C2C PHONE DEMO

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Summary of November Results

This month, a total of **fifteen (15)** claims were reviewed. The QIC **overturned 33.33% (favorable)**, **20% (partially favorable)**, and **upheld 46.67% (unfavorable)** of claims after conducting telephone conferences and receiving verbal testimony.

The following numbers are the denial reasons at the first level of appeal and prior to a telephone discussion. This month's telephone demonstration included **twelve (12)** home health claims. **One (1)** denied due to an invalid certification because the date of the face-to-face encounter was not documented by the certifying practitioner. **Two (2)** denied because the face-to-face encounter was invalid. **Nine (9)** claims denied because there was insufficient evidence to support skilled services were necessary.

The telephone demonstration included **three (3)** hospice claims. **One (1)** claim denied because there was insufficient documentation to support the need for physician services and **two (2)** denied because the documentation was insufficient to support a terminal prognosis.

Upon completion of a telephone discussion with the provider, **five (5)** claim denials were overturned (favorable), **three (3)** were partially overturned, and **seven (7)** were upheld.

TOTAL CLAIMS	**15**
Overturned	5
Partially Upheld	3
Upheld	7
Home Health	**12**
Certification missing/invalid	1
FTF Missing/Invalid/Untimely	2
Skilled Services Not Supported	9
Hospice	**3**
Physician services not supported	1
Terminal Prognosis Not Supported	2

HELPFUL LINKS

- Medicare Benefit Policy Manual, Chapter 7 - Home Health Services - https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c07.pdf
- Medicare Claims Processing Manual, Chapter 11 - Processing Hospice Claims - https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c11.pdf

HOME HEALTH BREAKDOWN OF RESULTS

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

1. **Home Health: Invalid certification/recertification (8.33%)**

   The initial plan of care (485 form) was not included with the recertification documentation.

   At the end of the 60-day certification, the beneficiary is eligible for recertification of 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 form). Ensure the face-to-face assessment data has not changed and include documentation to support the reason the beneficiary requires home health services and remains homebound. Also include documentation to support all elements of certification/recertification (Medicare Benefit Policy Manual, Chapter 7, Section 30.5.2), such as:

   - The beneficiary is confined to home (homebound)
   - The beneficiary requires skilled nursing services on an intermittent basis

DISCLAIMER

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- A plan of care has been established and will be reviewed by a physician
- 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)

2. Home Health: FTF missing/invalid/untimely (16.67%)

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 notes 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 (CAHs)
- Rural Health Clinics (RHCs).
- Federally Qualified Health Centers (FQHCs)
- Hospital or CAH-based Renal Dialysis Centers (including satellites)
- Skilled Nursing Facilities (SNFs)
- Community Mental Health Centers (CMHCs)

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: Skilled services not supported (75%)

For any home health services to be covered by Medicare, the patient must meet the qualifying criteria as specified in §30, including having a need for skilled nursing care on an intermittent basis (§40.1, §40.1.1), physical therapy, speech-language pathology services, or a continuing need for occupational therapy as defined in §40.2 and §40.2.1.

Skilled nursing services are necessary only when (a) the 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.

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.

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)

- **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: Physician services not supported (33.33%)**

   A physician must perform physicians' services, except the services of the hospice medical director or the physician member of the interdisciplinary group must be performed by a Doctor of Medicine or Doctor of Osteopathy. The hospice face-to-face encounter is an administrative requirement related to certifying the terminal illness. By itself, **it is not billable,** as it is considered administrative (see Pub. 100-04, Medicare Claims Processing Manual, chapter 11, §40.1.1).

   Payment for physicians' administrative and general supervisory activities is included in the hospice payment rates. These activities include **participating in the establishment, review and updating of plans of care, supervising care and services, establishing governing policies,** and are generally performed by the physician serving as the medical director and the physician member of the interdisciplinary group (IDG).

   Under the Medicare hospice benefit, an attending physician is defined as a doctor of medicine or osteopathy, or a nurse practitioner or physician assistant, who is identified by the patient at the time he/she elects hospice coverage as having the most significant role in the determination and delivery of his or her medical care. Payment for physicians, nurse practitioners, or physician assistants serving as the attending physician who provide direct patient care services, and who are hospice employees or working under arrangement with the hospice, is made in the following manner:

- Hospices establish a charge and bill the A/B MAC (HHH) for these services.
- The A/B MAC (HHH) pays the hospice at the lesser of the actual charge or 100 percent of the Medicare physician fee schedule for physician services or 85 percent of the fee schedule amount for nurse practitioner or physician assistant services. This payment is in addition to the daily hospice rates.
- Payment for attending physician services is counted with the payments made at the daily payment rates to determine whether the overall hospice cap amount has been exceeded.
- No payment is made for attending physician services furnished voluntarily. However, some attending physicians may seek payment for certain services while furnishing other services on a volunteer basis. Payment may be made for services not furnished voluntarily if the hospice is obligated to pay the attending physician for the services. An attending physician must treat Medicare patients on the same basis as other patients in the hospice, and may not designate all services rendered to non-Medicare patients as volunteer, and at the same time bill the hospice for services rendered to Medicare patients.
- EXAMPLE: Dr. Jones has an agreement with a hospice to serve as its medical director on a volunteer basis. Dr. Jones does not furnish any direct patient care services on a volunteer basis. A Medicare beneficiary enters the hospice and designates Dr. Jones as her attending physician. When he furnishes a direct service to the beneficiary, he bills the hospice for this service, and the hospice in turn, bills the A/B MAC (HHH) and is paid for the service. Dr. Jones may not bill Medicare Part B as an independent attending physician because, as a volunteer, he is deemed to be a hospice employee.
- No payment is made for nurse practitioner services that can be performed by a registered nurse, nor is payment made for nurse practitioner services that are performed outside of the attending physician role.

When hospice coverage is elected, the beneficiary waives all rights to Medicare Part B payments for professional services that are related to the treatment and management of his/her terminal illness during any period his/her hospice benefit election is in force, except for professional services of an independent attending physician, who is not an employee of the designated hospice nor receives compensation from the hospice for those services. For purposes of administering the hospice benefit provisions, an "attending physician" means an individual who:

- Is a Doctor of Medicine or Osteopathy, or
- A nurse practitioner (for professional services related to the terminal illness and related conditions that are furnished on or after December 8, 2003), or
- A physician assistant (for professional services related to the terminal illness and related conditions that are furnished on or after and January 1, 2019; and
- Is identified by the individual, at the time he/she elects hospice coverage, as having the most significant role in the determination and delivery of their medical care.

Hospices should reiterate with patients that they must not see independent physicians for care related to their terminal illness other than their independent attending physician unless the hospice arranges it.

Even though a beneficiary elects hospice coverage, he/she may designate and use an independent attending physician, who is not employed by nor receives compensation from the hospice for professional services furnished, in addition to the services of hospice-employed physicians. The professional services of an independent attending physician that are reasonable and necessary for the treatment and management of a hospice patient's terminal illness **are not considered Medicare Part A hospice services** and should be billed to the A/B MAC (B) through Medicare Part B.

Guidelines:

- CMS IOM Pub. 100-02, Medicare Benefit Policy Manual (MBPM), Chapter 9 - Coverage of Hospice Services Under Hospital Insurance: 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
  - Section 40.1.3 (Physician Services)
- CMS IOM 100-02, Medicare Claims Processing Manual, Chapter 11 – Processing Hospice Claims: 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

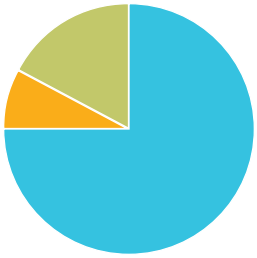
2. Hospice: Terminal prognosis not supported (66.67%)

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

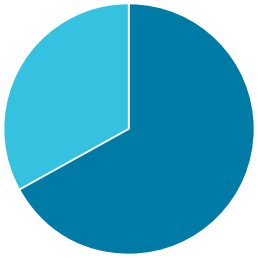
Distribution of Results: November 2021 - Home Health



- Medical Necessity (Skilled Services Not Supported) - 75%
- Certification invalid (FTF Missing/ Incomplete/Untimely) - 17%
- Certification Missing/Incomplete/ Untimely - 8%

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

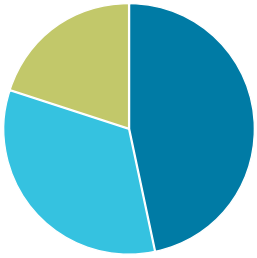
Distribution of Results: November 2021 - Hospice



- Terminal Prognosis Not Supported - 67%
- Physician Services Administrative in Nature - 33%

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

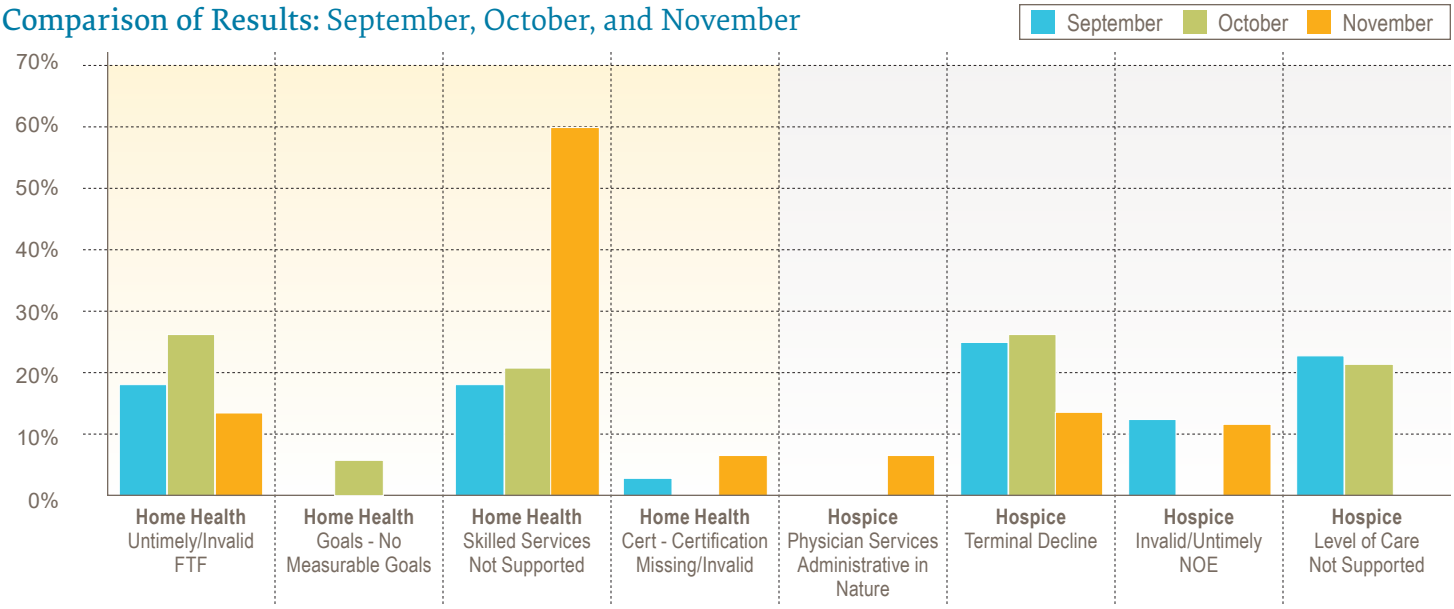
QIC Dispositions: November 2021



- Upheld - 46.67%%
- Overturned - 33.33%%
- Partially Overturned - 20.00%

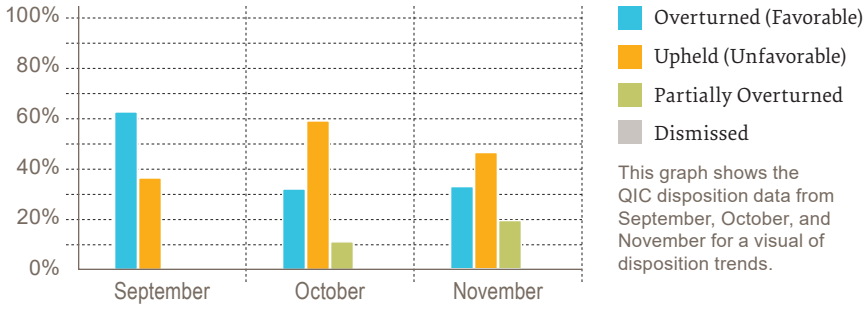
This pie chart illustrates dispositions (in percentages) after a telephone discussion was completed for both home health and hospice.

Comparison of Results: September, October, and November



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

QIC Dispositions: September - November
Overturned, Upheld, or Partially Overturned



This graph shows the QIC disposition data from September, October, and November for a visual of disposition trends.