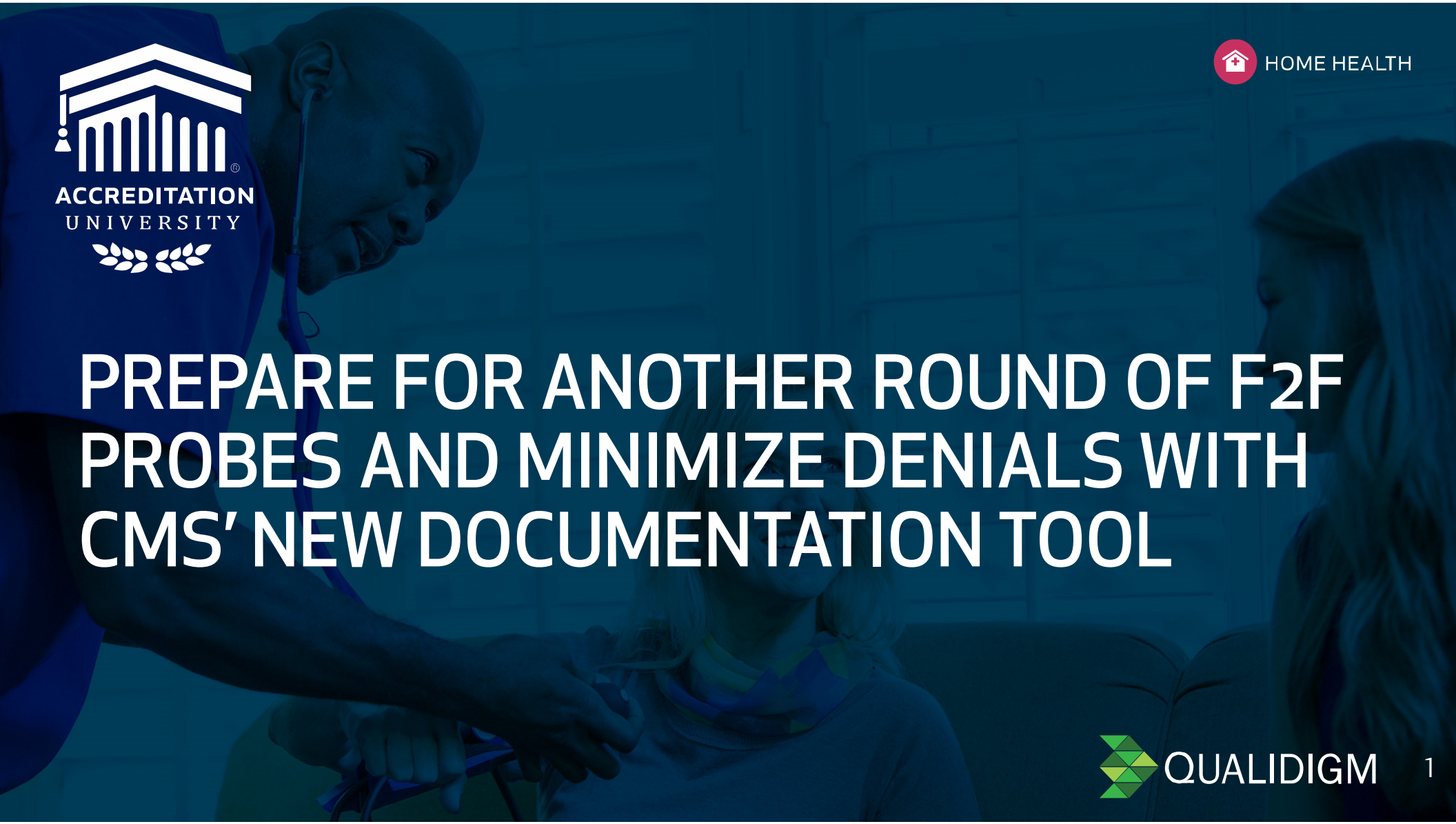
ACCREDITATION
UNIVERSITY
HOME HEALTH
PREPARE FOR ANOTHER ROUND OF F2F PROBES AND MINIMIZE DENIALS WITH CMS' NEW DOCUMENTATION TOOL
QUALIDIGM

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Navigating the Maze of "Probe and Educate"

6 Process Steps to Protect Your Agency's Reimbursement

QUALIDIGM

TODAY'S OBJECTIVES

At the conclusion of today's program, you will…

- Understand how to significantly improve your compliance with plans of care and certification requirements
- Learn Documentation Techniques for supporting homebound status, skilled care and need for therapy services
- Be able to implement specific process changes to minimize risk of denials in future rounds of reviews
- Take away tips for communicating with MACs about denials
- Formulate strategies for successful appeals
- Plan for your agency's success in managing this process!

A LITTLE BACKGROUND…..

- "Probe and Educate" is now beginning its 3rd round
- Rounds 1 and 2 focused heavily on face-to-face and compliance
- A secondary focus on documentation of homebound status and skilled services was also noted in the denials
- Denial rates averaged 50% but many providers lost 80-100% in their initial reviews
- Providers with high denial rates will now be subject to high volume (20-40 records) "intensive reviews"
- In late October, CMS provided excellent education on the Round 3 process with response and documentation tips (see Resources Slide)

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Can your agency survive the potential cash flow impact of losing the reimbursement for 80% of 20-40 claims?

- What can you do in your agency to protect your reimbursements?

WHAT ARE THE RULES OF THIS "MAZE"?

- Return to the basics:
  - Physician Orders (face-to-face, Certification Plan of Care, supporting documents)
  - Skilled Services (Assessment, Treatment, Education, Management Evaluation)
  - Homebound Status (F R E D)
- If it's not documented…..
  - Will your clinical documentation stand up under scrutiny?
- Know the system
  - From Initial ADR to "ALJ" and beyond-do you know the time frames, forms and documentation?
- Use the system to your advantage
  - Respond and support your claims through every possible avenue

REINFORCE THE BASICS

- Certification Requirements
  - Face-to-face: 5 required elements in the documentation (Date of encounter, Diagnosis for Medical necessity, services needed, skilled needs, legible complete signature)
  - Supporting documents: Office visit notes, All referral intake data
  - Timeliness: Encounter date 90 days prior/30 days post SOC; Signatures within 30 Days of orders
- Plan of Care Requirements
  - Physician certification of homebound status and medical necessity, duration of care needs
  - Orders and clinical summary that are clear, support skill
  - Is your OASIS timely and validated in the Repository?

IF IT'S NOT DOCUMENTED……

- Skilled Services: Assessment, Treatment, Education, Management/Evaluation
  - Assessment: Objective data, responses to change in condition
  - Treatment: Interventions "not ordinarily done by a lay person"
  - Education: What was taught, % of accurate teach-back
  - Management/Evaluation: A complex plan of care
- The physician plan of care/interim orders and the clinical notes must match exactly for the elements of frequency/duration, services provided
- Clinical notes should be clear, concise and support one or more of the 4 elements

MEDICALLY HOMEBOUND

- Has the definition changed? Or just a few of the words?
- Absences from home are of short duration, require the use of one or more "mobility aids" and/or persons and present a severe and taxing effort
- Absences are for primarily medical purposes and are medically contraindicated
- Dementia and Behavioral Health present unique issues
- "F R E D" - Frequency, Reason, Endurance and Duration
  - What to write?
  - How often to document it?

SUPPORTING THE NEED FOR THERAPY SERVICES

- What does your OASIS indicate?
  - Functional limitations
  - ADL limitations
- Therapy intervention should address a specific identified need
  - Objective data from baseline to goal and progress steps between
- Nursing and therapy documentation should complement each other and support the need for and the level of skill of the therapy provided.
  - Is the patient participating in the plan?
  - Is there progress being noted?
  - Care coordination between disciplines?

A NARRATIVE EXAMPLE

Pt seen for scheduled nursing visit. Sitting in living room chair, caregiver present, states son just went to the store prior to arrival. Pt sleepy but easily arousable and able to carry on a conversation. Answers questions appropriately and states "I don't always remember things." VS: 97.1-60-18 B/P 134/70. States she is taking her medicine in applesauce with out adverse reactions. Denies chest pain, pain, dizziness, N/V, heart palpitations, cough, SOB. Lungs CTA bilat, O2 sat 97% on RA, no pedal edema noted. Reviewed s/s hypo/hyperglycemia, none present. Abdomen soft, non distended, non tender, + BS in all 4 quadrants, states she had a BM yesterday and "I think I have to go again now." Pt ambulated to bathroom during visit with non skid shoes, assistance of CG and walker. Denies falls/injuries since last SNV. CG states appetite is good and has no difficulty chewing or swallowing. Skin is intact. Pt remains homebound d/t inability to safely leave home without AD, assistance of another, residual fatigue and cognitive deficits. PCN updated.

But do you need all of this information? Was this already entered elsewhere in the EMR?

A BETTER OPTION

Pt sleepy, easily arousable, able to carry on a conversation. Answers questions appropriately and states "I don't always remember things.". States she is taking her medicine in applesauce with out adverse reactions. Reviewed s/s hypo/hyperglycemia, none present. Pt states she had a BM yesterday, "I think I have to go again now." Pt ambulated with non skid shoes, assistance of CG and walker. Denies falls/injuries since last SNV. CG states appetite is good and has no difficulty chewing or swallowing. Skin is intact. Pt remains homebound d/t inability to safely leave home without AD, assistance of another, residual fatigue and cognitive deficits. PCN updated.

What are the differences? Can you spot the skills and the homebound statement?

WHERE IS THE SKILL?

Pt sleepy, easily arousable, able to carry on a conversation. Answers questions appropriately and states "I don't always remember things.". States she is taking her medicine in applesauce with out adverse reactions. Reviewed s/s hypo/hyperglycemia, none present. Pt states she had a BM yesterday, "I think I have to go again now." Pt ambulated with non skid shoes, assistance of CG and walker. Denies falls/injuries since last SNV. CG states appetite is good and has no difficulty chewing or swallowing. Skin is intact. Pt remains homebound d/t inability to safely leave home without AD, assistance of another, residual fatigue and cognitive deficits. PCN updated.

Is this a Medicare level skilled visit?

WHERE IS THE SKILL?

What did the clinician do that was skilled?

- Education was done "Reviewed s/s hypo/hyperglycemia"
- But where is the teach back or level of understanding?

Is this patient "medically homebound?"

- Yes! Good documentation of the 3 of 4 required elements

What clinical activities were performed?

- Lacking "Systems assessments completed, no adverse signs noted, parameters within designated limits"
- Document reporting of data outside parameters and MD response

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If your clinical documentation is strong… but the "ADR's" keep coming…

- What can you do in your agency to protect your reimbursements?

IT'S ALL ABOUT THE PROCESS!

- Supporting Documentation
  - The Role of Intake
  - Inpatient referral vs Inpatient to SNF to HHA vs Community MD
  - What do you need? How do you get it? What do you do with it?
- Promoting Compliance
  - Clinical Manager/QM audits of OASIS, Assessments, POC at OASIS time-points
  - What are you looking for?
- Ongoing Review
  - How often do you review clinical documentation between OASIS events?
  - Who is reviewing the skill and documentation for your therapies?

THE ROLE OF THE PRE-BILL AUDIT

- Minimize your risks
  - Obtain documentation
  - Verification of billing accuracy against existing signed orders
- Maximize your compliance
  - OASIS timeliness and accuracy
  - Quality documentation that supports skill
- But…who is doing these audits? And how are they doing them?
- And what about the cost of doing these time consuming audits? Won't they simply delay the billing and your reimbursement?

THE CMS TOOL

- What is this tool?
  - A step by step algorithm that CMS created to walk you through the process of reviewing documentation
  - The intent is to identify claims that do not meet the coverage criteria
- Where can you find it?
  - http://go.cms.gov/2xcHqL4
- How can this tool be helpful to your agency?
  - The tool outlines a "pre-bill" process that can be adapted or streamlined to give a new definition to a "clean claim"
  - Can you incorporate this into your process to audit all Medicare claims against this tool prior to submission?
  - Will the potential cost of this process be balanced by reducing potential lost revenue from denied claims?

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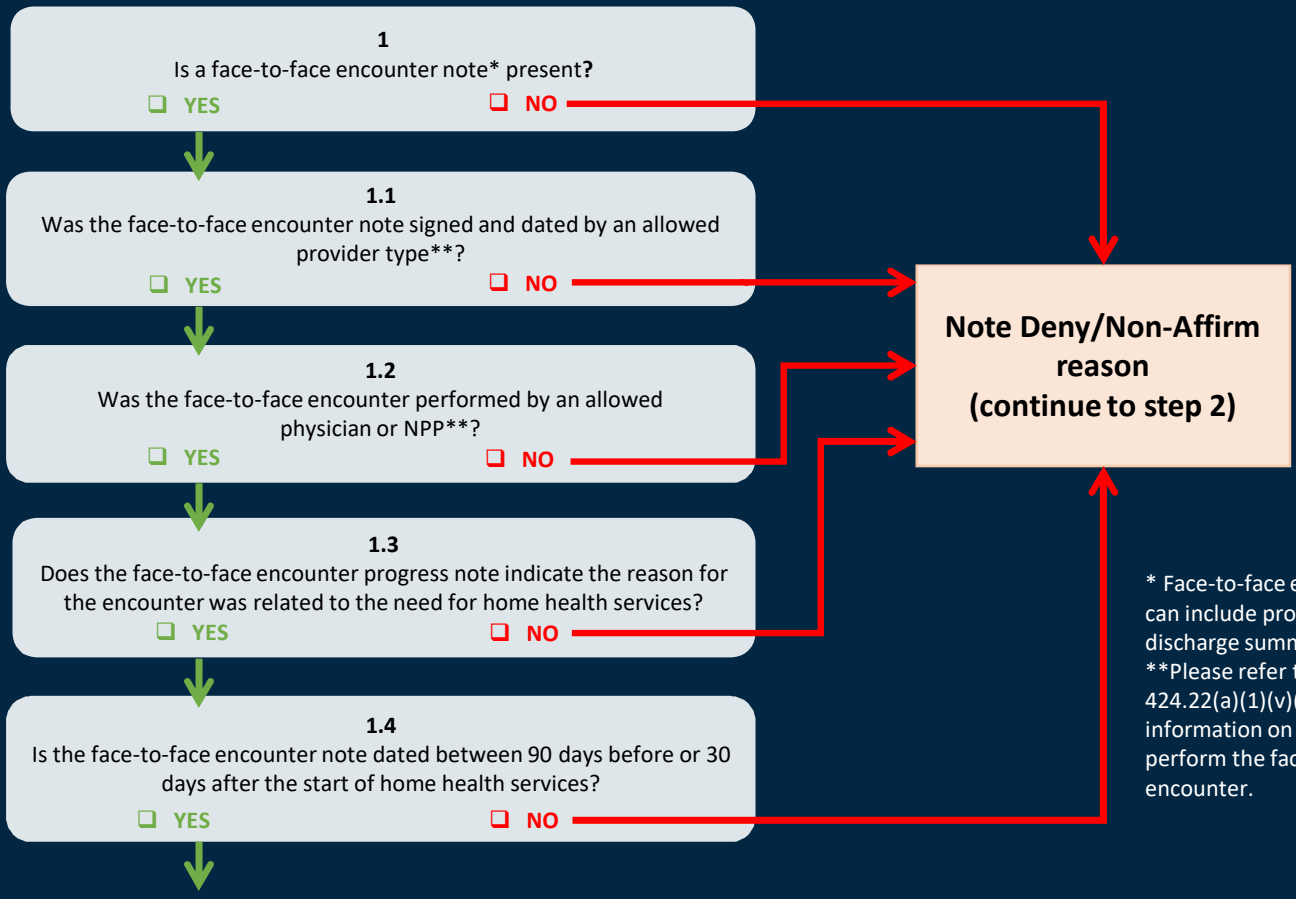
HOME HEALTH REVIEW TOOL STEP 1 (FACE-TO-FACE ENCOUNTER REQUIREMENT)



* Face-to-face encounter note can include progress notes, discharge summary, etc.
**Please refer to 42 CFR 424.22(a)(1)(v)(A) for detailed information on who can perform the face-to-face encounter.

F2F Encounter Requirement ARE MET. Proceed to Step 2 (Plan of Care Requirement)

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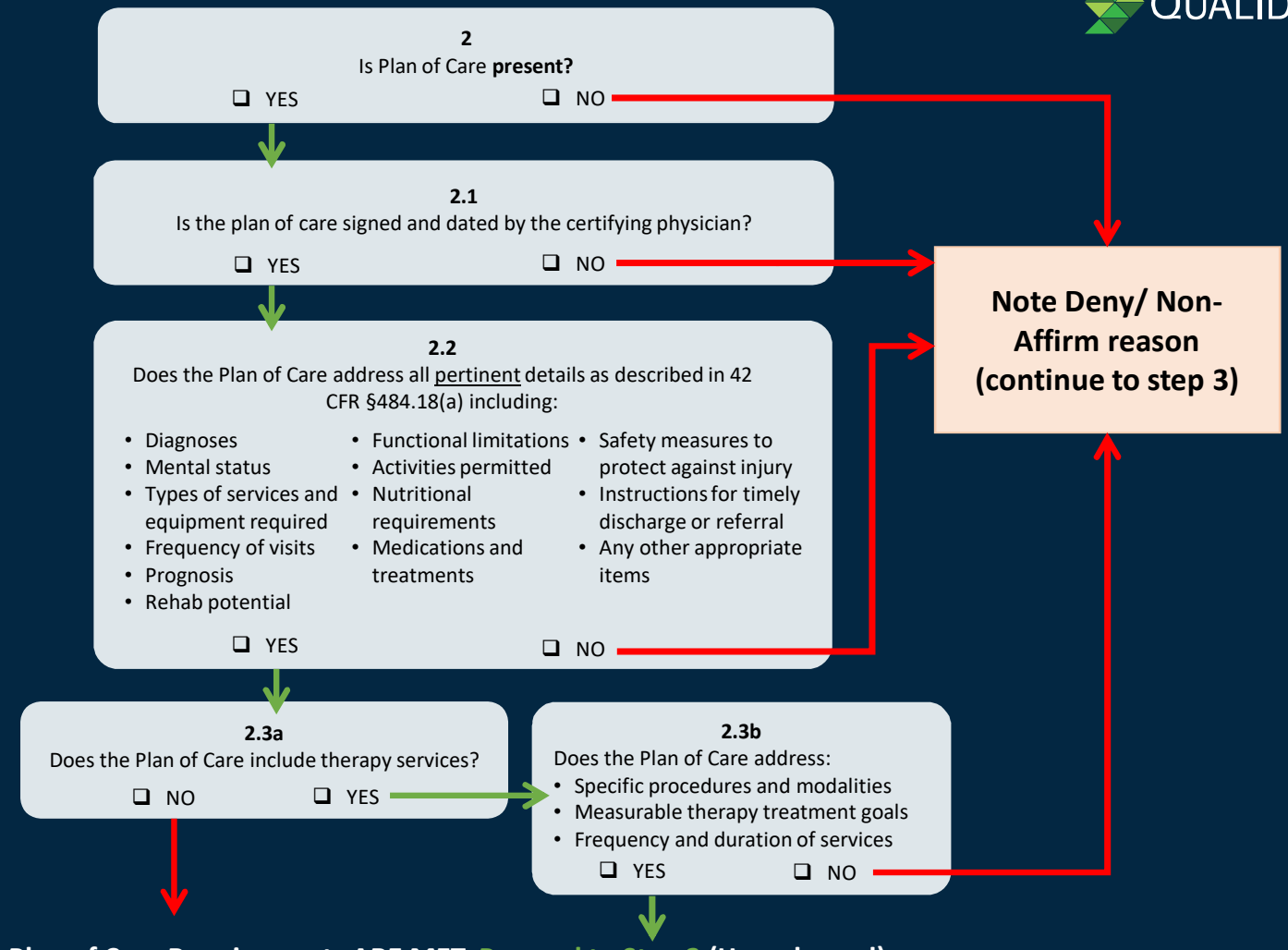
STEP 2 (PLAN OF CARE REQUIREMENT)



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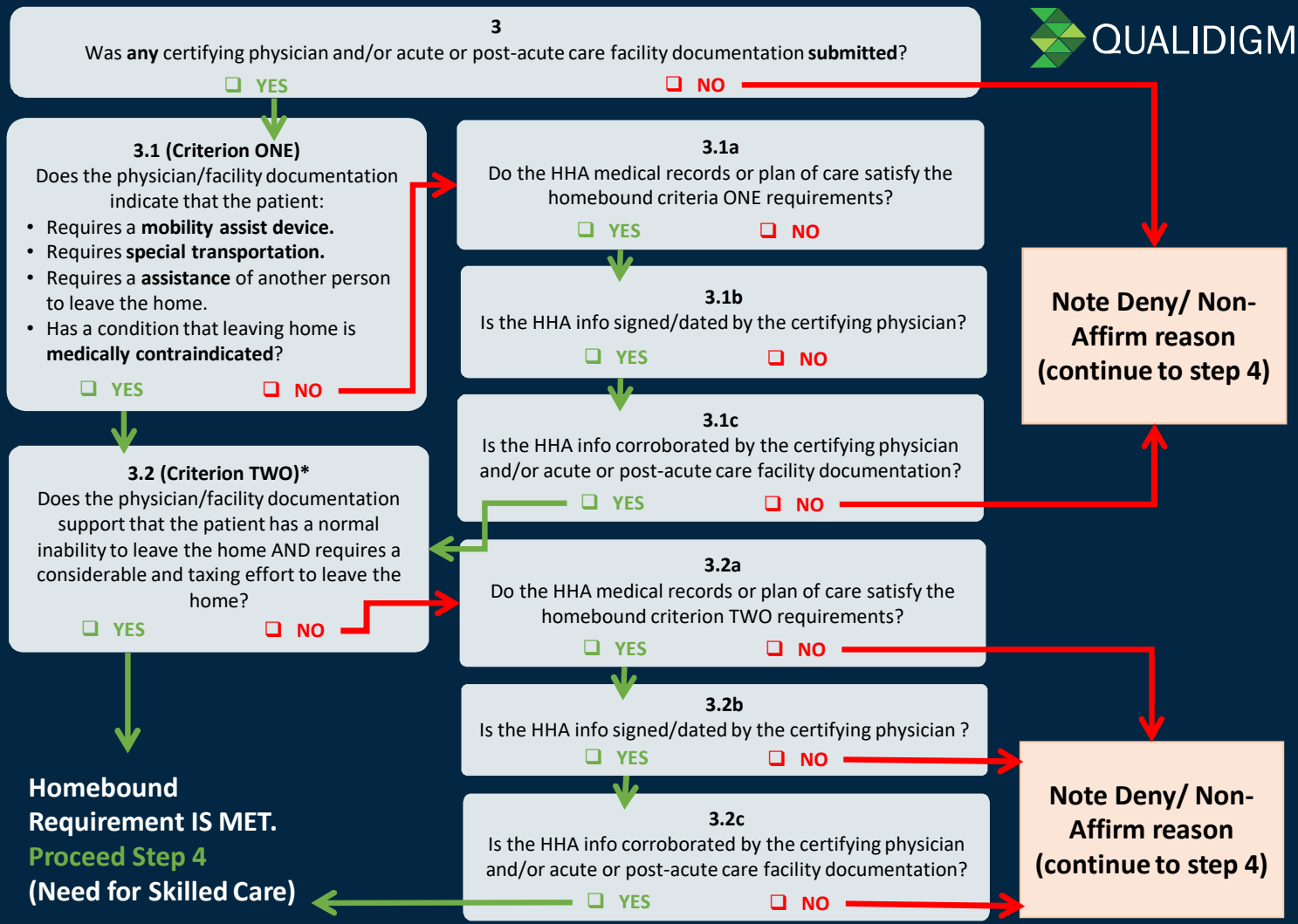
STEP 3 HOMEBOUND REQUIREMENT



*In determining whether the patient meets criterion two of the homebound definition, the clinician needs to take into account the illness or injury for which the patient met criterion one and consider the illness or injury in the context of the patient's overall condition.

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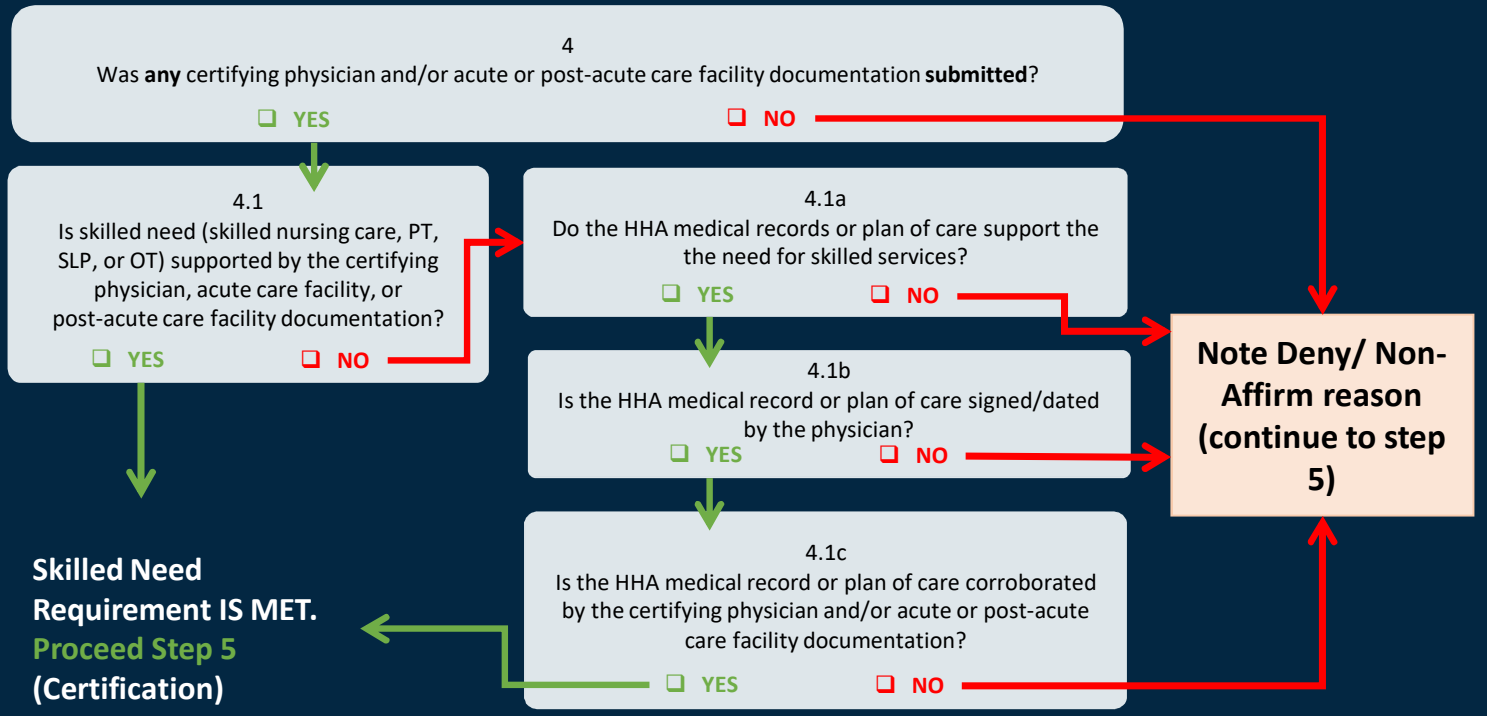
STEP 4 (NEED FOR SKILLED CARE REQUIREMENT)



Yes

*Skilled need may be substantiated through an examination of all submitted medical record documentation from the certifying physician, acute/post-acute care facility, and/or HHA (see below). The synthesis of progress notes, diagnostic findings, medications, nursing notes, etc., help to create a longitudinal clinical picture of the patient's health status.

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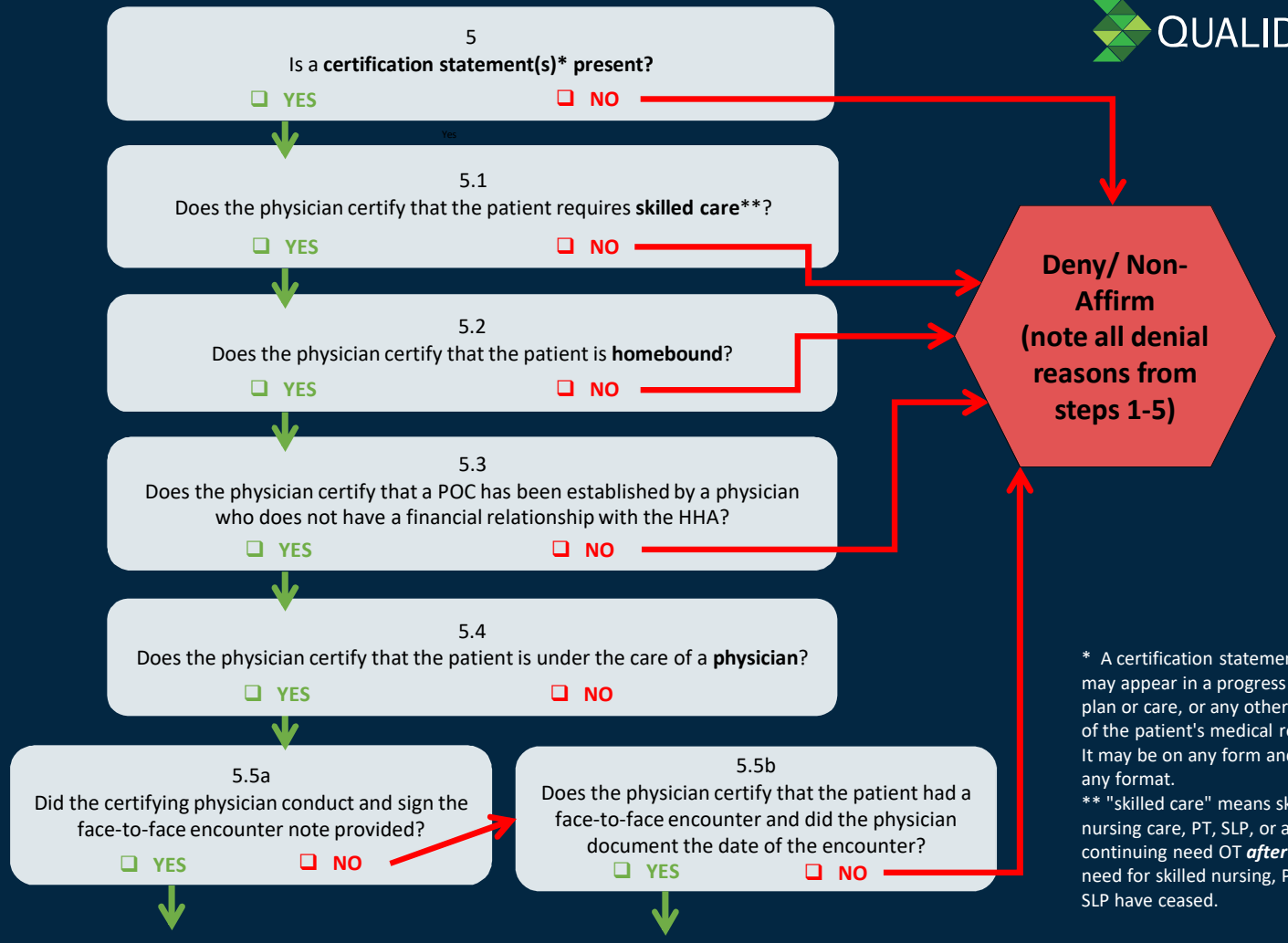
STEP 5 (CERTIFICATION REQUIREMENT)



* A certification statement may appear in a progress note, plan or care, or any other part of the patient's medical record. It may be on any form and in any format.
** "skilled care" means skilled nursing care, PT, SLP, or a continuing need OT ***after*** the need for skilled nursing, PT, or SLP have ceased.

ADAPTING THE TOOL FOR USE

- Paper vs. Electronic
- An Excel Version (paper or internal e-file)

FOCUSED AUDIT- Pre Bill Assessment				
QUERY	DATA ELEMENTS	CODE RANGE	SPECIAL INSTRUCTIONS	SKIP PATTERN
Is a face-to-face encounter note present?	The encounter note no longer needs to be the initial CMS form but may be an agency generated version, an electronic record generated version or a supplemental document provided by the referring/certifying physician.	Yes/No	Yes: a document that meets the criteria if found in the file; No: No document or supplemental information is found in file	If NO; drop to Line 22 and default it to NO

ADAPTING THE TOOL FOR USE

- An Automated Alternative:
  - SMARTAUDIT website
    - http://www.qualidigm.org/our-services/home-healthcare-consulting/smartaudit/
  - 2 min Live demo
    - https://vimeo.com/231763860

WHEN THE ADR'S STILL COME…

- Establish a consistent process managed by a consistent person with a designated back up
- Train all Clinical Managers in the CMS process
- Maintain records of all ADRs received, documents sent out at each step
- Track/Trend approved vs denied and the reasons given
- Treat the whole process as a Performance Improvement Project

PRESENTATION MATTERS!

The CMS Checklist

- **Order/Referral** for HH Services
- Written and signed by the certifying and/or referring physician
- For the patients current diagnosis (as witnessed during the time of the FTF encounter visit with the doctor)
- All pages are for the appropriate patient
- Proof of Provider Enrollment, Chain & Ownership System-**PECOS** Validation for all physicians involved in the patient's care for all dates of service in the episode
- Appropriate OASIS submission
- Any and all therapy evaluations and reevaluations where applicable
- The patient's name is on each page (front and back where appropriate)
- The correct dates of service for the claimed episode

PRESENTATION MATTERS!

- handwritten documentation
- Identifiable credentials for each clinician signature
- Signature sheets as appropriate from agency and referring facility/office
- Accuracy of documentation
- All staples, paperclips, binder clips, sticky notes, rubber bands, etc. are removed prior to submission
- Pages are not folded over, cut off or crinkled during copying/printing/faxing
- Highlighter is not utilized
- ADR is placed on the top of the medical record
- Reminder: Black ink copies best
- Provider contact name and telephone number

IMPORTANT TIPS!

- Documentation from the home health agency must be corroborated by other medical record entries and align with the time period in which services were rendered.
- Information from the home health agency can be incorporated into the certifying referring physician's and/or the community physician's medical record for the patient.
- The certifying physician must review and sign any documentation incorporated into the patient's medical record that is used to support the certification.
- If this documentation is to be used for verification of the eligibility criteria, it must be dated prior to submission of the claim.

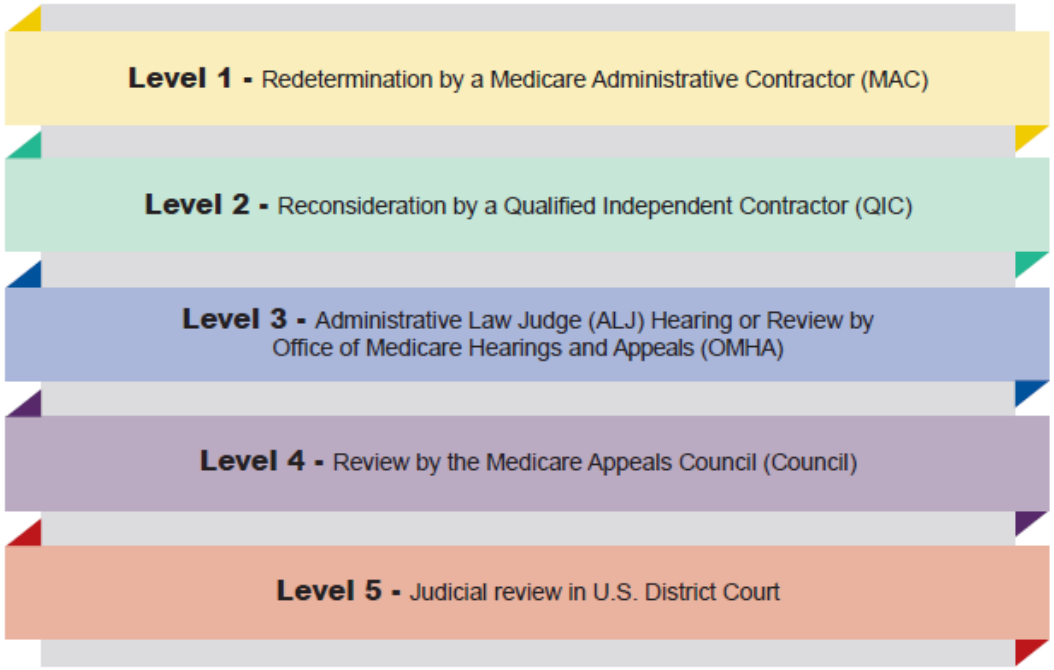
CMS REMINDERS!

- Certification
  - Statement from the certifying physician acknowledging all 5 Eligibility criteria (as above) have been met
  - Dated Signature below the statement from a Medicare enrolled physician
  - Certification cannot be completed/ signed by an NPP
- Recertification –
  - All above documentation regarding initial eligibility criteria
  - Date of FTF Encounter at the time of initial certification
  - Physician estimate regarding how much longer skilled services may be required
  - Statement from the community physician that is overseeing HH services acknowledging that all 5 eligibility criteria (as above) continue to be met
  - Dated signature below the statement from a Medicare enrolled physician

WHAT ARE THE STEPS IN THE PROCESS?

- ADR received; respond within 45 days
- If Denied:
  - **Level 1 -** Redetermination by a Medicare Administrative Contractor (MAC)
  - **Level 2 -** Reconsideration by a Qualified Independent Contractor (QIC)
  - **Level 3 -** Administrative Law Judge (ALJ) Hearing or Review by Office of Medicare Hearings and Appeals (OMHA)
  - **Level 4 -** Review by the Medicare Appeals Council (Council)
  - **Level 5 -** Judicial review in U.S. District Court

MEDICARE PARTS A & B APPEALS PROCESS



Target Audience: Medicare Fee-For-Service Program (also known as Original Medicare)

The Hyperlink Table, at the end of this document, provides the complete URL for each hyperlink.

TIPS FOR SUCCESSFUL RESPONSES

- Initial ADR Request: 45 Days
  - Respond to each item on the request
  - Always include the initial certification and F2F even if a subsequent episode is the one requested
  - Cover memo that points out specifically where/how the elements are met and documented
- Redetermination Request: 120 Days
  - Address the denial reason specifically with evidence of why it is in error
  - Cover memo should address F2F, homebound status and clinical need as well
  - Supplemental supportive documentation from the physician can be added

ADDITIONAL TIPS

- Reconsideration Request: 180 Days
  - Complete the CMS form for Reconsiderations
  - Cover memo should address specifically why cited denial rationale is incorrect and provide evidence
- Administrative Law Judge Hearing Request: 60 Days
  - Complete the CMS form for ALJ Request
  - Cover memo should address specifically why cited denial rationale is incorrect and provide evidence
  - Always cite the relevant supporting CFR citation and direct reviewer to relevant evidence in the file
- At all levels:
  - All documents are sent "Return Receipt"
  - Complete cc of all documents are kept in house

A PLAN FOR YOUR AGENCY'S SUCCESS

- Manage this process as a series of Performance Improvement Projects
  - Identify a point person
  - Create a plan
  - Evaluate progress
  - Address and correct issues/obstacles
- Project #1: Face-to-Face Documentation
- Project #2: Improving Clinical Documentation and Compliance
- Project #3: Timely complete responses to each level of the ADR process
- Project #4: Track and trend your denials by type, by team/discipline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RESOURCES

- https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MedicareAppealsprocess.pdf Appeals Process
- http://go.cms.gov/2xcHqL4 (CMS Audit Tool)
- https://app.smartaudit-tool.com