Medicare Clinical Updates from CGS

Home Care Association of Colorado
2017 Conference
Friday, May 19, 2017
Presenter: Sandy Decker RN BSN; Senior Provider Education Consultant

Home Health Coverage Resources

CMS "Medicare Benefit Policy Manual" (CMS Pub. 100-02); **Chapter 7**; Home Health Services

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

Medicare Benefit Policy Manual
Chapter 7 - Home Health Services

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Home Health Coverage Resources

CGS "Home Health Coverage Guidelines" Web page

- **http://www.cgsmedicare.com/hhh/coverage/Home_Health_Coverage_Guidelines.html**

Home Health Coverage Guidelines

Medicare Benefit Policy Manual, (CMS Publication 100-02, Ch. 7) PDF

CMS Quick Reference Information: Home Health Services PDF

Medicare pays for care in a beneficiary's home, when qualifying criteria are met, and documented. complete understanding of these criteria, as you have the right and responsibility, in collaboration qualifies for your services. The agency then must understand what services are covered, and how t topics for more information:

- Qualifying Criteria for Home Health Services
  - Physician orders, Plan of Care and Certification
    - Face-to-Face (FTF) Encounter
    - 2016 Leap Year Home Health Face-To-Face Encounter Calendar PDF
    - Face-To-Face Encounter Calendar Quick Resource Tool
  - Homebound;

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Probe and Educate Round 2

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Common Denial Reasons from Round 1

1. Face-to-Face
2. Recertification Estimate
3. Initial Certification Missing
4. Therapy Services Require Skills of a Therapist
5. Homebound Status

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Probe and Educate Letter

Claims Reviewed – #

Claims Denied – #

Reimbursement Reviewed - $#.##

Reimbursement Denied - $#.##

Error Rate – #.##% (based on $ amount)

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Probe and Educate Letter

Home Health PPS Denial Detail Report by Provider — *22-Mar-16*

(Date Range From 1/1/2016 through 2/29/2016)

HICN	From Dt	Thru Dt	Clms Rcvd	Clms Dnyd	Provider Submitted Payment	Medical Review Payment	Difference in Payment	Denial Rate	Denial Code	Denial Reason
123456 123123123 Bert and Ernie's Home Health Agency										
XXXXXXXXXD	10/01/15	11/29/15			$999.99	$0.00	$999.99		5HC01	F2F missing/incomplete/untimely
XXXXXXXXXD	10/01/15	11/29/15			$999.99	$0.00	$999.99		5HC01	F2F missing/incomplete/untimely
XXXXXXXXXD	10/01/15	11/29/15			$999.99	$0.00	$999.99		5HC01	F2F missing/incomplete/untimely
XXXXXXXXXD	10/01/15	11/29/15			$999.99	$0.00	$999.99			
XXXXXXXXXD	10/01/15	11/29/15			$999.99	$999.99	$0.00		5HC01	F2F missing/incomplete/untimely
Provider Total			5	4	$4,999.95	$999.99	$3,999.96	80%		

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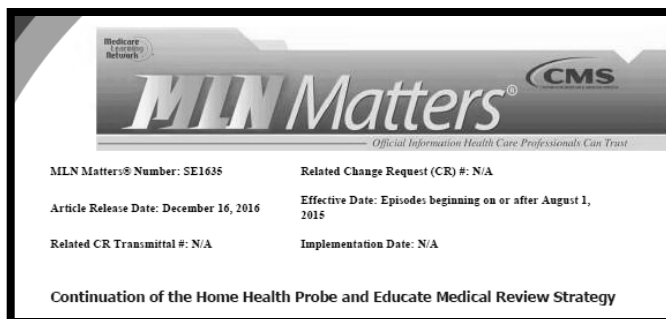
Probe and Educate

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1635.pdf



MLN Matters® Number: SE1635 | Related Change Request (CR) #: N/A

Article Release Date: December 16, 2016 | Effective Date: Episodes beginning on or after August 1, 2015

Related CR Transmittal #: N/A | Implementation Date: N/A

Continuation of the Home Health Probe and Educate Medical Review Strategy

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Probe and Educate – Round 2

- CGS will begin sending Additional Documentation Requests (ADRs) on or after January 19, 2017.
- This round of claim reviews and provider education will conclude in approximately one year.
- Letters to providers will be sent via the postal service at the conclusion of the probe review portion of the process.
- One-on-one education is available to ALL providers.

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Important!!!

- ***<u>If you choose not to reach out for education, this will be tracked as a refused offer.</u>*** Please note that the purpose of the P&E process is to identify areas of confusion and to address these areas through education, supporting providers in their goal of submitting claims that are in compliance with Medicare policy.

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Probe and Educate – Round 2

	No or Minor Concerns	Moderate/Major Concerns
5 claim sample	0-1*	2-5*
Action	For each provider with no or minor concerns, CMS will direct the MAC to: 1. Deny non-compliant claims; and 2. Send detailed review results letters explaining each denial. 3. Send summary letter that: • Offers the provider a 1:1 phone call to discuss claim denials if any; and • Indicates that no more reviews will be conducted under the Probe & Educate process. 4. **Await further instruction from CMS**	For each provider with major to moderate concerns CMS will direct the MAC to: 1. Deny non-compliant claims; and 2. Send detailed review results letters explaining each denial. 3. Send summary letter that: • Offers the provider a one-to-one phone call to discuss; • Indicates the review contractor may REPEAT Probe & Educate process with an additional claim sample 4. **Repeat Probe & Educate of five claims with dates of after the implementation of education.**

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Probe and Educate

http://www.cgsmedicare.com/hhh/medreview/hh_probe_educate_mr.html

Home Health Probe and Educate Medical Review

The Centers for Medicare & Medicaid Services (CMS) has implemented a Probe & Educate medical review strategy to ensure home health agencies (HHAs) and physicians (or allowed non-physician practitioners) understand the policy at CFR 424.22 (a)(1) and offers provider-specific education, as necessary.

Probe & Educate Process

- For round 2 of the Probe & Educate program, five claims will be selected for each HHA, excluding those providers who had 5 claims reviewed in Round 1, with zero or one claim in error. Third party liability, Medicare Advantage, and Medicare Secondary Payer (MSP) claims, as well as claims under review by other contractors, are excluded from this review.

  Note: Due to a variety of circumstances, CMS has limited Medicare Administrative Contractor claim review samples during the first Probe & Educate process. While CMS anticipates most facilities will be subject to medical review, if a provider has not submitted any claims for billing or has not been selected for medical review during the last several months, they may still receive generalized education on the final rule. Please contact CGS at J15HHProbeandEducation@cgsadmin.com, if you would like to receive educational information related to CMS Final Rule 1611 as it relates to home health certification/recertification
- The Probe & Education topic code will be **5014W or 5015W**.
- A Medical Review Additional Development Request (MR ADR) will be generated for claims that meet the Probe & Education criteria. For additional information about MR ADRs, refer to the "Medical Review Additional Development Request (ADR) Process" Web page.

IMPORTANT NOTE: During a nightly system cycle, it is likely that more than five of your claims will move into a suspended location. CGS will work to release claims in excess of the five claim sample before those claims move to SB6001 and an ADR request is sent. **Do not submit medical documentation unless your claim moves to SB6001 and you receive a MR ADR request**. If you feel you have received more than 5 ADRs for the probe and educate edit, please contact the Provider Contact Center (PCC) with the specific claim information so that we may research the issue.

MR ADR documentation may be submitted via the myCGS portal, electronic submission of medical documentation esMD, fax (1.615.660.5981) or mail.

- Claims will be reviewed for valid Face-to-Face encounter documentation, medical necessity, compliance with the Centers for Medicare & Medicaid Services (CMS) coverage guidelines, correct billing, and coding associated with updates in the CMS-1611-F, Calendar Year (CY) 2015 Home Health Prospective Payment System (HH PPS) Final Rule EXT .

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Face-to-Face (FTF) Encounter

Face-to-Face - When?

Certifying physician must document FTF took place within:

- **90 days prior to start of care (SOC),** or
- **30 days after SOC**

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Face-to-Face - When?

Reminder:

- FTF must be related to **primary reason** for home health admission
- **Exceptional** circumstance: Patient death **before** FTF can be performed

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FTF Documentation: Important Reminders

The home health agency's (HHA's) **responsibilities** include:

- Facilitating and coordinating between patient and physician to ensure FTF **occurs timely**
- Ensuring all FTF requirements are met
- Ensuring physician's documentation is complete
- Delaying submission of claim until documentation complete

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Supporting Documentation

Documentation in **certifying physician's medical record** and/or acute/post-acute care facility's medical record:

- Will be used as basis for patient's home health eligibility
- Must contain information to justify the referral for home health services including:
  - **Need for skilled services; and**
  - **Homebound status**

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Certification Examples

"Certifying Patients for the Medicare Home Health Benefit" SE1436 – document examples. 7 pages.

http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1436.pdf

MLN Matters® Number: SE1436	Related Change Request (CR) #: NA
Related CR Release Date: NA	Effective Date: NA
Related CR Transmittal #: NA	Implementation Date: NA

Certifying Patients for the Medicare Home Health Benefit

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Face-to-Face before Certification

The face-to-face encounter with the beneficiary must happen ***before*** the physician's certification

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Supporting Documentation

HHAs may send information to the certifying physician:

- Created/generated by HHA
- Other information created/generated by other sources

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Supporting Documentation

Examples of supporting documentation to send to physician's medical record:

- Start of care (SOC) OASIS
- Face-to-face encounter documentation
- Plan of care
- Certification/recertification statement
- Discharge summaries
- History and physical examination (H&P)

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Supporting Documentation

The certifying physician may consider and/or use any information sent by the HHA, that has been incorporated into the medical record, as the **basis for certification** of the patient's eligibility for home health services

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Supporting Documentation

- Supporting documentation must be **signed/dated** by certifying physician to indicate acceptance of documentation into their medical records
- Physician's dated signature (sign off)must be **on/before the time of claim submission**

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Supporting Documentation

Documentation in the certifying physician's medical record and/or acute/post-acute care facility's medical record:

- **Must** be provided to home health agency (HHA) when requested

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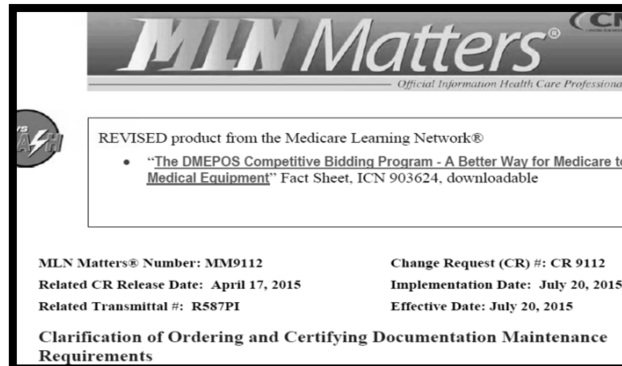
Supporting Documentation

http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9112.pdf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- "The DMEPOS Competitive Bidding Program - A Better Way for Medicare to Medical Equipment" Fact Sheet, ICN 903624, downloadable

MLN Matters® Number: MM9112 | Change Request (CR) #: CR 9112

Related CR Release Date: April 17, 2015 | Implementation Date: July 20, 2015

Related Transmittal #: R587PI | Effective Date: July 20, 2015

Clarification of Ordering and Certifying Documentation Maintenance Requirements

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Important

Documentation submitted must contain the actual clinical note for the FTF encounter visit

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Important

Certifying physician must document the date of the FTF encounter before the claim is submitted for billing

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FTF/Certification Combo

If a provider performs FTF encounter **and also** certifies patient for home health, they must identify the community physician who will follow the patient.

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Important!!!

- Diagnoses/clinical findings on FTF **must be related to reason for home care**
- Altered documentation must have **acceptable** notations for changes
- **Don't forget the date** of FTF encounter
- **Make sure to clearly title** the face-to-face encounter

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Recertification

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Physician Recertification

The physician must include an estimate of how much longer skilled services will be required (preferably a timespan or interval of time)

- As part of the **recertification document**

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Physician Recertification

The achievement of a treatment goal as an estimate of how much longer a patient may need HH services is **not acceptable.**

Unacceptable examples of treatment goals:

- Services will be required **until the patient can walk safely**
- Services will be required **until the ulcer heals**

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Physician Recertification

Acceptable examples of timespan used to convey how much longer the services will be needed:

- **Another 45 days.**
- **Another 4 weeks**.

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Initial Certification Missing

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Initial Certification

Always send **initial certification and initial F2F**, along with the current certification.

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Therapy Documentation

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Medical Necessity

http://www.cgsmedicare.com/hhh/coverage/HH_Coverage_Guidelines/1E.html

Medically Necessary and Reasonable

Medicare Benefit Policy Manual (CMS Pub. 100-02, Ch. 7 §20.1) PDF

All services billed to Medicare must meet the criteria of "medically necessary and reasonable." To determine whether a service is reasonable and necessary, the Medicare home health benefit considers each beneficiary's unique medical condition. The medical record documentation, including the Plan of Care and OASIS, provide the basis for this determination. Coverage decisions are always based upon the objective clinical evidence of the beneficiary's individual need for care.

- It is the home health agency's responsibility to provide clear documentation of the medical necessity and reasonableness. This includes: progress or lack of progress, medical condition, functional losses, and treatment goals.
- The length of time services will be covered is generally determined by the beneficiary's needs.

Impact of Caregivers on Medical Necessity

National and Local Coverage Determinations

Documenting Medical Necessity

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Medical Necessity

It is the home health agency's responsibility to provide **clear documentation** of the medical necessity and reasonableness.

This includes: progress or lack of progress, medical condition, functional losses, treatment goals, etc..

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Therapy Documentation

Patient requires supervision and frequent rest breaks with ambulation due to CHF and gait instability after **70-80 feet** and then **2-3 hours to recover after extended outings**

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Therapy Documentation

HEP plan has been in place for 2 weeks for patient to increase strength and confidence without skilled services. Patient understands and agrees with HEP.

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Therapy Documentation

PT Goal: Return to **PLOF**

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Therapy Documentation

Patient very confused today and hard to keep on task.

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Therapy Documentation

Patient requires frequent rest breaks due to CHF after 50-60’ and supervision due to gait instability to leave home, then 2-3 hours to recover after outings

Considerable and taxing effort to leave home, taking 1-2 hours to recover due to decreased independence with gait transfers and balance.

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Therapy Documentation

February 18th

Patient’s family cancelled the therapy appointment due to falling twice in the last 24 hours. Patient was rescheduled for Monday the 23rd.

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Therapy Documentation

Patient called and cancelled appointment because his bike broke down yesterday and he had to walk it home for a very long distance.

Happened more than once!

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Therapy Documentation

Patient requires frequent rest periods to decrease SOB. Fatigues quickly.

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Therapy Documentation

Patient will ambulate 225 feet with cane or walker independently, including up and down stairs in order to safely get in and out of home to access health care outside of the home.

Patient reports good compliance with HEP, still needs to increase ability to stand upright with UE support, increased reps on sitting, unable to do in standing position due to pain L hip.

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Therapy Documentation

Patient lives alone.

Patient unable to ambulate without assist of at least one person.

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Therapy Documentation

Initial Finding: Patient able to gait train 0' feet with max assistance in transfers and FWW for balance and stability

Goal: To gait train 600 feet with or without AD and independent transfers on level/uneven surfaces to allow patient to get into and out of doctor office and exit home in case of emergency.

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Therapy Documentation

Goal: Patient will be able to ambulate 900 feet on even and uneven surfaces without assistive device. Patient will be able to climb 50+ steps without unsteadiness or shortness of breath.

Patient is 88 years old.

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Homebound Status

Homebound Status

http://www.cgsmedicare.com/hhh/coverage/HH_Coverage_Guidelines/1C.html

Homebound

Medicare Benefit Policy Manual (CMS Pub. 100-02, Ch. 7 §30.1, §30.1.1) PDF

One of Medicare's qualifying criteria for home health care is that the beneficiary is homebound and that the physician certifies t
the beneficiary is homebound.

The certifying physician's medical records and/or the acute/post-acute care facility's medical records are used to determine the
home health services. This medical record documentation must substantiate the patient's need for skilled services, and their hor
home health agencies documentation, such as the initial and/or comprehensive assessment of the patient can be incorporated i
physician's medical record and used to support the patient's homebound status and need for skilled care. For additional informa
Documentation" section on the CGS "Home Health Face-to-Face (FTF) Encounter" Web page.

The beneficiary shall be considered homebound if the following two criteria are met.

Criteria-One:

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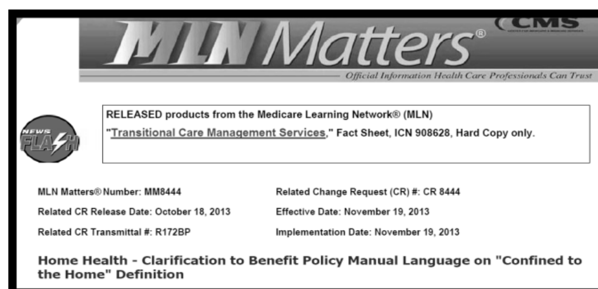
Homebound Status

http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8444.pdf


MLN Matters®

Official Information Health Care Professionals Can Trust

RELEASED products from the Medicare Learning Network® (MLN)

"Transitional Care Management Services," Fact Sheet, ICN 908628, Hard Copy only.

MLN Matters® Number: MM8444 — Related Change Request (CR) #: CR 8444

Related CR Release Date: October 18, 2013 — Effective Date: November 19, 2013

Related CR Transmittal #: R172BP — Implementation Date: November 19, 2013

Home Health - Clarification to Benefit Policy Manual Language on "Confined to the Home" Definition

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Homebound Status

Criteria-One:

The patient must **either**:

- Because of illness or injury, need the aid of supportive devices such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the assistance of another person in order to leave their place of residence.

OR

- Have a condition such that leaving his or her home is medically contraindicated.

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Homebound Status

Criteria-Two:

- There must exist a normal inability to leave home

AND

- Leaving home must require a considerable and taxing effort

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Homebound Status

The patient may be considered homebound (confined to the home) if absences from the home are:

- infrequent
- for periods of relatively short duration
- for the need to receive health care treatment
- for religious services
- to attend adult daycare programs
- for other unique or infrequent events
- the patient may have more than one home
  - vacation home, home of caregiver, seasonal home

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Homebound Status

Examples of **good documentation to support homebound status**:

- "After ambulating 20 feet, patient has increased dyspnea and complains of back pain."
- "Patient has unsteady gait, and must sit to rest after 10 feet of ambulation due to uncontrolled vertigo."

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Homebound Supporting Documentation

In her current condition, she becomes significantly short of breath with even minimal physical activity such as walking 10 feet or less. She is unable to navigate stairs. This makes travel outside the house very difficult and taxing.

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Resources

Home Health Coverage Resources

CMS “Medicare Benefit Policy Manual” (CMS Pub. 100-02); **Chapter 7**; Home Health

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

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Medicare Benefit Policy Manual
Chapter 7 - Home Health Services

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CGS HH&H Website

http://www.cgsmedicare.com/hhh/index.html

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Navigation Menu

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CGS HH&H Website: Education & Resources

http://www.cgsmedicare.com/hhh/education/index.html

Calendar of Events, Education & Resources: Advisory Group, Calendar of Events, FAQs, Online Education Center & More…

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CGS HH&H Website: Educational Materials

http://www.cgsmedicare.com/hhh/education/materials/index.html

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Education & Resources
Advisory Group
Calendar of Events
CMS Educational Resources
Educational Materials
FAQs
New Provider Resources Center
Online Education Center
Video Education
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Forms
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Medical Review
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Educational Materials & Resources

Home Health and Hospice Education

- Adjustments/Cancels
  - Limitation on Recoupment (935)
- Checking Eligibility
- Comprehensive Error Rate Testing (CERT) Program
- Fiscal Intermediary Standard System (FISS) Guide
- Medicare Secondary Payer (MSP)
  - Submitting MSP Claims and Adjustments
  - Medicare Secondary Payer (MSP) Billing and Adjustments PDF Quick Resource Tool
  - Medicare Secondary Payer (MSP) Online Tool
- Resources for the Most Common Home Health and Hospice Questions
- Return to Provider
- Timely Claim Filing Requirements
- Top Claim Submission Errors (Reason Codes) and How to Resolve

Home Health Education

- Claims Processing and Reimbursement for Home Health Supplies
- Home Health Claims Filing and Special Claims Filing Situations
- Home Health Coverage Guidelines
- Home Health Quick Resource Tools
- Resolving Rejected Home Health Claims Caused by Billing Errors
- Medicare Learning Network Home Health Prospective Payment System Fact Sheet PDF
- Medicare Learning Network The Medicare Home Health Benefit PDF

Hospice Education

- Change Request 8877
- Hospice Claims Filing and Special Claims Filing Situations
- Hospice Coverage Guidelines
- Hospice Quick Resource Tools
- Hospice Sequential Billing
- Medicare Learning Network Hospice Payment System Fact Sheet PDF

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CGS HH&H Website: News & Publications

http://www.cgsmedicare.com/hhh/pubs/index.html

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Home Health & Hospice News & Publications

The News & Publications left side menu includes important and timely information and articles issued by CGS and the Centers for Medicare & Medicaid Services (CMS). Refer to the following for the latest Medicare news.

- Recent News
- Archived News
- CGS Home Health & Hospice Medicare Bulletin
- EDI Connection

Keep up to date on the most recent news by selecting "Join/Update ListServ" to receive electronic mailings from CGS, or update your contact information or preferences.

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Questions?

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1.877.299.4500

Option 1: Customer Service

Option 2: Electronic Data Interchange (EDI)

Option 3: Provider Enrollment

Option 4: Overpayment Recovery (OPR)

Option 5: PreClaim Review (PCR)

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