C2C PHONE DEMO

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Summary of October Results

This month, a total of **nineteen (19)** claims were reviewed. The QIC **overturned 31.58% (favorable)**, **10.53% (partially favorable)**, and **upheld 57.89% (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 **ten (10)** home health claims. **Five (5)** claims denied because the face-to-face encounter was invalid. **Four (4)** denied because there was insufficient evidence to support skilled services were necessary and **one (1)** claim denied because there were no measurable goals documented.

The telephone demonstration included **nine (9)** hospice claims. **Five (5)** claims denied because the documentation was insufficient to support the level of care provided and **four (4)** claims denied because a terminal prognosis was not supported by the documentation.

Upon completion of a telephone discussion with the provider, **six (6)** claim denials were overturned (favorable), **two (2)** denials were partially overturned, and **eleven (11)** denials were upheld.

TOTAL CLAIMS	**19**
Overturned	6
Partially Upheld	2
Upheld	11
Home Health	**10**
FTF Missing/Invalid/Untimely	5
Skilled Services Not Supported	4
No Measurable Goals	1
Hospice	**9**
Level of Care Not Supported	5
Terminal Prognosis Not Supported	4

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: FTF missing/invalid/untimely (50%)**

   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).

DISCLAIMER

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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); and
- 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)

2. 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
- 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)

- **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

3. Home Health: No measurable goals (10%)

The development, implementation, management, and evaluation of a patient care plan based on the physician's orders constitute skilled therapy services when, because of the patient's clinical condition, those activities require the specialized skills, knowledge, and judgment of a qualified therapist to ensure the effectiveness of the treatment goals and ensure medical safety. Where the specialized skills, knowledge, and judgment of a therapist are needed to manage and periodically reevaluate the appropriateness of a maintenance program, such services would be covered, even if the skills of a therapist were not needed to carry out the activities performed as part of the maintenance program.

Initial Therapy Assessment

- For each therapy discipline for which services are provided, a qualified therapist (instead of an assistant) must assess the patient's function using a method which objectively measures activities of daily living such as, but not limited to, eating, swallowing, bathing, dressing, toileting, walking, climbing stairs, using assistive devices, and mental and cognitive factors. The measurement results must be documented in the clinical record.
- Where more than one discipline of therapy is being provided, a qualified therapist from each of the disciplines must functionally assess the patient. The therapist must document the measurement results which correspond to the therapist's discipline and care plan goals in the clinical record.

If the plan of care includes a course of treatment for therapy services:

- The course of therapy treatment must be established by the physician after any needed consultation with the qualified therapist;
- The plan must include measurable therapy treatment goals which pertain directly to the patient's illness or injury, and the patient's resultant impairments.

Suggestion: Include therapy goals (both short-term and long-term) that are measurable and contain an objectively measurable component with an achievement timeframe/date for each goal. If goals are included in the therapy evaluation, ensure the physician has either signed the evaluation or incorporated the goals into the physician plan of care. Goals should be measurable and specific to the patient's illness or injury. All goals must also be signed by the physician or can be acknowledged with the submission of an attestation to confirm the physician concurs with the goals established. Measurable goals can be, but are not limited to, ambulation distance (in feet), timed up and go (TUG) score, number of stairs, etc.

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 40.2** (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: Level of Care Not Supported (55.56%)

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 -** TThe 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 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" 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)]

2. Hospice: Terminal prognosis not supported (44.44%)

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.

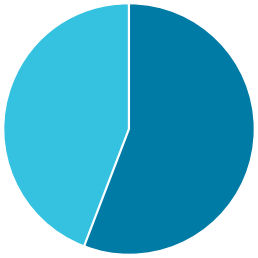
Guidelines: Hospice Local Coverage Determination (LCD), "Determining Terminal Status" - https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?lcdid=34538&ver=13&contractorName=9&contractorNumber=236%7C2&lcdStatus=A&sortBy=title&bc=AAAAgAAAAAAA

Distribution of Results: October 2021 - Home Health

- CERT - Invalid Certification (FTF Missing/Incomplete/Untimely - 50%
- Med Nec - Skilled Services Not Supported - 40%
- Homebound Not Supported - 10%

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

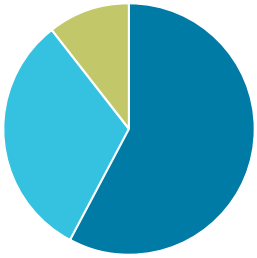
Distribution of Results: October 2021 - Hospice



- Level of Care Not Supported - 56%
- Terminal Prognosis Not Supported - 44%

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

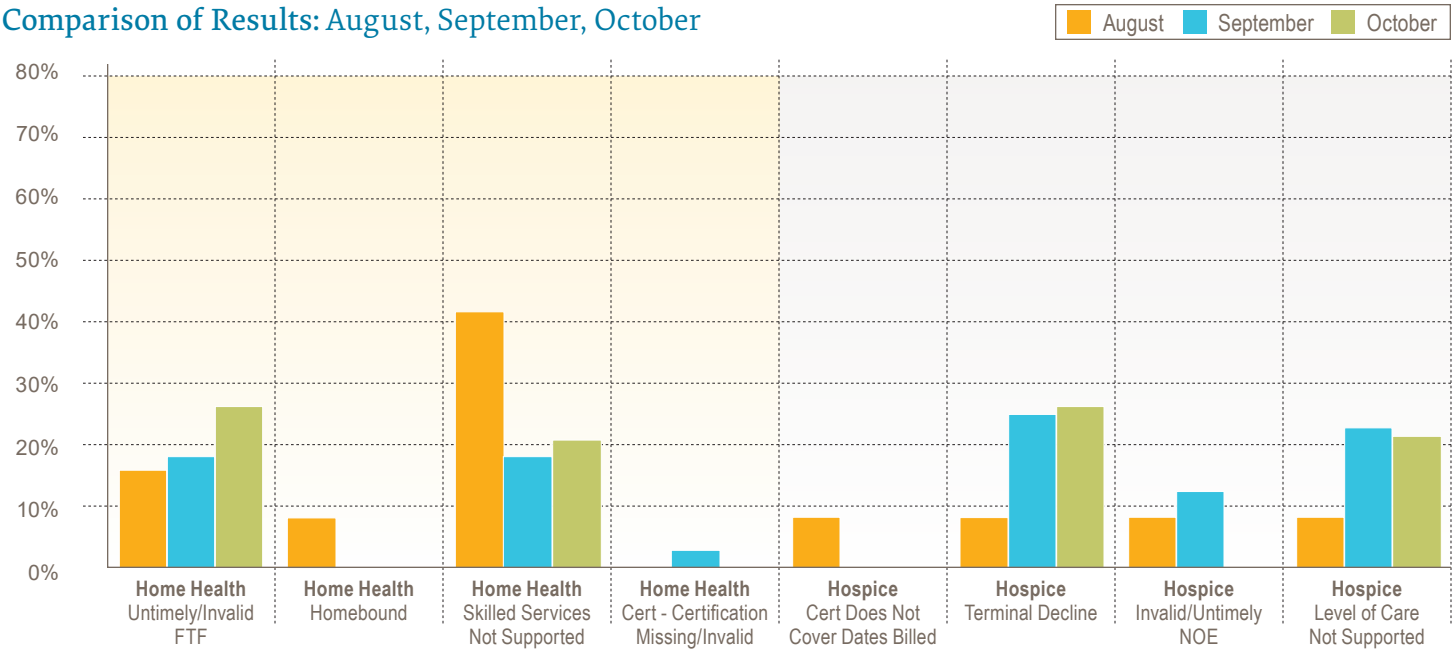
QIC Dispositions: October 2021



- Upheld - 57.89%
- Overturned - 31.58%
- Partially Overturned - 10.53%

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

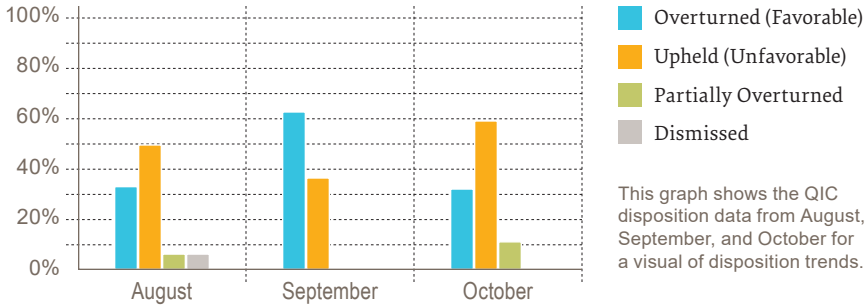
Comparison of Results: August, September, October



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

QIC Dispositions: August - October

Overturned, Upheld, or Partially Overturned



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

