C2C PHONE DEMO

Summary of October's Results

This month, a total of **42 telephone conferences** were conducted with home health/hospice agency representatives. After a telephone conference was conducted and verbal testimony was provided, 11.90% of the claims were overturned (favorable)and 88.10% were upheld (unfavorable).

Nine (9) home health claims claims were included in this month's telephone demonstration. The denials resulted from documentation that did not support the need for skilled services (8) and an invalid certification as a result of a missing or invalid provider signature (1).

The medical record is reviewed in its entirety to determine whether the documentation supports a need for skilled services. Ensuring thorough, consistent documentation will often circumvent this error and provide enough support for the skilled services.

When submitting documentation, review it carefully to ensure it is all signed according to requirements and that all signatures are dated prior to final bill submission.

Thirty-three (33) hospice claims were included in the telephone demonstration. Thirty-two (32) claims were denied because the documentation did not support a terminal prognosis. One (1) claim was denied because of a missing or invalid Notice of Election (NOE).

The thirty-two (32) hospice claims denied for lack of support for medical necessity were for the same beneficiary and was reviewed by the Supplemental Medical Review Contractor (SMRC). There was insufficient evidence to support a terminal prognosis of six months or less which is a required element of the hospice certification. One (1) claim included an NOE that was not submitted within the required timeframe; therefore, it was invalid and certification requirements were not sufficiently met. (Local Coverage Determination (LCD) L34538 Hospice Determining Terminal Status and the Medicare Benefit Policy Manual (MBPM), Publication 100-02, Chapter 9, Section 10). One (1) claim denied because the NOE was not submitted timely.

TOTAL CLAIMS	**42**
Favorable (Overturned)	5
Unfavorable (Upheld)	37
Home Health Claims	**9**
Skilled services not supported	8
Invalid certification (signature invalid/untimely)	1
Hospice	**33**
Terminal prognosis not supported	32
Notice of Election Missing or Invalid	1

BREAKDOWN OF OCTOBER HOME HEALTH RESULTS

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

1. **Home Health - Documentation Did Not Support the Need for Skilled Services (88.89%)**

   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.

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The home health clinical notes must document as appropriate:

- the history and physical exam pertinent to the day's visit, (including the response or changes in behavior to previously administered skilled services) and the skilled services applied on the current visit, and
- the patient/caregiver's response to the skilled services provided, and
- the plan for the next visit based on the rationale of prior results,
- a detailed rationale that explains the need for the skilled service considering the patient's overall medical condition and experiences,
- the complexity of the service to be performed, and
- any other pertinent characteristics of the beneficiary or home

Clinical notes should be written so that they adequately describe the reaction of a patient to his/her skilled care and provide a clear picture of the treatment, as well as "next steps" to be taken. Vague or subjective descriptions of the patient's care should not be used. For example, terminology such as the following would not adequately describe the need for skilled care:

- Patient tolerated treatment well
- Caregiver instructed in medication management
- Continue with POC

Objective measurements of physical outcomes of treatment should be provided and/or a clear description of the changed behaviors due to education programs should be recorded in order that all concerned can follow the results of the applied services.

To be covered as skilled therapy, the services must require the skills of a qualified therapist and must be reasonable and necessary for the treatment of the patient's illness or injury. Coverage does not turn on the presence or absence of an individual's potential for improvement, but rather on the beneficiary's need for skilled care.

The service of a physical therapist, speech-language pathologist, or occupational therapist is deemed reasonable and necessary if the complexity of the service is such that it can be performed safely and/or effectively **only by or under the general supervision** of a skilled therapist. To be covered, assuming all other eligibility and coverage criteria have been met, the skilled services must also be **reasonable and necessary to the treatment of the patient's illness or injury or to the restoration or maintenance of function affected by the patient's illness or injury**. It is necessary to determine whether individual therapy services are skilled and whether, in view of the patient's overall condition, skilled management of the services provided is needed.

The beneficiary's medical condition is a valid factor in the determination of medical necessity; however, the diagnosis or prognosis should not be the only factor in determining medical necessity of therapy services. The question to be answered is whether the services can be completed by unskilled personnel.

To be considered reasonable and necessary for the treatment of the illness or injury:

a) The services must be consistent with the nature and severity of the illness or injury, the patient's medical needs, including the requirement that the amount, frequency, and duration of the services must be reasonable; and

b) The services must be considered, under accepted standards of medical practice, to be specific, safe, and effective treatment for the patient's condition, meeting the standards noted below. The home health record must specify the purpose of the skilled service provided.

The therapist must document measurable results in the initial therapy assessment and include it in the reassessment that is to be performed at least every 30 days.

Suggestion: Clinical notes should provide communication records between the entire home care team and clearly document the need for the skilled service. This can include a clear, concise history and physical exam on the date of the visit which notes changes in behavior and the skilled services provided during the visit. Additionally, it is important to note the patient's and caregiver's response to the skilled service provided as well as the plan for further visits. A detailed note describing the rationale for the skilled service, the complexity of the service, and any pertinent characteristics of the beneficiary or environment where he/she is receiving care.

Guidelines: CMS IOM Pub. 100-02, Medicare Benefit Policy Manual (MBPM), Chapter 7 - Home Health Services - https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c07.pdf

- **Section 40.1.1** (General Principles Governing Reasonable and Necessary Skilled Nursing Care)
- **Section 40.2** (Skilled Therapy Services)
- **Section 40.2.1** (General Principles Governing Reasonable and Necessary Physical Therapy, Speech-Language Pathology Services, and Occupational Therapy)

2. Home Health – Certification/POC Signature Missing or Invalid (11.11%)

The home health agency (HHA) must be acting upon a physician plan of care (POC) that meets the requirements. For services to be covered the POC must indicate the services necessary to meet the patient's needs as identified in the comprehensive assessment. The POC must also identify the disciplines that will provide the services, the frequency of the services and the duration of the services, as well as any items listed in **42 CFR 484.60(a)** that establish the need for the services (**§30.2.1**). The physician who signs the plan of care must be qualified to sign the physician certification as described in **42 CFR 424.22 (§30.2.3)**.

The plan of care or oral order may be transmitted by facsimile. The HHA is not required to have the original signature on file. However, the HHA is responsible for obtaining original signatures if an issue surfaces that would require verification of an original signature (**§30.2.7**).

HHAs that maintain patient records by computer rather than hard copy may use electronic signatures. However, all such entries must be appropriately authenticated and dated. Authentication must include signatures, written initials, or computer secure entry by a unique identifier of a primary author who has reviewed and approved the entry. The HHA must have safeguards to prevent unauthorized access to the records and a process for reconstruction of the records in the event of a system breakdown (**§30.2.8**).

Suggestion: Prior to submission of claim, ensure the home health certification/plan of care includes a valid physician signature. The signature must be of the physician listed as the "certifying physician" on the plan of care. An attestation may also be submitted to verify signatures.

Guidelines: CMS IOM Pub. 100-02, Medicare Benefit Policy Manual (MBPM), Chapter 7 - Home Health Services -

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https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c07.pdf

- **Section 30.2.1** (Content of the Plan of Care)
- **Section 30.2.3** (Who Signs the Plan of Care)
- **Section 30.2.7** (Facsimile Signatures)
- **Section 30.2.8** (Alternative Signatures).

BREAKDOWN OF OCTOBER HOSPICE RESULTS

Percentage is based on the total number of hospice claims

3. **Home Health – Documentation does not support a trajectory of terminal decline (96.97%)**

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: Hospice Services Under Hospital Insurance https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c11.pdf

- **Section 10** (Requirements – General)
- Local Coverage Determination (LCD) L34538 Hospice Determining Terminal Status
- Hospice Terminal Prognosis Non-Disease Specific - https://www.cgsmedicare.com/hhh/education/materials/pdf/hospice_terminal_prog_non-disease_specific.pdf

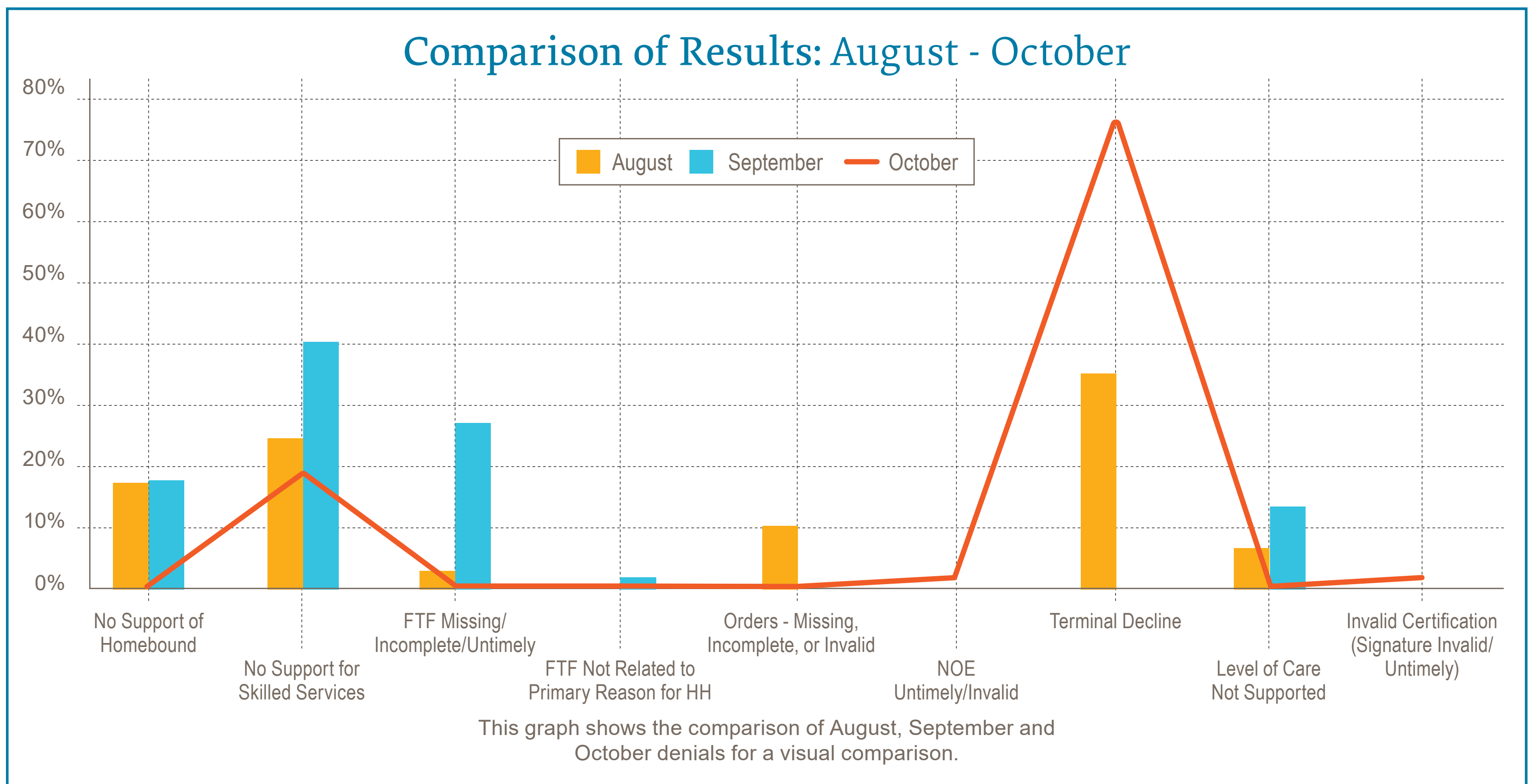
4. **Hospice – Notice of election untimely or invalid. (3.03%)**

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.

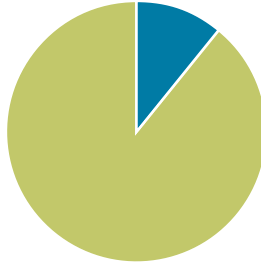
Guidelines: CMS IOM, Pub. 100-04, Medicare Claims Processing Manual (MCPM), Chapter 11 - Processing Hospice Claims - https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c11.pdf

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



This graph shows the comparison of August, September and October denials for a visual comparison.

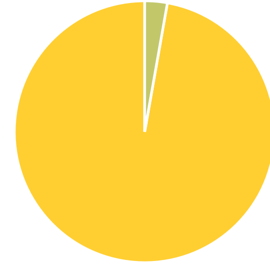
Distribution of Denials: October 2020 - Home Health



Med Nec - Skilled Services Not Supported - 88.89%
Cert - Invalid Certification (Signature Invalid/Untimely) - 11.11%

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

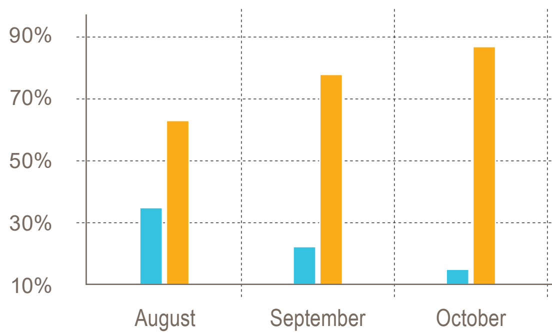
Distribution of Denials: October 2020 - Hospice



Terminal Prognosis Not Supported - 96.97%
Level of Care Not Supported - 3.03%

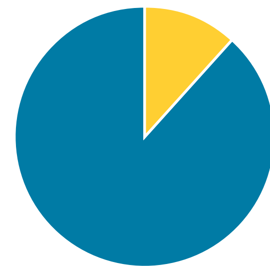
This pie chart illustrates the percentage of each hospice denial, allowing for a visual comparison of the denial reasons.

Dispositions: August - October Overturned, Upheld, or Partially Overturned



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

Dispositions Overturned or Upheld by QIC: October 2020



Upheld (unfavorable) - 88.20%
Overturned (favorable) - 11.80%

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

DISCLAIMER

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