sole factor in deciding that a service the patient needs is either skilled or not skilled. Skilled care may, depending on the unique condition of the patient, continue to be necessary for patients whose condition is stable.

The home health clinical notes must document as appropriate:

- the history and physical exam pertinent to the day's visit, (including the response or changes in behavior to previously administered skilled services) and the skilled services applied on the current visit, and
- the patient/caregiver's response to the skilled services provided, and
- the plan for the next visit based on the rationale of prior results,
- a detailed rationale that explains the need for the skilled service in light of the patient's overall medical condition and experiences,
- the complexity of the service to be performed, and
- any other pertinent characteristics of the beneficiary or home

Clinical notes should be written so that they adequately describe the reaction of a patient to his/her skilled care and provide a clear picture of the treatment, as well as "next steps" to be taken. Vague or subjective descriptions of the patient's care should not be used. For example, terminology such as the following would not adequately describe the need for skilled care:

- Patient tolerated treatment well
- Caregiver instructed in medication management
- Continue with POC

Objective measurements of physical outcomes of treatment should be provided and/or a clear description of the changed behaviors due to education programs should be recorded in order that all concerned can follow the results of the applied services.

To be covered as skilled therapy, the services must require the skills of a qualified therapist and must be reasonable and necessary for the treatment of the patient's illness or injury. Coverage does not turn on the presence or absence of an individual's potential for improvement, but rather on the beneficiary's need for skilled care.

The service of a physical therapist, speech-language pathologist, or occupational therapist is deemed reasonable and necessary if the complexity of the service is such that it can be performed safely and/or effectively **only by or under the general supervision** of a skilled therapist. To be covered, assuming all other eligibility and coverage criteria have been met, the skilled services must also be **reasonable and necessary to the treatment of the patient's illness or injury or to the restoration or maintenance of function affected by the patient's illness or injury**. It is necessary to determine whether individual therapy services are skilled and whether, in view of the patient's overall condition, skilled management of the services provided is needed.

The beneficiary's medical condition is a valid factor in the determination of medical necessity; however, the diagnosis or prognosis should not be the only factor in determining medical necessity of therapy services. The question to be answered is whether the services can be completed by unskilled personnel.

To be considered reasonable and necessary for the treatment of the illness or injury:

a) The services must be consistent with the nature and severity of the illness or injury, the patient's medical needs, including the requirement that the amount, frequency, and duration of the services must be reasonable; and

b) The services must be considered, under accepted standards of medical practice, to be specific, safe, and effective treatment for the patient's condition, meeting the standards noted below. The home health record must specify the purpose of the skilled service provided.

The therapist must document measurable results in the initial therapy assessment and include it in the reassessment that is to be performed at least every 30 days.

Suggestion: Clinical notes should provide communication records between the entire home care team and clearly document the need for the skilled service. This can include a clear, concise history and physical exam on the date of the visit which notes changes in behavior and the skilled services provided during the visit. Additionally, it is important to note the patient's and caregiver's response to the skilled service provided as well as the plan for further visits. A detailed note describing the rationale for the skilled service, the complexity of the service, and any pertinent characteristics of the beneficiary or environment where he/she is receiving care.

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

- **Section 40.1.1** (General Principles Governing Reasonable and Necessary Skilled Nursing Care)
- **Section 40.2** (Skilled Therapy Services)
- **Section 40.2.1** (General Principles Governing Reasonable and Necessary Physical Therapy, Speech-Language Pathology Services, and Occupational Therapy)

2. Home Health – Documentation did not support homebound (31.25%)

Documentation was submitted; however, was insufficient to support the patient is confined to the home. To determine homebound, the face-to-face encounter assessment information and clinical records are reviewed to determine whether the beneficiary is unable to leave the home unassisted or leaving the home requires a significant, taxing effort. Submissions included documentation that noted the following assessment information that **does not** sufficiently support homebound:

- Normal mobility with good range of motion and adequate strength in all extremities
- No extremity deformities noted
- No assistive device used for ambulation
- Beneficiary states that they leave the home for activities not supported by the guidelines for homebound

The patient may be considered homebound if the absences from the home are infrequent or for periods of relative short durations or are for the need to receive health care treatment. Examples may be attendance at adult day care centers, ongoing outpatient kidney dialysis or outpatient chemotherapy or radiation therapy.

Suggestion: Include clear documentation of beneficiary's physical status which includes strength, gait, balance, and any additional factors that affect mobility. Document any assistive devices and whether the beneficiary's requires assistance leaving the home . The Outcome and Assessment Information Set (OASIS) can be used to substantiate the beneficiary's homebound status and his/her need for skilled care; however, assessment data must coincide with additional documentation found within the medical record.

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

- **Section 30.1.1** (Patient Confined to the Home)
- **Section 30.1.2** (Patient's Place of Residence)
- **Section 30.5.1** (Physician Certification)
- **Section 30.5.1.1** (Face-to-Face Encounter)
- **Section 30.5.1.2** (Supporting Documentation Requirements)

3. Home Health – Orders missing/incomplete/untimely (18.75%)

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 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, 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)

4. Home Health – Face-to-face encounter missing/incomplete/untimely (6.25%)

The face-to-face encounter is one element of certification for home health services. The encounter is required to be conducted by either the certifying physician, a physician who cared for the beneficiary in the acute/post-acute facility or an allowed non-physician practitioner (NPP). The encounter note or additional supporting documentation from the agency needs to provide assessment data that supports the beneficiary's homebound status and the beneficiary's need for home health services.

The following NPPs can conduct the face-to-face encounter:

- A **nurse practitioner or a clinical nurse specialist** working in accordance with State law and in collaboration with the certifying physician or in collaboration with an acute or post-acute care physician, with privileges, who cared for the patient in the acute or post-acute care facility from which the patient was directly admitted to home health;

- A **certified nurse midwife**, as authorized by State law, under the supervision of the certifying physician or under the supervision of an acute or post-acute care physician with privileges who cared for the patient in the acute or post-acute care facility from which the patient was directly admitted to home health;
- A **physician assistant** under the supervision of the certifying physician or under the supervision of an acute or post-acute care physician with privileges who cared for the patient in the acute or post-acute care facility from which the patient was directly admitted to home health.

NPPs performing the encounter are subject to the same financial restrictions with the HHA as the certifying physician, as described in 42 CFR 424.22(d).

The encounter note must be performed either **90 days prior** to the start of care (SOC) date or **within 30 days after** the beneficiary was admitted to home health (SOC). When a physician orders home health care for a patient based on a new condition not present during the encounter 90 days prior to the SOC, either the certifying physician or an allowed NPP must see the patient again within 30-days of his/her admission to home health. A new encounter is needed in order to develop a care plan which is more effective to treat the patient's condition.

Should a patient expire after admission to home health but before a face-to-face encounter was conducted, the contractor will determine whether a good faith effort existed on the part of the HHA to facilitate and/or coordinate the encounter. If that is the case, and all other conditions have been met, the certification is considered complete.

There are also provisions to allow for telehealth services. Under normal circumstances, the encounter may be performed via telehealth services from an approved originating site. An originating site is one that is the location of an eligible Medicare beneficiary. Additionally, telehealth services are allowed only if the originating site is in a rural health area with a professional shortage or in a county that is outside a Metropolitan Statistical Area.

Originating sites authorized by law are:

- Physician or practitioner office;
- Hospital;
- Critical Access Hospitals (CAH);
- Rural Health Clinics (RHC);
- Federally Qualified Health Centers (FQHC);
- Hospital-based or CAH-based Renal Dialysis Centers (including satellites);
- Skilled Nursing Facilities (SNF); and
- Community Mental Health Centers (CMHC).

Exceptions during the COVID-19 Public Health Emergency (PHE)

With the onset of the current PHE, there have been some allowances afforded to physicians and beneficiaries. These waivers are to facilitate the containment of the spread of the virus. Although telehealth services are allowed during the PHE, there are requirements for what type of technology may be used. The home health face-to-face encounter requires the use of two-way audio and visual equipment that allows for real-time communication. This allows for dialog and physical assessment of the beneficiary. For additional waivers amidst the PHE, please refer to the CGS website or the CMS website.

Suggestion: To avoid delays in claim processing, ensure the face-to-face encounter has been performed within the required timeframe, supports the beneficiary is homebound, and addresses the reason the beneficiary requires home health services. If the encounter was performed by a practitioner other than the certifying physician, include documentation, such as an attestation signed by the certifying physician, to support that the face-to-face encounter was completed, and the certifying physician reviewed the encounter note. The certifying physician must acknowledge that he/she has reviewed the face-to-face encounter note. If the beneficiary is admitted directly from the community, the certifying physician must perform the encounter. If admitted directly to home health from an acute or post-acute care facility, the encounter note should be one that was authored by a physician or NPP who cared for that patient in either facility.

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

- **Sections 30.5.1.1** (Face-to-Face Encounter)

BREAKDOWN OF AUGUST HOSPICE RESULTS

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

5. Hospice – Trajectory of Terminal Decline Not Supported (83.33%)

Hospice care is provided to those patients who are certified as terminally ill. An individual is considered to be terminally ill if the medical prognosis is that the individual's life expectancy is 6 months or less if the illness were to run its normal course. **Section 1814(a)(7)** of the Social Security Act (the Act) specifies that certification of terminal illness for hospice benefits shall be based on the clinical judgment of the hospice medical director or physician member of the interdisciplinary group (IDG) and the individual's attending physician, if he/she has one, regarding the normal course of the individual's illness. No one other than a medical doctor or doctor of osteopathy can certify or re-certify a terminal illness. Predicting of life expectancy is not always exact. The fact that a beneficiary lives longer than expected in itself is not cause to terminate benefits.

Suggestion: All documentation should provide adequate support of the patient's terminal illness. This includes, but is not limited to, clear and concise documentation of symptoms, treatment, appetite, food and liquid oral intake, presence of infections, wounds that are stage III or greater, weight gain or loss of 10% or greater over a period of 6 consecutive months, and/or intractable pain. Documentation of the weight, appetite, ulcers etc. alone does not help paint the picture. Use of comparative data will help clearly illustrate the patient's status and the trending decline in condition. The physician's clinical judgment must be supported by clinical information and other documentation that provides a basis for the six-month certification.

Documenting weight, appetite, wounds, etc. does not always provide a clear picture of the beneficiary's status. Using comparative data allows for a clearer picture of the beneficiary's declining condition.

Guidelines: CMS IOM, Pub. 100-02, MBPM, Chapter 9 - Coverage of Hospice Services Under Hospital Insurance https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c09.pdf

- **Section 10** (Requirements – General)
- **Local Coverage Determination (LCD) L34538** Hospice Determining Terminal Status

6. Hospice – Documentation does not support level of care rendered (17%)

A description of each level of care follows.

Routine Home Care - The hospice is paid the **routine home care rate** for each day the patient is **under the care of the hospice and not receiving one of the other categories of hospice care**. This rate is paid without regard to the volume or intensity of routine home care services provided on any given day and is also paid when the patient is receiving outpatient hospital care for a condition unrelated to the terminal condition.

Continuous Home Care - The hospice is paid the **continuous home care** rate when continuous home care is provided in the patient's home. Continuous home care is **not paid during a hospital, skilled nursing facility or inpatient hospice facility stay**. This rate is paid only during a period of crisis and only as necessary to maintain the terminally ill individual at home. The continuous home care rate is divided by 24 hours in order to arrive at an hourly rate. A minimum of 8 hours must be provided. Nursing care must be provided for more than half of the period of care and must be provided by either a registered nurse or licensed practical nurse. Parts of an hour are identified through the reporting of time for continuous home care days in 15-minute increments and these increments are used in calculating the payment rate. **Only patient care provided during the period of crisis is to be reported.** Payment is based upon the number of 15-minute increments that are billed for 32 or more units. Rounding to the next whole hour is no longer applicable. Units should only be rounded to the nearest increment. Billing for CHC should not reflect nursing shifts and non-direct patient increments (e.g., meal beaks, report, education of staff). Continuous home care is not intended to be used as respite care.

The hospice provides a **minimum of 8 hours of care during a 24-hour day**, which begins and ends at midnight. This care need not be continuous, i.e., 4 hours could be provided in the morning and another 4 hours in the evening, but care must reflect the needs of an individual in crisis. The care must be predominantly nursing care provided by either a registered nurse (RN) or licensed practical nurse (LPN). In other words, at least half of the hours of care are provided by the RN or LPN. Homemaker or home health aide (also known as a hospice aide) services may be provided to supplement the nursing care.

Care by a home health aide and/or homemaker may not be discounted or provided "at no charge" in order to qualify for continuous home care. The care provided by all members of the interdisciplinary and/or home health team must be documented in the medical record regardless if that care does or does not compute into continuous home care.

For more detailed information on Continuous Home Care, see **Pub. 100-02, Chapter 9, §40.2.1**.

Inpatient Respite Care - The hospice is paid at the **inpatient respite care rate** for each day on which the beneficiary is in an **approved inpatient facility and is receiving respite care**. Payment for respite care may be made for a **maximum of 5 continuous days** at a time including the date of admission but not counting the date of discharge. Payment for the sixth and any subsequent days is to be made at the routine home care rate. More than one respite period (of no more than 5 days each) is allowable in a single billing period. If the beneficiary dies under inpatient respite care, the day of death is paid at the inpatient respite care rate. Payment at the respite rate is made when respite care is provided at a Medicare or Medicaid certified hospital, SNF, hospice facility, or NF.

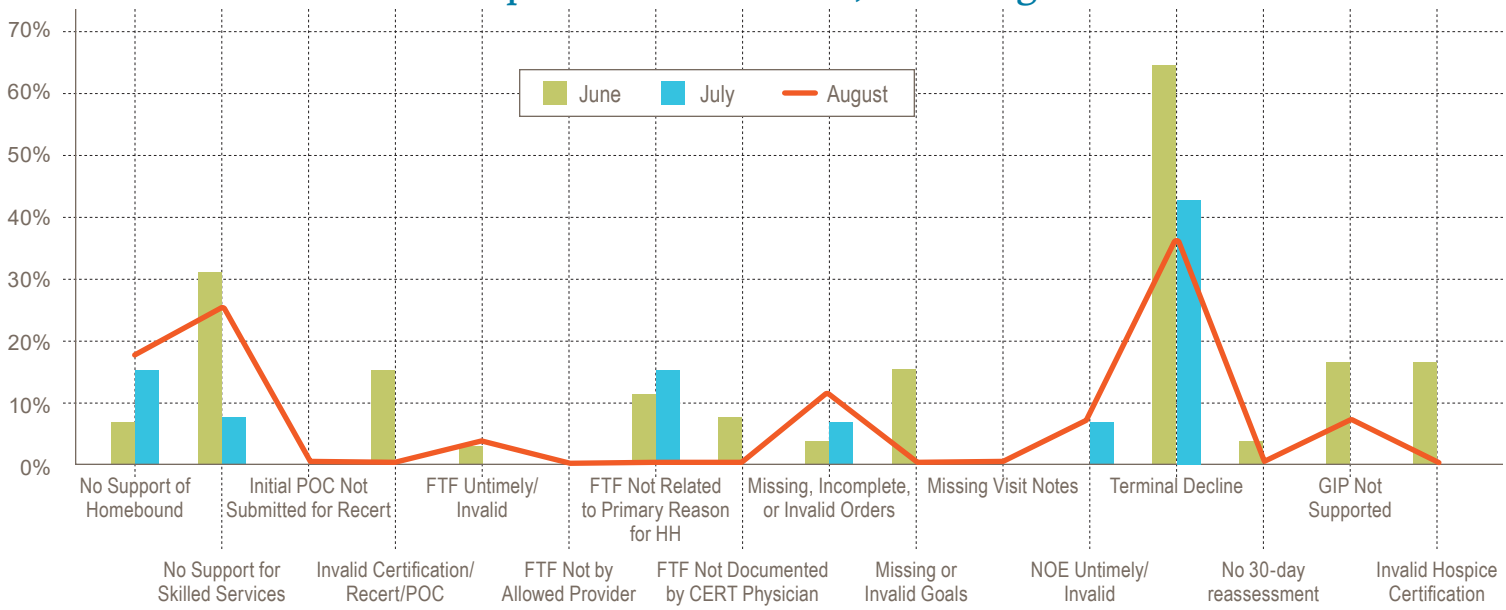
General Inpatient Care - Payment at the inpatient rate is made when general inpatient care is provided at a Medicare certified hospice facility, hospital, or skilled nursing facility.

Suggestion: For payment of hospice services, the patient's symptoms must be those which require the specific levels of care indicated above. Ensure clear documentation of patient's symptoms, medication management, appetite, status changes, etc. for additional support for the level of care for which payment is being requested. Documentation should be detailed and consistent with additional medical records.

Guidelines: CMS IOM, Pub. 100-04, MCPM, Chapter 11 - Processing Hospice Claims - https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c09.pdf

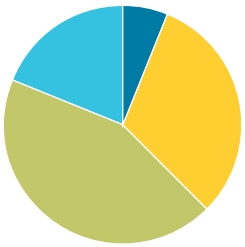
- **Section 30.1** [(Levels of Care Data Required on the Institutional Claim to A/B MAC (HHH)]

Comparison of Results: June - August



This graph shows the comparison June's denials with those noted January-July, allowing for a visual comparison of the results during the months of June and July in relation to denials for the month of August.

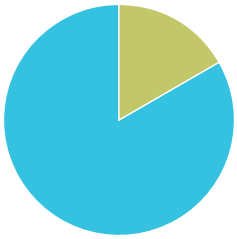
Distribution of Denials: August 2020 - Home Health



- FTF missing/incomplete/untimely - 6.25%
- Med Nec - skilled services not supported - 43.75%
- Homebound not supported - 31.25%
- Orders - missing/incomplete/invalid - 18.75%

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

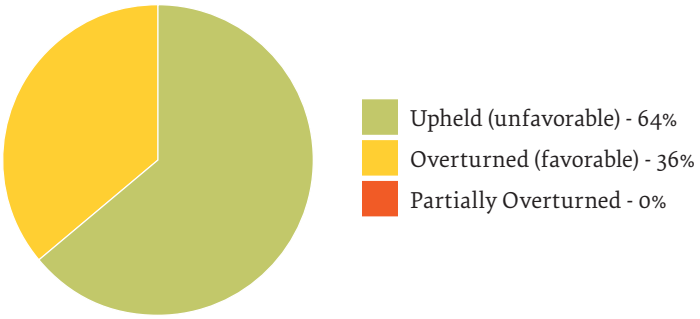
Distribution of Denials: August 2020 - Hospice



- Terminal prognosis not supported - 83.33%
- Level of care not supported - 16.67%

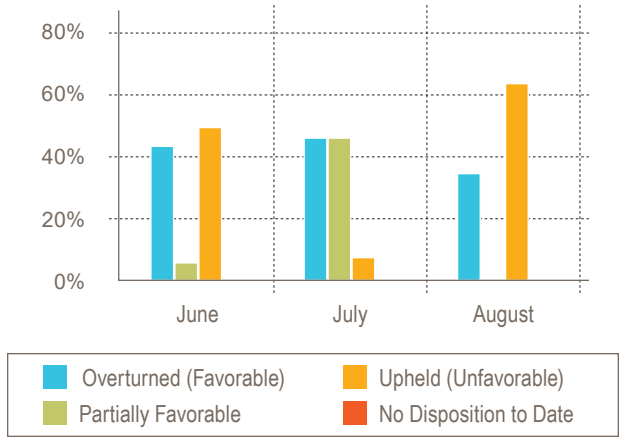
This pie chart illustrates the percentage of each hospice denial, allowing for a visual comparison of the denial reasons.

Dispositions Overturned, Upheld, or Partially Upheld by QIC: August 2020



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

Dispositions: June - August
Overturned, Upheld, or Partially Overturned



The bar graph are a comparison of decisions for the months of June, July, and August that were either overturned (favorable), upheld (unfavorable), or partially favorable

