C2C PHONE DEMO

CGS®
A CELERIAN GROUP COMPANY

Summary of February's Results

This month, a total of **one hundred fifty-five claims (155)** were included in February's review. After a telephone conference was conducted and verbal testimony was provided, 4.52% of the claims were overturned (favorable), 8.39% were partially overturned (partially favorable), and 87.10% were upheld (unfavorable). There were seven appeal numbers that were either reviewd by a Unified Program Integrity Contractor (UPIC) or Supplemental Medical Review Contractor(SMRC) and included multiple claims with each appeal number.

Thirty-one (31) home health claims were included in this month's telephone demonstration. **Fourteen (14) claims** were denied because the documentation was insufficient to support the patient was confined to the home or that leaving the home requried considerable/taxing effort. **Six (6) claims** were denied for lack of support of the need for skilled services. **Four (4) claims** denied because the initial plan of care (485 form) was not included with the recertification documentation. The omission of measurable goals was the reason for two **(2) of the claims** denied. Lastly, a missing certificaiton statement of an invalid/untimely signature was the denial reason for **two (2) claims** (one claim each).

To determine if there is sufficient support that the patient is homebound and there is a need for home health services, the medical record is reviewed in its entirety. While the entire record is reviewed, the information found is compared to clinical notes and assessment information. Ensuring thorough, consistent documentation will often circumvent this error and provide enough support for these two elements. When submitting documentation, ensure that all visit notes, assessments and physician notes are included.

One hundred twenty-four (124) hospice claims were included in the telephone demonstration. **One hundred nine (109) claims** were denied because the documentation did not support a terminal prognosis. **Six (6) claims** were denied because the documentation did not support the level of care provided. **Eight (8) claims** denied because the physician narrative statement was either missing or in valid and **one (1) claim** denied because the Notice of Election (NOE) was missing or invalid.

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

TOTAL CLAIMS	**155**
Favorable (Overturned)	7
Unfavorable (Upheld)	135
Partially Favorable	13
Home Health	**31**
Homebound Not Supported	14
Med Nec - Skilled Services Not Supported	6
Initial POC Not Submitted with REcert Documentation	4
OASIS - Invalid/Not Submitted	3
No Measurable Goals	2
Invalid Certification	2
Hospice	**124**
Terminal Prognosis Not Supported	109
Narrative Statement Missing/Invalid	8
Level of Care Not Supported	6
NOE Invalid/Missing	1

HOME HEALTH BREAKDOWN OF RESULTS

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

1. **Home Health - Homebound Not Supported (45.16%)**

   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

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

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.

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 30.1.1** (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)

2. Home Health – Skilled Services Not Supported (19.35%)

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 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 considering 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, Medicare Benefit Policy Manual (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

3. Home Health – Invalid Certification/Recertification (19.35%)

Claims that denied for this error was because the initial plan of care (485 form) was not included with the submission of the recertification documentation.

At the end of the 60-day certification, the beneficiary is eligible for recertification for a subsequent 60-day period. The plan of care must be reviewed and signed by the physician every 60 days unless:

- A beneficiary transfers to another HHA; or
- A discharge and return to home health during the 60-day certification

For recertification, the physician must attest that the beneficiary is homebound, needs intermittent skilled nursing services, a plan of care has been established, and the beneficiary is under the care of a physician who will periodically review the plan of care.

Beneficiaries are not limited to the number of 60-day recertifications if they continue to meet eligibility criteria for home health services. The physician certification may cover a period of less than 60 days, but not greater.

Suggestion: When submitting documentation for recertification, include the initial home health certification/plan of care (485). Ensure that the face-to-face assessment data has not changed and there reason the beneficiary requires home health services is clearly documented in addition to documentation to support the beneficiary remains homebound. The submission should include documentation to support all elements of certification/recertification such as (see the Medicare Benefit Policy Manual, Chapter 7, Section 30.5.2)

- The beneficiary is confined to home (homebound)
- The beneficiary requires skilled nursing services on an intermittent basis
- A plan of care has been established and will be reviewed by a physician and
- The beneficiary is under the care of a physician

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

4. Home Health – OASIS was Invalid/Missing (9.68%)

The Outcome Assessment Information Set (OASIS) exists as a condition of payment beginning on January 1, 2010. The OASIS must provide patient-specific, accurate assessment data that reflects the patient's current health status. Elements such as clinical needs, functional status and service utilization are specifically used to calculate payment.

A registered nurse must conduct the initial assessment to determine care needs of the patient and to determine Medicare Home Health eligibility. The initial assessment must be completed within 48 hours of the referral, within 48 hours of the patient's return home, or on the certifying practitioner's ordered start of care date. If therapy service (speech therapy, physical therapy or occupational therapy) is the only service ordered, the OASIS may be completed by that skilled professional.

The assessment should include the following:

1) The patient's current health, psychosocial, functional, and cognitive status;
2) The patient's strengths, goals, and care preferences, including information that may be used to demonstrate the patient's progress toward achievement of the goals identified by the patient and the measurable outcomes identified by the HHA;
3) The patient's continuing need for home care;
4) The patient's medical, nursing, rehabilitative, social, and discharge planning needs;
5) A review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy.
6) The patient's primary caregiver(s), if any, and other available supports, including their:
   i. Willingness and ability to provide care, and
   ii. Availability and schedules;
7) The patient's representative (if any);
8) Incorporation of the current version of the Outcome and Assessment Information Set (OASIS) items, using the language and groupings of the OASIS items, as specified by the Secretary). The OASIS data items determined by the Secretary must include: clinical record items, demographics and patient history, living arrangements, supportive assistance, sensory status, integumentary status, respiratory status, elimination status, neuro/emotional/behavioral status, activities of daily living, medications, equipment management, emergent care, and data items collected at inpatient facility admission or discharge only.

The comprehensive assessment must be updated and revised as the patient's condition changes but no less frequently than:

1) The last 5 days of every 60 days beginning with the start-of-care date, unless there is a -
   i. Beneficiary elected transfer;
   ii. Significant change in condition; or
   iii. Discharge and return to the same HHA during the 60-day episode.
2) Within 48 hours of the patient's return to the home from a hospital admission of 24 hours or more for any reason other than diagnostic tests, or on physician or allowed practitioner-ordered resumption date;
3) At discharge.

Suggestion: Prior to the submission of the claim, review the documentation to ensure the OASIS requirements have been met. Documenting pertinent assessment information on the form is critical to ensure that the patient's conditions, needs, and treatment plan are clear. Become familiar with timeframe requirements related

to the OASIS and adhere to them. Complete new comprehensive assessments as the patient's condition either improves or declines.

Guidelines: CMS IOM Pub. 100-08, Medicare Program Integrity Manual (MPIM), Chapter 3, **Section 3.2.3.1.A** for Outcome Assessment Information Set https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c03.pdf and **Title 42 of the Code of Federal Regulations (CFR), Section 484.55**, https://www.ecfr.gov/cgi-bin/text-idx?node=pt42.5.484&rgn=div5

5. Home Health – Nl Measurable Therapy Goals (6.45%)

The plan of treatment should address specific therapeutic goals for which modalities and procedures are planned out specifically in terms of type, frequency, and duration. The therapist must document the patient's functional limitations and therapeutic short- and long-term goals in terms that are objective and measurable. To ensure therapy services are effective, a qualified therapist (not an assistant) must perform the ordered therapy service. During this visit, the therapist must assess the patient using a method that allows for objective measurement of function and successive of measurements. The therapist must document the measurement results in the clinical record.

Suggestion: Include therapy goals (both short-term and long-term) that are measurable and contain an objectively measurable component with an achievement timeframe/date for each goal.

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 40.2** (Skilled Therapy Services)

HOSPICE BREAKDOWN RESULTS

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

1. Hospice – Documentation Does Not Support a Trajectory of Terminal Decline (87.90%)

Hospice care is provided to those patients who are certified as terminally ill. An individual is considered 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. The physician's clinical judgment must be supported by clinical information and other documentation that provides a basis for the six-month certification.

Guidelines: CMS IOM, Pub. 100-02, Medicare Benefit Policy Manual, 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

2. Hospice – Invalid Certification (6.45%)

For the first 90-day period of hospice coverage, the hospice must obtain oral or written certification of the terminal illness by the medical director of the hospice or the physician member of the hospice interdisciplinary group (IDG) and the individual's attending physician, if the individual has one. This must be obtained no later than **2 calendar days** after hospice care is initiated. Initial certifications may be completed **up to 15 days prior** to election of hospice care and recertifications may be completed up to 15 days prior to the next certification period; however, for subsequent periods, the hospice must obtain a written certification statement from the medical director of the hospice or physician of the hospice's IDG no later than 2 calendar days after the first day of each period. A brief narrative explanation of the clinical findings that supports a life expectancy of 6 months or less must be included (see guidelines for specific narrative requirements).

As of October 1, 2009, the physician's brief narrative explanation of the clinical findings that supports a life expectancy of 6 months or less as part of the certification and recertification forms, or as an addendum to the certification and recertification forms;

- If the narrative is part of the certification or recertification form, then the narrative must be located immediately above the physician's signature.
- If the narrative exists as an addendum to the certification or recertification form, in addition to the physician's signature on the certification or recertification form, the physician must also sign immediately following the narrative in the addendum.
- The narrative shall include a statement directly above the physician signature attesting that by signing, the physician confirms that he/she composed the narrative based on his/her review of the patient's medical record or, if applicable, his or her examination of the patient. The physician may dictate the narrative.
- The narrative must reflect the patient's individual clinical circumstances and cannot contain check boxes or standard language used for all patients. The physician must synthesize the patient's comprehensive medical information in order to compose this brief clinical justification narrative.
- For recertifications on or after January 1, 2011, the narrative associated with the third benefit period recertification and every subsequent recertification must include an explanation of why the clinical findings of the face-to-face encounter support a life expectancy of 6 months or less.

Suggestion: To avoid errors in processing hospice claims, ensure that the narrative is included in the certification or recertification and appears directly above the physician's dated signature. The narrative may also be submitted on an addendum; however, must be signed and dated by the physician immediately below the narrative statement. All documentation should include clear, concise documentation of assessment data to support a life expectancy of 6 months or less.

Guidelines: CMS IOM Pub. 100-02, Chapter 9 - Coverage of Hospice Services Under Hospital Insurance - https://www.cms.

gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c09.pdf

- **Section 20** (Certification and Election Requirements)
- **Section 20.1** (Timing and Content of Certification)

3. Hospice – Level of Care Not Supported (4.84%)

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

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

4. Hospice – Notice of Election Untimely or Invalid (.81%)

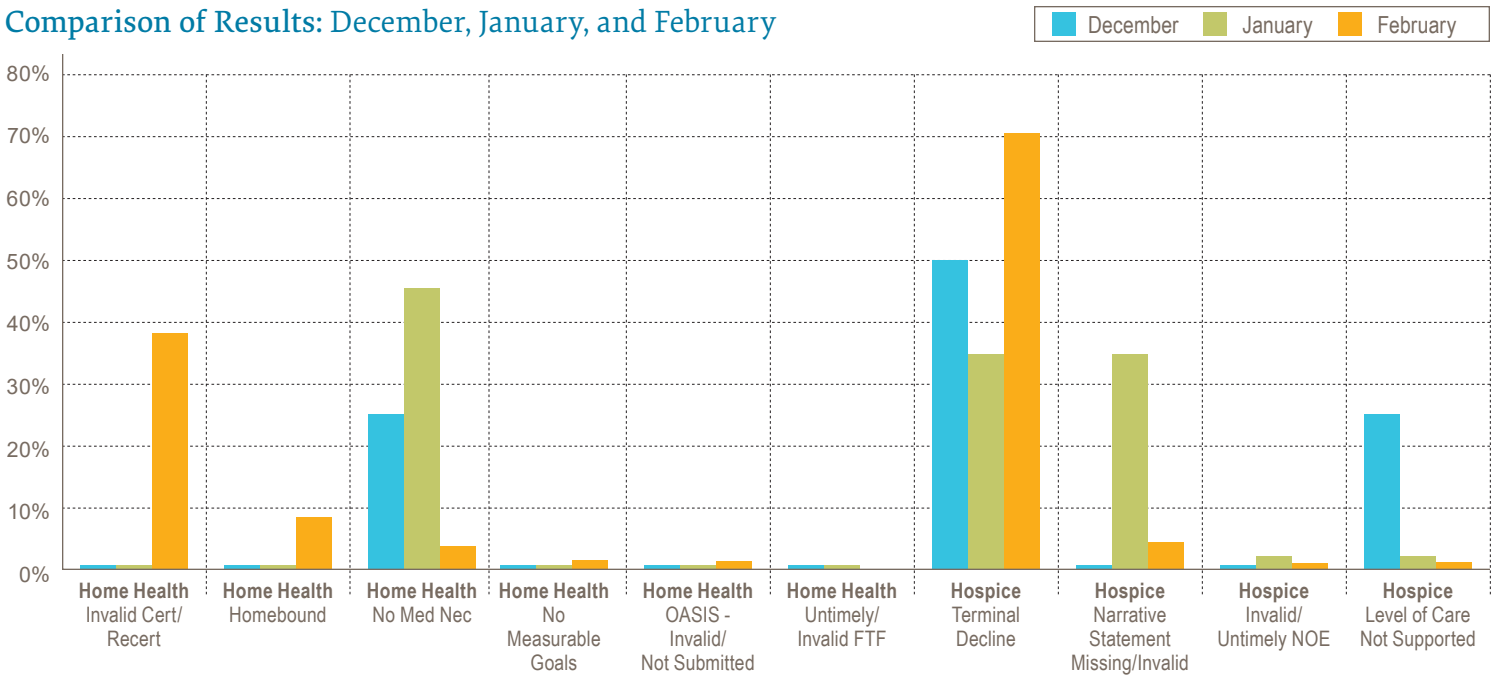
When a beneficiary elects hospice services, a valid Notice of Election (NOE) must be submitted timely. Timely-filed NOEs shall be filed within 5 calendar days after the date of the hospice admission. The election statement must include the effective date of the election, which may be the first date of 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.

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. 100-04, Medicare Claims Processing Manual (MCPM), Chapter 11 - Processing Hospice Claims - https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c11.pdf

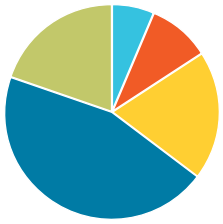
- **Section 20.1.1** [Notice of Election (NOE)]

Comparison of Results: December, January, and February



This graph shows the data from December, January, and February denials for a visual comparison.

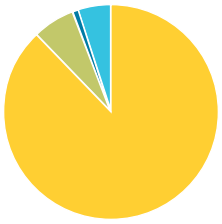
Distribution of Results: February 2021 - Home Health



- Invalid Cert/Recert - 3.87%
- Homebound - 9.0%
- No Med Nec - 3.9%
- No Measurable Goals - 1.3%
- OASIS - Invalid/Not Submitted - 1.9%

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

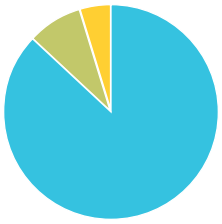
Distribution of Results: February 2021 - Hospice



- Terminal Decline - 70.32%
- Level of Care Not Supported - 3.87%
- Invalid/Untimely NOE - 0.625%
- Narrative Statement Missing/Invalid - 5.16%

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

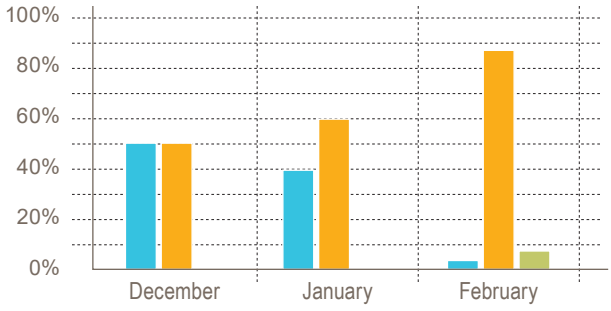
Dispositions Overturned or Upheld by QIC: February 2021



- Upheld (unfavorable) - 4.52%
- Overturned (favorable) - 8.39%
- Partially Upheld - 87.10%

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

Dispositions: December - February Overturned, Upheld, or Partially Overturned



- Overturned (Favorable)
- Upheld (Unfavorable)
- 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.

