C2C PHONE DEMO

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Summary of May Results

This month, a total of **one hundred eleven (111)** claims were included in the review. After a telephone conference was conducted and verbal testimony was provided, **59.46%** of the claims were overturned (favorable), **1.80%** were partially overturned (partially favorable), and **38.74%** were upheld (unfavorable).

Six (6) home health claim were included in this month's telephone demonstration. **Three (3)** claims were denied because the certification was invalid due to a face-to-face encounter that was either missing, incomplete, or untimely. **Two (2)** claims denied because the documentation was insufficient to support the skilled services and **one (1) c**laim denied because homebound criteria was not met.

One hundred five (105) hospice claims were included in the telephone demonstration. Of these claims, **one hundred two (102**) were reviewed as part of Unified Program Integrity Contractor (UPIC) review and were included in the **one hundred three (103)** claims that 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.

Upon completion of a telephone discussion with the provider, **sixty-six (66) claims** were overturned (favorable), two (2) claims were partially overturned (partially favorable), and **forty-three (43)** claims were upheld (unfavorable).

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

TOTAL CLAIMS	**111**
Favorable (Overturned)	66
Unfavorable (Upheld)	43
able (Partially Overturned)	2
Home Health	**6**
FTF - Missing/Incomplete/Invalid	3
Skilled Services Not Supported	2
Homebound Not Supported	1
Hospice	**105**
Terminal Prognosis Not Supported	103
NOE Invalid/Missing/Untimely	2

HOME HEALTH BREAKDOWN OF RESULTS

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

1. **Home Health - Skilled Services Not Supported (33.33%)**

   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
   - the patient/caregiver's response to the skilled services provided, and

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- 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

b) medical needs, including the requirement that the amount, frequency, and duration of the services must be reasonable; and

c) The services must be considered, under accepted standards of medical practice, to be specific,

d) safe, and effective treatment for the patient's condition, meeting the standards noted below. The

e) 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 - Documentation Did Not Support the Need for Skilled Services (50%)

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 is 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
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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.

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

3. **Home Health – Homebound not supported (16.67%)**

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 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)

HOSPICE BREAKDOWN RESULTS

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

1. **Hospice – Documentation Does Not Support Terminal Decline (98.10%)**

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=AAAAgAAAAAAA

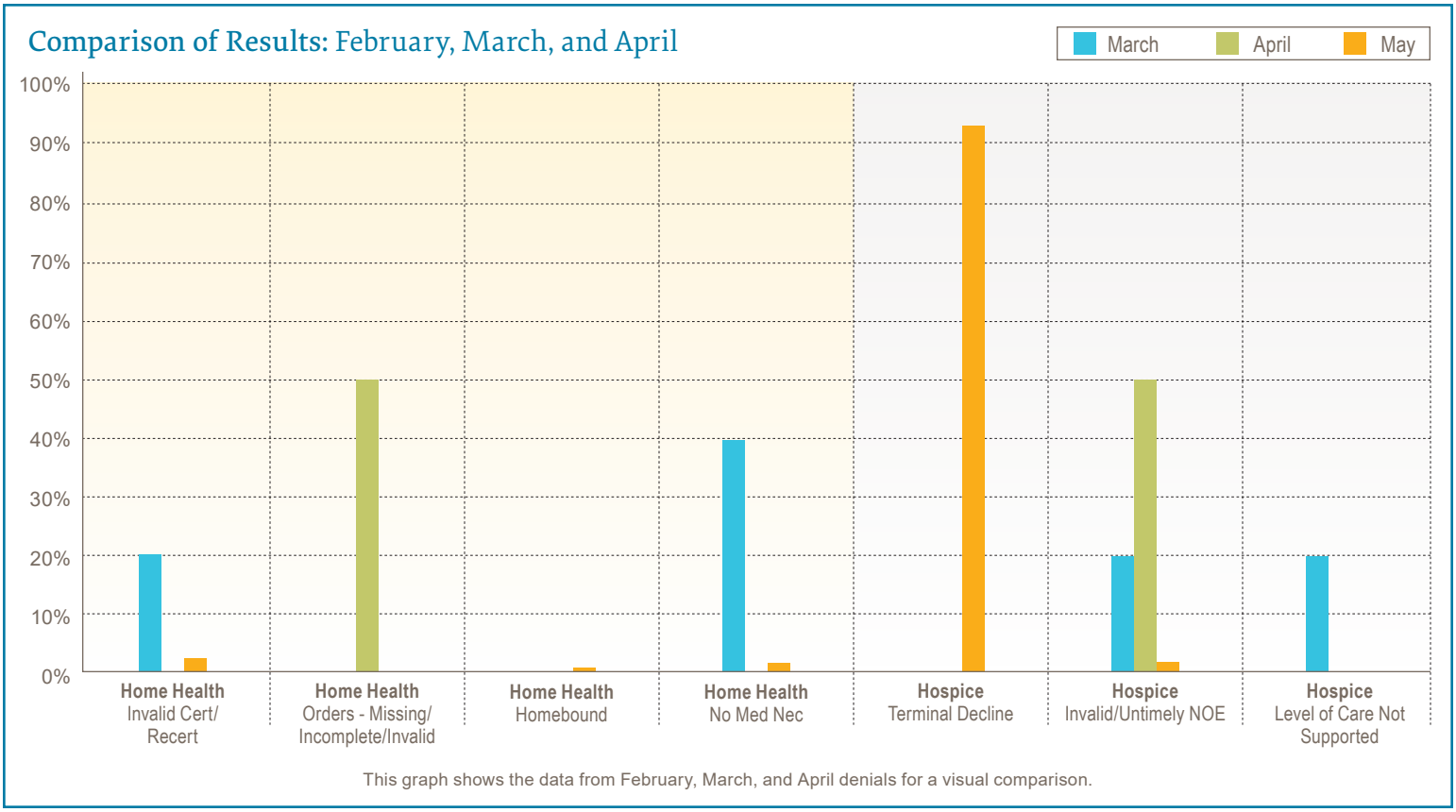
2. Hospice – Notice of Election Untimely or Invalid

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.

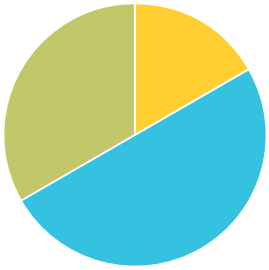
Suggestion: To avoid delays with the submission of the NOE, all information should be carefully entered. The election date cannot be retroactive, and the submission should be within the 5-day timeframe requirement. If any exceptions exist, providing careful documentation of the reason for the delay should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



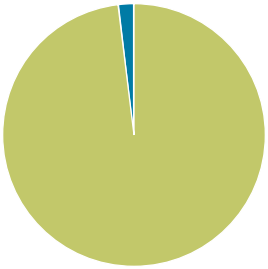
Distribution of Results: May 2021 - Home Health



- CERT - Invalid Certification (FTF Missing/Incomplete/Untimely - 50.00%
- Med Nec - Skilled Services Not Supported - 33.33%
- Homebound Not Supported - 16.67%

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

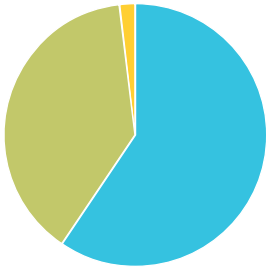
Distribution of Results: May 2021 - Hospice



- Terminal Prognosis Not Supported - 98.10%
- NOE Invalid/Missing - 1.90%

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

QIC Dispositions: May 2021

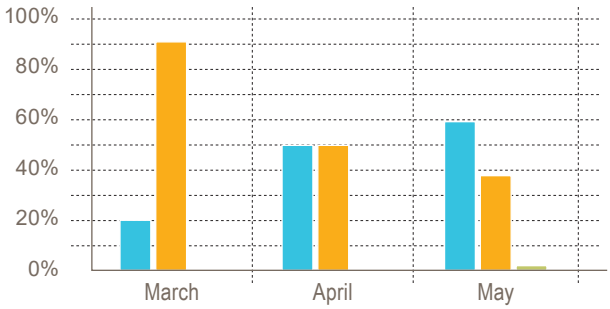


- Overturned - 59.46%
- Partially Overturned - 38.74%
- Upheld - 1.80%

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

QIC Dispositions: March - May

Overturned, Upheld, or Partially Overturned



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

