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Summary of January's Results

This month, **a total of 20 claims** were included in January's review. After a telephone conference was conducted and verbal testimony was provided, 40% of the claims were overturned (favorable) and 60% were upheld (unfavorable).

Nine (9) home health claim was included in this month's telephone demonstration. All these claims were denied as a result of documentation that was insufficient to support the need for skilled services.

To support home health services, the medical record is reviewed in its entirety to determine whether the documentation. Ensuring thorough, consistent documentation will often circumvent this error and provide enough support for the skilled services. When submitting documentation, ensure that all visit notes, assessments and physician notes are included.

Eleven (11) hospice claims were included in the telephone demonstration. **Seven (7)** claims were denied because the documentation did not support a terminal prognosis. **Two (2)** claims were denied because the Notice of Election (NOE) was missing or invalid; and **two (2)** were denied because there was insufficient documentation to support the level of care provided.

After a telephone discussion with the provider representative, **five (5)** hospice claims were overturned and **six (6)** hospice claims were upheld while **three (3)** home health claims were overturned and **six (6)** home health claims were upheld.

TOTAL CLAIMS	**20**
Favorable (Overturned)	8
Unfavorable (Upheld)	12
Home Health	**9**
Skilled Services Not Supported	9
Hospice	**11**
Terminal Prognosis Not Supported	7
NOE Invalid/Missing	2
Level of Care Not Supported	2

HOME HEALTH BREAKDOWN OF RESULTS

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

1. **Home Health - Documentation did not support the need for skilled services (100%)**

   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,

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- 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

- **Sections 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

HOSPICE BREAKDOWN RESULTS

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

1. **Hospice – Documentation does not support a trajectory of terminal decline (63.64%)**

   Hospice care is provided to those patients who are certified as terminally ill. An individual is 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 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: https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=34538&ContrId=236&ver=12&ContrVer=2&CntrctrSelected=236*2&Cntrctr=236&s=8&DocType=1&bc=AAIAAACAAAAA&

2. **Hospice – Notice of election untimely or invalid (18.18%)**

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)]

3. **Hospice – Documentation does not support level of care rendered (18.18%)**

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.

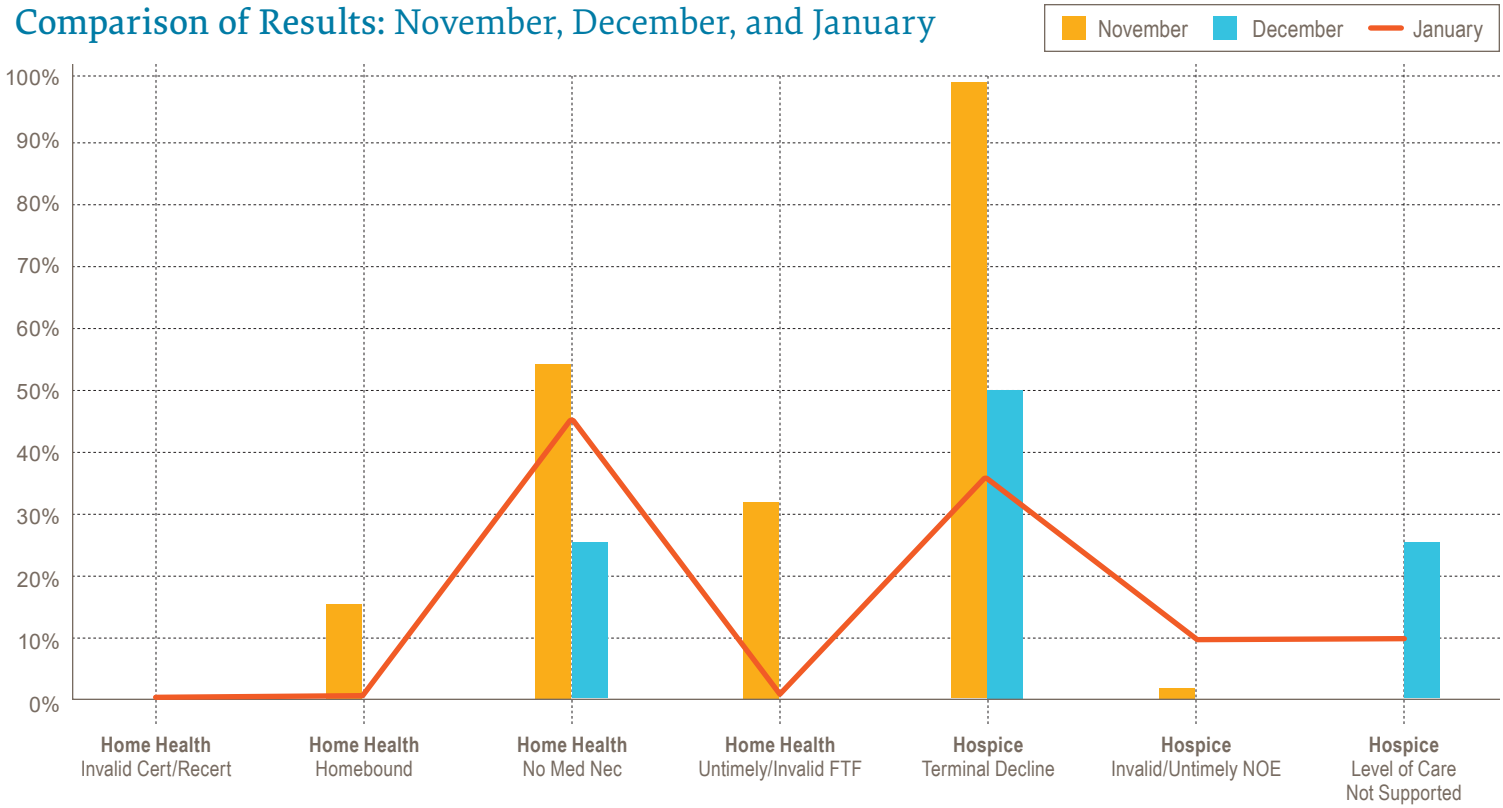
General Inpatient Care - Payment at the inpatient rate is made when general inpatient care is provided at a Medicare certified hospice facility, hospital, or skilled nursing facility.

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

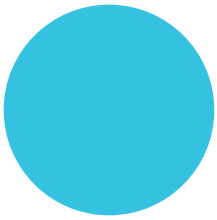
- **Section 30.1** [(Levels of Care Data Required on the Institutional Claim to A/B MAC (HHH)]

Comparison of Results: November, December, and January



This graph shows the data from October, November, and December denials for a visual comparison.

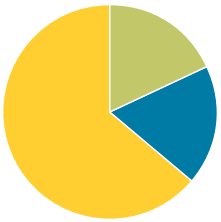
Distribution of Denials: January 2021 - Home Health



Med Nec - Skilled Services Not Supported - 100%

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

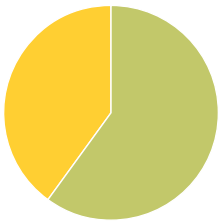
Distribution of Denials: January 2021 - Hospice



Terminal Prognosis Not Supported - 63.64%
NOE Invalid/Missing - 18.18%
Level of Care Not Supported - 18.18%

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

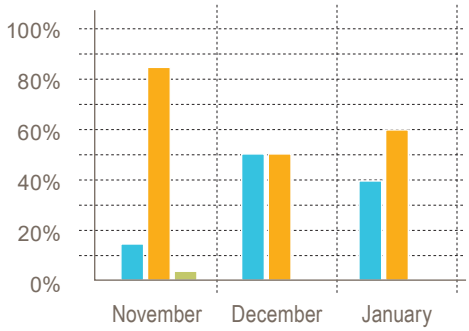
Dispositions Overturned or Upheld by QIC: January 2021



Upheld (unfavorable) - 60%
Overturned (favorable) - 40%

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

Dispositions: November - January Overturned, Upheld, or Partially Overturned



Overturned (Favorable)
Upheld (Unfavorable)
Partially Overturned

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

