



C2C PHONE DEMO

Summary of July Results

This month, a total of **thirty-one (31)** claims were included in the review. After a telephone conference was conducted and verbal testimony was provided, **77.42%** of the claims were overturned (favorable), and **22.58%** were upheld (unfavorable).

The following numbers are the denial reasons at the first level of appeal and prior to a telephone discussion. **Five (5)** home health claims were included in this month's telephone demonstration. **Two (2)** were denied because there was insufficient evidence to support skilled services were necessary. **Two (2)** claims denied because the certification was invalid (one of which was because there was no initial certification submitted with the recertification documents and another because the face-to-face encounter was not included in the submission). **One (1)** home health claim denied because the face-to-face encounter did not provide sufficient support of homebound status.

Twenty-six (26) hospice claims were included in the telephone demonstration. Of these claims, **twenty-five (25)** were included with one appeal that was reviewed by the Supplemental Medical Review Contractor (SMRC). **Twenty-four (24)** of the SMRC reviewed claims were denied at the first level of appeal because the documentation was insufficient to support a terminal prognosis. **One (1)** claim denied because the certification did not support the dates of service billed and **one (1)** claim denied because the level of care provided was not supported by the submitted documentation.

Upon completion of a telephone discussion with the provider, **twenty-four (24)** claims were overturned (favorable) and **seven (7)** claims were upheld (unfavorable).

HOME HEALTH BREAKDOWN OF RESULTS

The percentages represent claims denied based on the total home health claims.

1. Home Health: Skilled services not supported (40%)

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 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

TOTAL CLAIMS	31
Overtuned	24
Upheld	7

Home Health	5
Homebound Not Supported	1
Invalid Certification	2
Skilled Services Not Supported	2
Hospice	26
Certification does not cover dates billed	1
Level of Care Not Supported	1
Terminal Prognosis Not Supported	24

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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- 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:

- 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
- 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))

2. Home Health: Invalid certification – FTF missing/incomplete/untimely (40%)

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 home health agency (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 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)
- Community Mental Health Centers (CMHC)

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

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

3. Home Health: Homebound not supported (20%)

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 relatively 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 the beneficiary's physical status which includes strength, gait, balance, and any additional factors that affect mobility. Document any assistive devices and whether the beneficiary 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), 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)

HOSPICE BREAKDOWN RESULTS

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

1. Hospice: Terminal prognosis not supported (92.31%)

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 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: Hospice Local Coverage Determination (LCD), "Determining Terminal Status" - <https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?lcdid=34538&ver=13&contractorName=9&contractorNumber=236%7C2&lcdStatus=A&sortBy=title&bc=AAAAgAAAAA>

2. Hospice: Certification does not cover dates billed (3.85%)

The certification should be based on the clinical judgment of the hospice medical director (or physician member of the

interdisciplinary group (IDG)), and the patient's attending physician, if he/she has one. Nurse practitioners and physician assistants cannot certify or recertify an individual is terminally ill. If the patient's attending physician is a nurse practitioner or a physician assistant, the hospice medical director or the physician member of the hospice IDG certifies the individual as terminally ill.

In addition to the initial certification for hospice, the patient must be recertified for each subsequent hospice benefit period.

The written certification/recertification must include:

- The statement that the patient's medical prognosis is that their life expectancy is 6 months or less if the terminal illness runs its normal course
- A brief narrative, written by the certifying physician, explaining the clinical findings that support the patient's life expectancy of six months or less. This narrative can be a part of the certification/recertification form or as an addendum to the form.
 - If the narrative is part of the form, it must be located immediately above the physician's signature.
 - If the narrative is an addendum, the physician must also sign the addendum immediately following the narrative.
 - Do not include check boxes or standard language used for all patients. The narrative cannot be completed by other hospice personnel; it must be completed by the certifying physician.
 - The narrative shall include a statement, located above the physician signature and date, that attests to the fact that by signing the form, the physician confirms that he/she composed the narrative based on his/her review of the patient's medical record or his/her examination of the patient.
- **The benefit period dates that the certification or recertification covers.**
- Effective for recertifications on/after January 1, 2011, narratives associated with the third benefit period and subsequent benefit periods must explain why the clinical findings of the face-to-face encounter support a life expectancy of six months or less. Documentation must include the date of the encounter, an attestation by the physician or nurse practitioner that he/she had an encounter with the beneficiary. If the encounter was done by a nurse practitioner, he/she must attest that clinical findings were provided to the certifying physician.

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: Medicare Benefit Policy Manual (CMS Pub. 100-02), Ch. 9 (<https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c09.pdf>)

- **Section 20.1** (Timing and Content of the Certification)

3. Hospice: Level of care not supported (3.85%)

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 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 breaks, 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" 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.

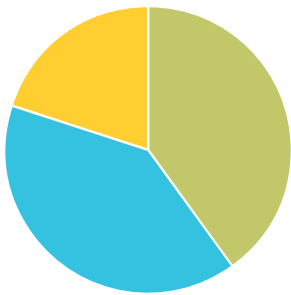
Suggestion: For payment of hospice services, the patient's symptoms must be those which require the specific levels of care indicated above. Ensure clear documentation of patient's symptoms,

medication management, appetite, status changes, etc. for additional support of 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)]

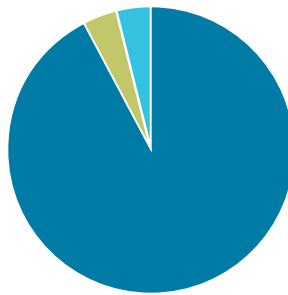
Distribution of Results: July 2021 - Home Health



- Med Nec - Skilled Services Not Supported - 40%
- CERT - Invalid Certification (FTF Missing/Incomplete/Untimely) - 40%
- Homebound Not Supported - 20%

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

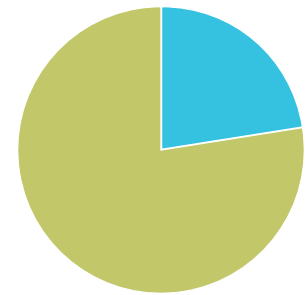
Distribution of Results: July 2021 - Hospice



- Terminal Prognosis Not Supported - 92.31%
- Level of Care Not Supported - 3.85%
- Certification Does Not Cover Dates Billed - 3.85%

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

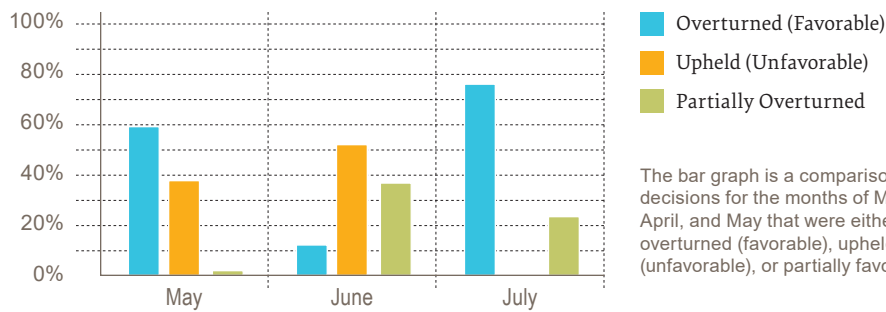
QIC Dispositions: July 2021



- Upheld - 22.58%
- Overturned - 77.42%

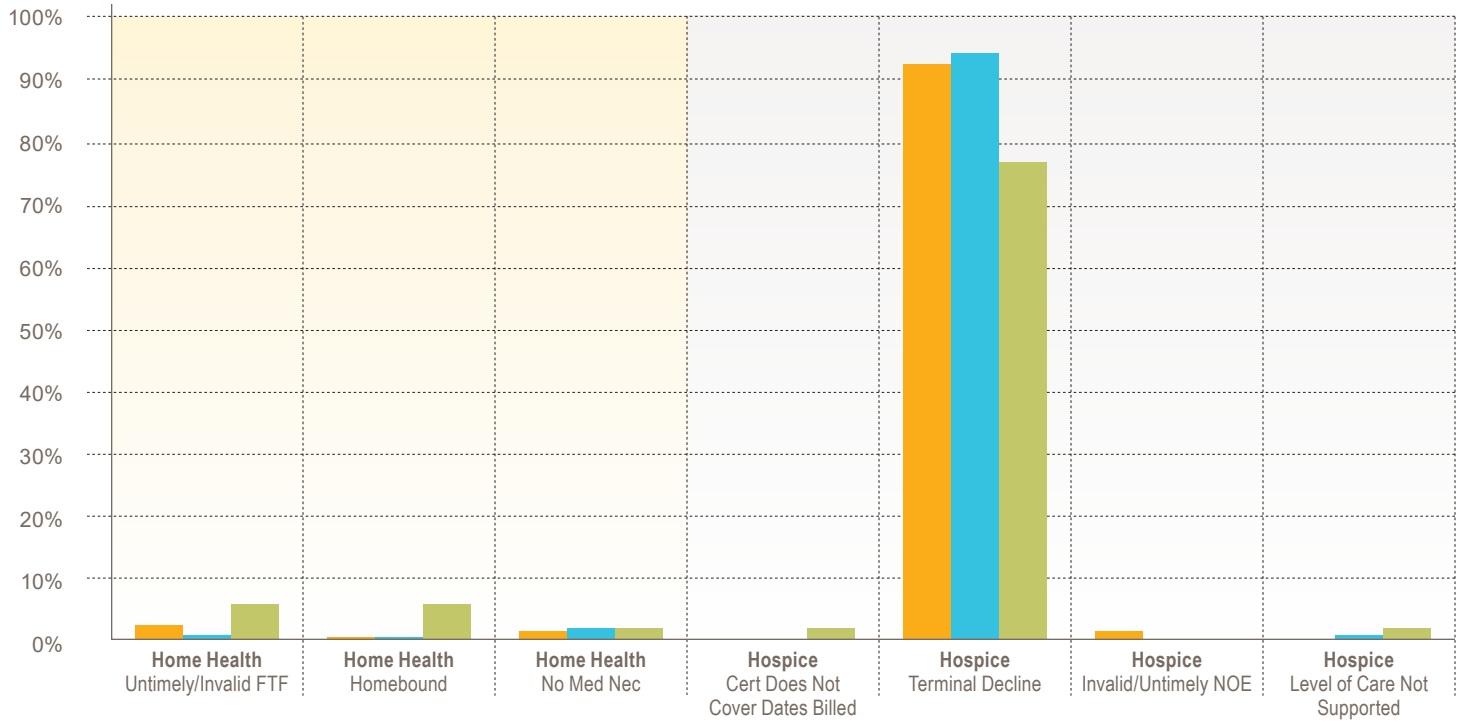
The pie chart provides a visual comparison of decisions that were either overturned (favorable) or upheld (unfavorable).

QIC Dispositions: May - July Overturned, Upheld, or Partially Overturned



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

Comparison of Results: May, June, and July



This graph shows the data from May, June, and July denials for a visual comparison.