# C2C PHONE DEMO

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## April 2020 Summary of Results

This month, a total of **19 telephone conferences** were conducted with home health/hospice agency representatives. After a telephone conference was conducted and verbal testimony was provided, 11% of the claims were favorable and 11% were unfavorable. At the time of review, 78% of the denied claims still had no disposition.

**Eleven (11) home health claims** were included in this month's telephone demonstration. The denials were related to the lack of support for the need for skilled nursing (3) or skilled therapy (3). Two (2) of the claims were denied for a lack of support for homebound, two (2) for an invalid recertification, and one (1) for an admitting diagnosis that was not addressed in the face-to-face encounter. One of the claims was denied for the primary reason of an invalid certification/ recertification was also denied for lack of support for therapy services. Because the primary denial was certification related, it was counted in that category.

The most common issue was in relation to support for the medical necessity for skilled nursing and skilled therapy services. The medical record in its entirety, in addition to the face-to-face encounter note, must substantiate beneficiary's need for skilled services (see Centers for Medicare and Medicaid Services (CMS), Internet-Only Manual, Publication 100-02, MBPM Chapter 7, Section 30.5.1.1 – Face-to-Face Encounter and Section 30.5.1.2 -Supporting Documentation Requirements). Ensuring thorough, consistent documentation encounter is reviewed for evidence will often circumvent this error and provide enough support for the skilled services.

**Eight (8) hospice claims** were included in the telephone demonstration. Six (6) denials were due to documentation that did not support general inpatient hospice services (GIP), one (1) denial was related to an NOE that was backdated making it invalid and one (1) denied for the lack of support of trajectory of terminal decline. [see Centers for Medicare and Medicaid Services (CMS), Internet-Only Manual, Publication 100-04, Medicare Claims Processing Manual Chapter 11, Section 20.1.1 for NOE submission requirements and Publication 100-02, Medicare Benefit Policy Manual (MBPM), Publication 100-02, Chapter 9, Section 20.1 for certification requirements].

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|---|---|
| **TOTAL CLAIMS** | **19** |
| Favorable | 4 |
| Partially Favorable | 6 |
| Unfavorable | 2 |
| No Disposition | 7 |
| **Home Health** | |
| Skilled Nursing Not Supported | 3 |
| Therapy not supported | 3 |
| Homebound not supported | 2 |
| Invalid cert/recert | 2 |
| Admitting diagnosis not addressed in FTF | 1 |
| **Hospice** | |
| GIP not supported supported | 6 |
| Invalid NOE | 1 |
| Trajectory of terminal decline | 1 |

## BREAKDOWN OF APRIL RESULTS

1. **Home Health - Documentation did not support the need for skilled services (32%)**

   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.

## 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

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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 in light of 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.

## Skilled Therapy 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 particular 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

- **Sections 40.1** (Skilled Nursing Care), **40.1.1** (General Principles Governing Reasonable and Necessary Skilled Nursing Care), **Sections 40.2** (Skilled Therapy Services), and **40.2.1** (General Principles Governing Reasonable and Necessary Physical Therapy, Speech-Language Pathology Services, and Occupational Therapy)

**2. Hospice- General Inpatient (GIP) Services Not Supported (32%)**

Short-term inpatient care may be provided in a participating hospital, hospice inpatient unit, or a participating skilled nursing facility (SNF). Medicare covers two levels of inpatient care: respite care for relief of the patient's caregivers, and general inpatient (GIP) care which is for pain control and symptom management. GIP care may only be provided in a Medicare participating hospital, SNF, or hospice inpatient facility and is allowed when the patient's medical condition requires a short-inpatient stay for pain control or acute or chronic symptom management which cannot feasibly be provided in other settings. For a hospice to provide and bill for the general inpatient level of care, the patient must require an intensity of care directed towards pain control and symptom management that cannot be managed in any other setting.

**Suggestion:** For payment of hospice services that include GIP care, the patient's symptoms must be that which cannot be managed in any other setting. GIP care may be need when the patient elects hospice at the end of a covered hospital stay. If this is the case and the patient requires symptom management or pain control, ensure that such services cannot be provided in any other setting.

**Guidelines:** CMS IOM, Pub. 100-04, Medicare Claims Processing Manual (MCPM), Chapter 11 - Processing Hospice Claims - https://www.cms.gov/files/document/chapter-11-processing-hospice-claims.pdf

- **Section 40.1.5** (Short-Term Inpatient Care)

**3. Home Health – Homebound not supported (11%)**

Documentation was submitted; however, was insufficient to support the patient is confined to the home. To determine homebound, the

face-to-face encounter assessment information and clinical records are reviewed to determine whether the beneficiary is unable to leave the home unassisted or leaving the home requires a significant, taxing effort. Submissions included documentation that noted the following assessment information that does not sufficiently support homebound:

- Normal mobility with good range of motion and adequate strength in all extremities
- No extremity deformities noted
- No assistive device used for ambulation
- Beneficiary states that they leave the home for activities not supported by the guidelines for homebound

The patient may be considered homebound if the absences from the home are infrequent or for periods of relative short durations or are for the need to receive health care treatment. Examples may be attendance at adult day care centers, ongoing outpatient kidney dialysis or outpatient chemotherapy or radiation therapy.

**Suggestion:** Include clear documentation of beneficiary's physical status which includes strength, gait, balance, and any additional factors that affect mobility. Document any assistive devices and whether the beneficiary's requires assistance leaving the home.

**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 30.1.1** (Patient Confined to the Home), **30.1.2** (Patient's Place of Residence), **30.5.1** (Physician Certification), **30.5.1.1** (Face-to-Face Encounter), **30.5.1.2** (Supporting Documentation Requirements)

**4. Home Health – Invalid Certification/Recertification (11%)**

The claim that denied for this error was because the physician signature on the initial certification was different than the one on the recertification.

At the end of the 60-day certification, the beneficiary is eligible for recertification for 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). Ensure that the face-to-face assessment data has not changed and there reason the beneficiary requires home health services is clearly documented in addition to documentation to support the beneficiary remains homebound. The submission should include documentation to support all elements of certification/recertification such as (see the Medicare Benefit Policy Manual, Chapter 7, Section 30.5.2)

- The beneficiary is confined to home (homebound)
- The beneficiary requires skilled nursing services on an intermittent basis
- A plan of care has been established and will be reviewed by a physician and
- 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

- **Sections 30.5.1** (Physician Certification), **30.5.2** (Physician Recertification)
- MLN Matters® Number: SE1436 (Revised) - Certifying Patients for the Medicare Home Health Benefit - https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1436.pdf

**5. Home Health – Invalid Face-to-Face/Does not address admitting diagnoses (5%)**

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 note 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

in order 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).

## Exceptions during the COVID-19 Public Health Emergency (PHE)

With the onset of the current PHE, there have been some allowances afforded to physicians and beneficiaries. These waivers are to facilitate the containment of the spread of the virus. Although telehealth services are allowed during the PHE, there are requirements for what type of technology may be used. The home health face-to-face encounter requires the use of two-way audio and visual equipment that allows for real-time communication. This allows for dialog and physical assessment of the beneficiary. For additional waivers amidst the PHE, please refer to the CGS website or the CMS website.

**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

- **Sections 30.5.1.1** (Face-to-Face Encounter)

6. **Hospice – Invalid NOE (5%)**

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.

The NOE submitted for the first level of appeal contained an NOE that included an election date that was 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/files/document/chapter-11-processing-hospice-claims.pdf

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

7. **Hospice – Trajectory of Terminal Decline Not Supported (5%)**

Hospice care is provided to those patients who are certified as terminally ill. An individual is considered to be 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 in itself is not cause to terminate benefits.

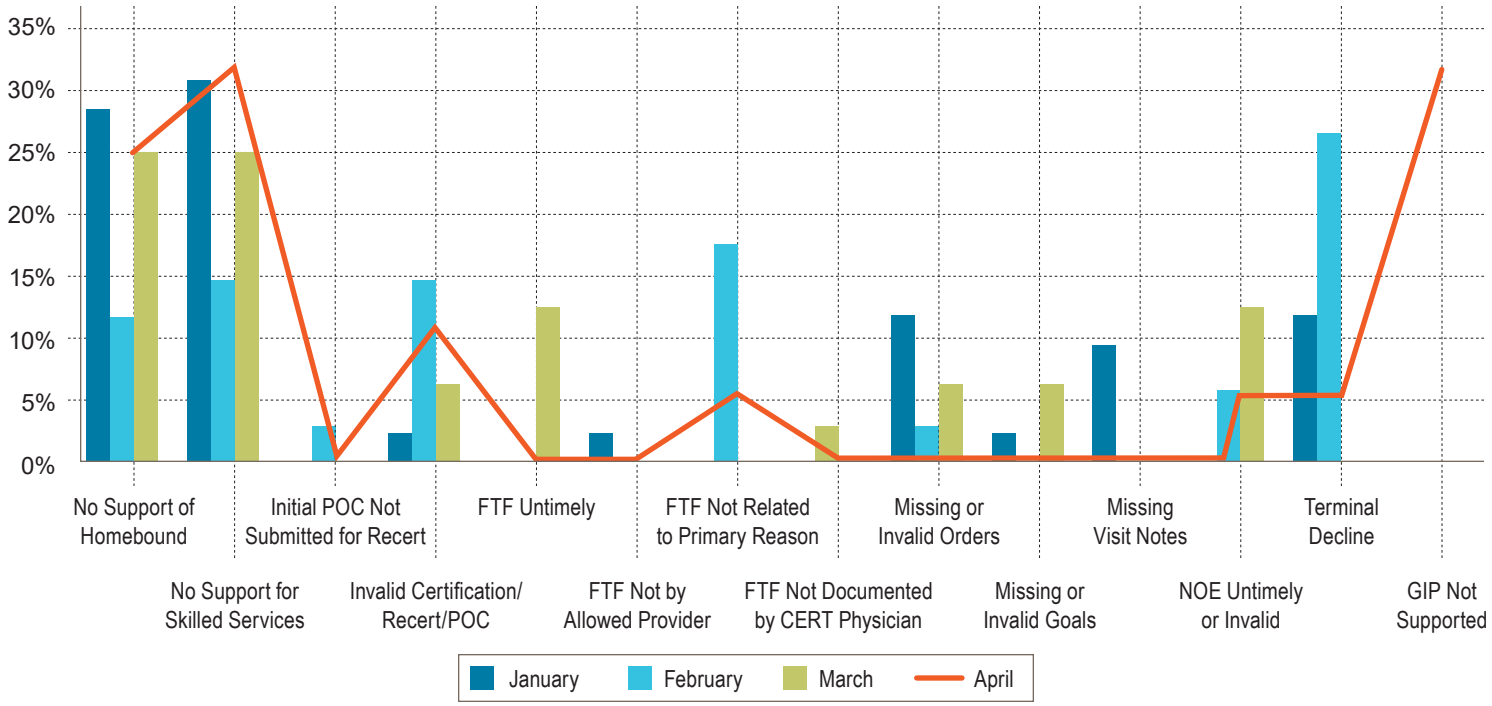
**Suggestion:** All documentation should provide adequate support of the patient's terminal illness. This includes, but is not limited to, clear and concise documentation of symptoms, treatment, appetite, food and liquid oral intake, presence of infections, wounds that are stage III or greater, weight 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:** CMS IOM, Pub. 100-04, Medicare Claims Processing Manual (MCPM), Chapter 9 - Coverage of Hospice Services Under Hospital Insurance https://www.cms.gov/files/document/chapter-11-processing-hospice-claims.pdf

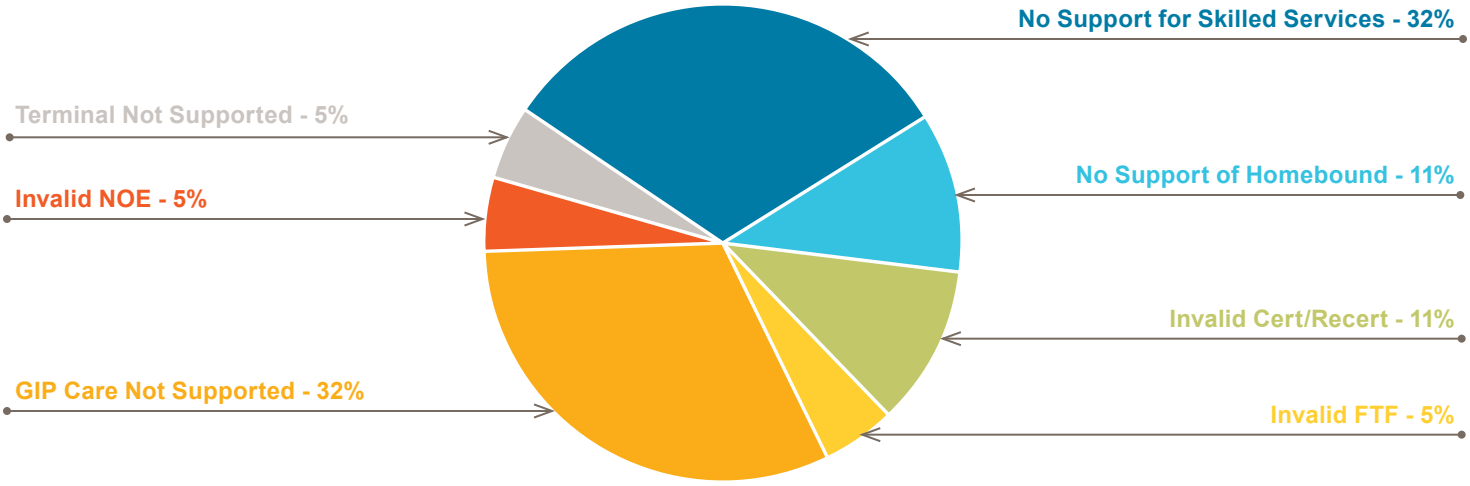
- **Section 10** (Requirements – General)
- Local Coverage Determination (LCD) L34538 Hospice Determining Terminal Status

## Comparison of Results: January - March




## Distribution of Denials: March 2020

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