C2C PHONE DEMO

Summary of June's Results

This month, a total of **32 telephone conferences** were conducted with home health/hospice agency representatives. After a telephone conference was conducted and verbal testimony was provided, 44% of the claims were favorable and 6% were partially favorable and 50% were unfavorable.

Twenty-six (26) 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 therapy services (7), missing or invalid signature on the certification/plan of care (4), no measurable therapy goals (4), face-to-face encounter that either did not support homebound or that there was a need for skilled services (5). There were two (2) claims in which the certifying physician did not document the date of the face-to-face encounter and one (1) included a face-to-face that did not have a valid signature. Additionally, one (1) claim did not include documentation sufficient to support the need for skilled services, one (1) in which the 30-day therapy reassessment was omitted, and one (1) that did not include orders for the services provided.

As it was last month, the most common error was a result of therapy services that were not sufficiently supported by the documentation submitted for the initial (Level 1) review. 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.

Six (6) hospice claims were included in the telephone demonstration. Four (4) claims were denied because of documentation that was insufficient to support a trajectory of terminal decline. Of the two other hospice claims, one (1) was denied because the physician certification of terminal illness was not included and one (1) was denied because there was insufficient documentation to support general inpatient (GIP) services [see Centers for Medicare and Medicaid Services (CMS), Internet-Only Manual, Publication 100-02, Medicare Benefit Policy Manual, Chapter 9, Section 40.1.5 for guidelines for short-term inpatient care].

TOTAL CLAIMS	**32**
Favorable	14
Partially Favorable	2
Unfavorable	16
Home Health Claims	**26**
Documentation did not support skilled services	7
Certification/POC - signature missing or invalid	4
No measurable therapy goals	4
FTF did not address reason for HH admission	3
Documentation did not support homebound	2
Certifying physician did not document date of FTF	2
Invalid FTF (invalid signature)	1
Documentation did not include skilled nursing services	1
No 30-day therapy reassessment	1
No orders	1
Hospice	**6**
Documentation does not support trajectory of terminal decline	4
Invalid certification	1
Documentation does not support level of care rendered	1

BREAKDOWN OF JUNE RESULTS

1. **Home Health - Documentation did not support the need for therapy services (26%)**

   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

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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 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.

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

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

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

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

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

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

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

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

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

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

2. Home Health – Certification/ POC signature missing or invalid (15%)

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

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

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

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

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

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

3. **Home Health – No measurable therapy goals (15%)**

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 e**nsure 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

- **Sections 40.2** - Skilled Therapy Services
- **Sections 40.2.1** - General Principles Governing Reasonable and Necessary Physical Therapy, Speech-Language Pathology Services, and Occupational Therapy

4. **Home Health – Invalid face-to-face; FTF does not address reason for home health admission (12%)**

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

- **Section 30.5.1.1** - Face-to-Face Encounter

5. **Home Health – Documentation did not support homebound (8%)**

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

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

6. **Home Health - Certifying physician did not document face-to-face encounter (8%)**

As part of the certification of patient eligibility for home health services, a face-to-face encounter must be conducted no more than 90 days prior to or within 30 days after the start of the home health care and the certifying physician must also document the date of the encounter.

When a physician orders home health services for a beneficiary that is based on a new condition not evident during a visit within 90 days prior to the start of care, the certifying physician or an allowed non-physician practitioner must see the patient within 30 days of admission to home health.

Suggestion: Include documentation such as progress notes, patient history and physical, operative notes, acute inpatient notes, and any additional clinical documentation that is dated no more than 90 days prior to the beneficiary's start of care. If an encounter note that is dated 90 days prior is not available, ensure that an encounter is completed and documented within 30 days of the beneficiary's home health admission date.

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)

7. **Home Health – Invalid face-to-face – invalid signature (4%)**

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

The plan of care or oral order may be transmitted by facsimile. The HHA is not required to have the original signature on file.

However, the HHA is responsible for obtaining original signatures if an issue surfaces that would require verification of an original signature **(§30.2.7)**.

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

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

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

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

8. Home Health - Documentation did not support the need for skilled nursing services (4%)

To be covered as skilled nursing services, the services must require the skills of a registered nurse, or a licensed practical (vocational) nurse under the supervision of a registered nurse, must be reasonable and necessary to the treatment of the patient's illness or injury as discussed in §40.1.1, below, and must be intermittent as discussed in §40.1.3. Coverage of skilled nursing care does not turn on the presence or absence of a patient's potential for improvement from the nursing care, but rather on the patient's need for skilled care.

If all other eligibility and coverage requirements under the home health benefit are met, skilled nursing services are covered when an individualized assessment of the patient's clinical condition demonstrates that the specialized judgment, knowledge, and skills of a registered nurse or, when provided by regulation, a licensed practical (vocational) nurse ("skilled care") are necessary. Skilled nursing services are covered where such skilled nursing services are necessary to maintain the patient's current condition or prevent or slow further deterioration so long as the beneficiary requires skilled care for the services to be safely and effectively provided. When, however, the individualized assessment does not demonstrate such a necessity for skilled care, including when the services needed do not require skilled nursing care because they could safely and effectively be performed by the patient or unskilled caregivers, such services will not be covered under the home health benefit.

Skilled nursing care is 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. To be considered a skilled service, 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.

Some services may be classified as a skilled nursing service based on complexity alone (e.g., intravenous and intramuscular injections or insertion of catheters) and, if reasonable and necessary to the treatment of the patient's illness or injury, would be covered on that basis. If a service can be safely and effectively performed (or self-administered) by an unskilled person, without the direct supervision of a nurse, the service cannot be regarded as a skilled nursing service although a nurse provides the service. However, in some cases, the condition of the patient may cause a service that would ordinarily be considered unskilled to be considered a skilled nursing service. This would occur when the patient's condition is such that the service can be safely and effectively provided only by a nurse. A service is not considered a skilled nursing service merely because it is performed by or under the supervision of a nurse. The unavailability of a competent person to provide a non-skilled service, regardless of the importance of the service to the patient, does not make it a skilled service when a nurse provides the service.

A service that, by its nature, requires the skills of a nurse to be provided safely and effectively continues to be a skilled service even if it is taught to the patient, the patient's family, or other caregivers.

The skilled nursing service must be reasonable and necessary to the diagnosis and treatment of the patient's illness or injury within the context of the patient's unique medical condition. To be considered reasonable and necessary for the diagnosis or treatment of the patient's illness or injury, the services must be consistent with the nature and severity of the illness or injury, the patient's medical needs, and accepted standards of medical and nursing practice. The determination of whether the services are reasonable and necessary should be made in consideration that a physician has determined that the services ordered are reasonable and necessary. The services must, therefore, be viewed from the perspective of the condition of the patient when the services were ordered and what was, at that time, reasonably expected to be appropriate treatment for the illness or injury throughout the certification period.

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.

As is outlined in home health regulations, as part of the home health agency (HHA) Conditions of Participation (CoPs), the clinical record of the patient must contain progress and clinical notes. Additionally, in Pub. 100-04, Medicare Claims Processing Manual, Chapter 10; "Home Health Agency Billing", instructions specify that for each claim, HHAs are required to report all services provided to the beneficiary during each 30-day period, which includes reporting each visit in line-item detail. As such, it is expected that the home health records for every visit will reflect the need for the skilled medical care provided. These clinical notes are also expected to provide important communication among all members of the home care team regarding the development, course and outcomes of the skilled observations, assessments, treatment and training performed. Taken as a whole, the clinical notes are expected to tell the story of the patient's achievement towards his/her goals as outlined in the Plan of Care. In this way, the notes will serve to demonstrate why a skilled service is needed.

Therefore, 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

Suggestion: Clinical notes should be written so that they adequately describe the reaction of a patient to his/her skilled care. Clinical notes should also 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.

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 40.2.1** - General Principles Governing Reasonable and Necessary Physical Therapy, Speech-Language Pathology Services, and Occupational Therapy

9. Home Health – No 30-day therapy reassessment (4%)

The therapist must document the measurement results in the clinical record and perform a **reassessment** at least **every 30 days** (performed in conjunction with an ordered therapy service).

- At least once every 30 days, for each therapy discipline for which services are provided, a qualified therapist (instead of an assistant) must provide the ordered therapy service, functionally reassess the patient, and compare the resultant measurement to prior assessment measurements. The therapist must document in the clinical record the measurement results along with the therapist's determination of the effectiveness of therapy, or lack thereof.
- For multi-discipline therapy cases, a qualified therapist from each of the disciplines must functionally reassess the patient. The therapist must document the measurement results which correspond to the therapist's discipline and care plan goals in the clinical record.
- The 30-day clock begins with the first therapy service (of that discipline) and the clock resets with each therapist's visit/assessment/measurement/documentation (of that discipline).

Suggestion: Ensure that documentation includes all therapy notes and a 30-day reassessment that was performed by a qualified therapist (instead of an assistant). Each therapy discipline must conduct the 30-day reassessment and the therapist must document measurement results for that specific discipline. The 30-day clock begins with the first therapy service (of that discipline) and the clock resets with each therapist's visit/assessment/measurement/documentation (of that discipline).

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 40.2.1** - General Principles Governing Reasonable and Necessary Physical Therapy, Speech-Language Pathology Services, and Occupational Therapy

10. Home Health – No orders for services rendered (4%)

The orders on the plan of care must indicate the type of services to be provided to the patient, both with respect to the professional who will provide them and the nature of the individual services, as well as the frequency of the services. Orders for care may indicate a specific range in the frequency of visits to ensure that the most appropriate level of services is provided to home health patients under a home health plan of care. When a range of visits is ordered, the upper limit of the range is considered the specific frequency. Orders for services to be furnished "as needed" or "PRN" must be accompanied by a description of the patient's medical signs and symptoms that would require a visit and a specific limit on the number of those visits to be made under the order before an additional physician order would have to be obtained **(§30.2.2)**.

Use of Oral (Verbal) Orders

The Home Health Agency (HHA) must be acting upon a physician plan of care that meets the requirements for HHA services to be covered. For HHA services to be covered, the individualized plan of care must specify the services necessary to meet the patient-specific needs identified in the comprehensive assessment. In addition, the plan of care must include the identification of the responsible discipline(s) and the frequency and duration of all visits as well as those items listed in 42 Code of Federal Regulations (CFR) 484.60(a) that establish the need for such services. All care provided must be in accordance with the plan of care. The orders on the plan of care must include the type of services to be provided, who will provide the service, the nature of the service, and the frequency of the services. The plan of care must be signed and dated by a physician before the final claim is submitted for payment. Any changes in the plan of care must also be signed and dated by a physician prior to submission of the final claim.

When services are rendered based on the physician's verbal orders, the orders must be accepted and put into writing by personnel authorized to so under State and Federal laws and regulations as well as by any internal policies set forth by the HHA. The verbal orders must be signed and dated with the date the orders were received. This can be done by a registered nurse or qualified therapist (physical therapist, speech-language pathologist, occupational therapist or licensed medical social worker). Rendering of services will not be delayed without supervising registered nurse or therapist signature; however, verbal orders must be signed and dated by the physician prior to the submission of the final bill.

When services are furnished based on a **physician's oral orde**r, the orders may be accepted and put in writing by personnel authorized to

do so by applicable State and Federal laws and regulations as well as by the HHA's internal policies. The **orders must be signed and dated** with the **date of receipt** by the registered nurse or qualified therapist (i.e., physical therapist, speech-language pathologist, occupational therapist, or medical social worker) responsible for furnishing or supervising the ordered services. The orders may be signed by the supervising registered nurse or qualified therapist after the services have been rendered, if HHA personnel who receive the oral orders notify that nurse or therapist before the service is rendered. Thus, the rendering of a service that is based on an oral order would not be delayed pending signature of the supervising nurse or therapist. Oral orders must be countersigned and dated by the physician before the HHA bills for the care in the same way as the plan of care.

Services which are provided from the beginning of the 60-day certification period based on a request for anticipated payment and before the physician signs the plan of care are considered to be provided under a plan of care established and approved by the physician where there is an oral order for the care prior to rendering the services which is documented in the medical record and where the services are included in a signed plan of care.

Services that are provided in the subsequent 60-day certification period are considered provided under the plan of care of the subsequent 60-day episode where there is an oral order before the services provided in the subsequent period are furnished and the order is reflected in the medical record. However, services that are provided after the expiration of the plan of care, but before the acquisition of an oral order or a signed plan of care are not considered provided under a plan of care **(§30.2.5)**.

Suggestion: Documentation submitted should include valid physician orders for the services to be rendered. A valid order should include the service to be provided to the patient (who will provide them and the nature of the services) and the frequency of the services. The frequency of visits may be stated as a specific range to ensure the appropriate level of care is provided. If a range is indicated, the upper limit of the range will be considered the frequency. If PRN orders are included, signs and symptoms that initiate the visit must be included in addition to the limit on the number of PRN visits.

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 30.2** - Services Are Provided Under a Plan of Care Established and Approved by a Physician
- **Section 30.2.2** - Specificity of Orders
- **Section 30.2.5** - Use of Oral (Verbal) Orders
- **Section 30.3** - Under the Care of a Physician

11. Hospice – Invalid certification (66%)

For the first 90-day period of hospice coverage, the hospice must obtain oral or written certification of the terminal illness by the medical director of the hospice or the physician member of the hospice interdisciplinary group (IDG) and the individual's attending physician, if the individual has one. This must be obtained no later than **2 calendar days** after hospice care is initiated. Initial certifications may be completed **up to 15 days prior** to election of hospice care and recertifications may be completed up to 15 days prior to the next certification period; however, for subsequent periods, the hospice must obtain a written certification statement from the medical director of the hospice or physician of the hospice's IDG no later than 2 calendar days after the first day of each period. A brief narrative explanation of the clinical findings that supports a life expectancy of 6 months or less must be included (*see guidelines for specific narrative requirements*).

As of October 1, 2009, the physician's brief narrative explanation of the clinical findings that supports a life expectancy of 6 months or less as part of the certification and recertification forms, or as an addendum to the certification and recertification forms;

- If the narrative is part of the certification or recertification form, then the narrative must be located immediately above the physician's signature.
- If the narrative exists as an addendum to the certification or recertification form, in addition to the physician's signature on the certification or recertification form, the physician must also sign immediately following the narrative in the addendum.
- The narrative shall include a statement directly above the physician signature attesting that by signing, the physician confirms that he/she composed the narrative based on his/her review of the patient's medical record or, if applicable, his or her examination of the patient. The physician may dictate the narrative.
- The narrative must reflect the patient's individual clinical circumstances and cannot contain check boxes or standard language used for all patients. The physician must synthesize the patient's comprehensive medical information in order to compose this brief clinical justification narrative.
- For recertifications on or after January 1, 2011, the narrative associated with the third benefit period recertification and every subsequent recertification must include an explanation of why the clinical findings of the face-to-face encounter support a life expectancy of 6 months or less.

Suggestion: To avoid errors in processing hospice claims, ensure that the narrative is included in the certification or recertification and appears directly above the physician's dated signature. The narrative may also be submitted on an addendum; however, must be signed and dated by the physician immediately below the narrative statement. All documentation should include clear, concise documentation of assessment data to support a life expectancy of 6 months or less.

Guidelines: CMS IOM Pub. 100-02, Chapter 9 - Coverage of Hospice Services Under Hospital Insurance - https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c09.pdf

- **Section 20** - Certification and Election Requirements
- **Section 20.1** - Timing and Content of Certification

12. Hospice – Documentation does not support a trajectory of terminal decline (17%)

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

13. Hospice – Documentation does not support level of care rendered (17%)

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 - The 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 in order 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" in order 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/files/document/chapter-11-processing-hospice-claims.pdf

- **Section 30.1** - Levels of Care Data Required on the Institutional Claim to A/B MAC (HHH)

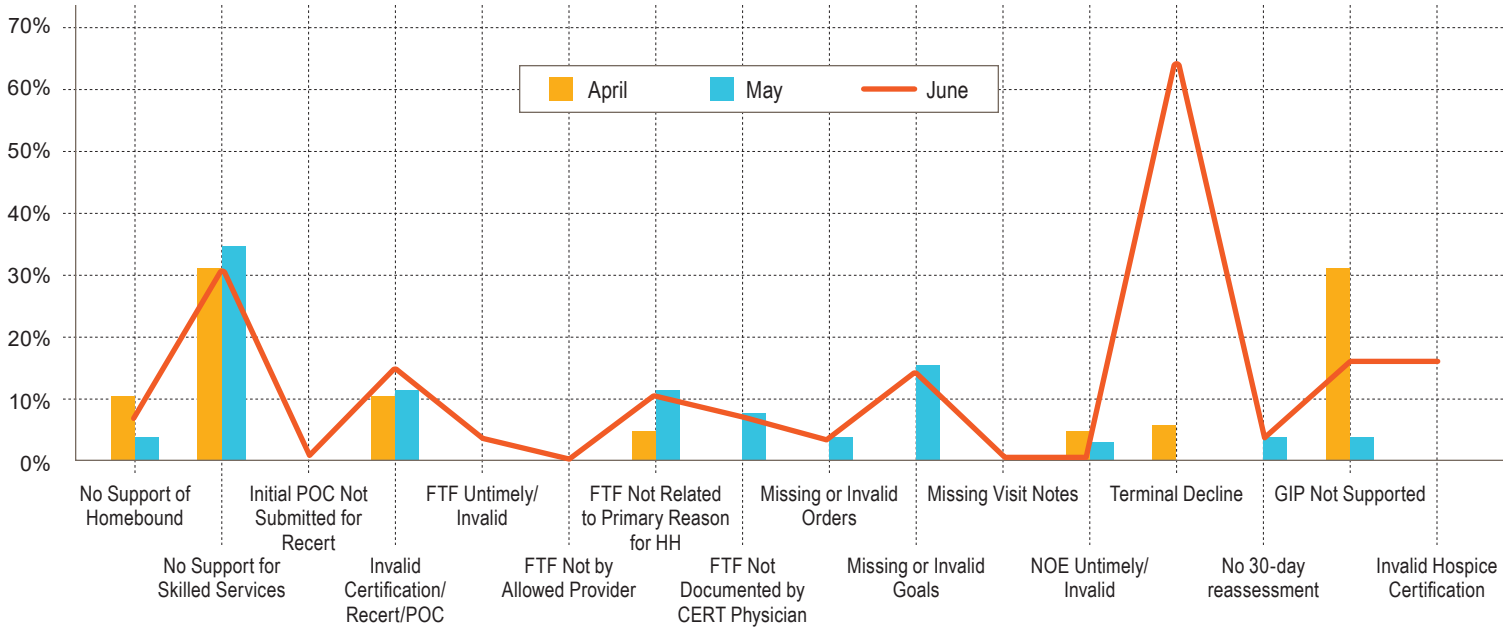
Helpful Links

Centers for Medicare and Medicaid Services (CMS), Internet-Only Manual, Publication 100-02, Medicare Benefit Policy Manual, Chapter 9: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c09.pdf

Centers for Medicare and Medicaid Services (CMS), Internet-Only Manual, Publication 100-02, Medicare Benefit Policy Manual, Chapter 7: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c07.pdf

Local Coverage Determination (LCD): Hospice Determining Terminal Status (L34538): https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=34538&ContrId=236&ver=8&ContrVer=2&CntrctrSelected=236*2&Cntrctr=236&DocType=1&bc=AAEBAAIAAAAA&

Comparison of Results: April - June



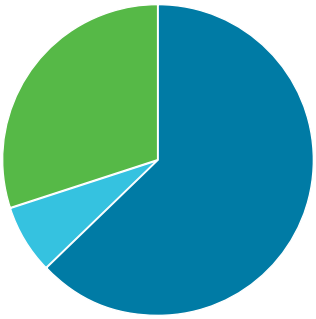
This graph shows the comparison June's denials with those noted January-May, allowing for a visual comparison of the results during the months of April, and May in relation to denials for the month of June. The category "no support for skilled services" includes the eight (7) claims denied for insufficient support for therapy services and one (1) claim denied for insufficient support for skilled nursing, totaling eight (8) claims denied for medical necessity.

Distribution of Denials: June 2020 - Home Health

- No support - therapy services - 30%
- CERT/POC signature invalid or missing - 15%
- No measurable therapy goals - 12%
- Invalid FTF/does not support admitting diagnosis - 12%
- Documentation does not support homebound - 6%
- Certifying physician did not document FTF - 4%
- Invalid signature on FTF - 4%
- Skilled nursing services not supported - 4%
- No 30-day therapy reassessment - 4%

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

Distribution of Denials: June 2020 - Hospice



- Invalid hospice certification - 63%
- Documentation does not support trajectory of terminal decline - 7%
- Documentation does not support level of care rendered (GIP) - 30%

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

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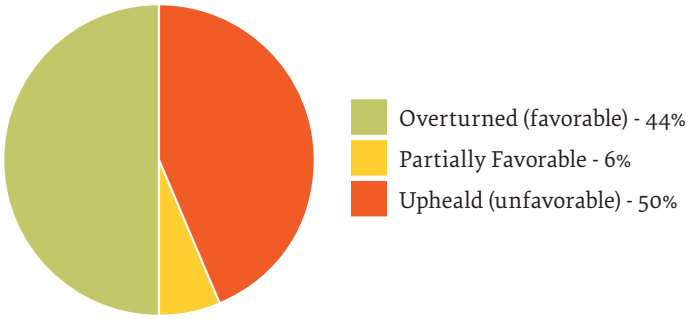
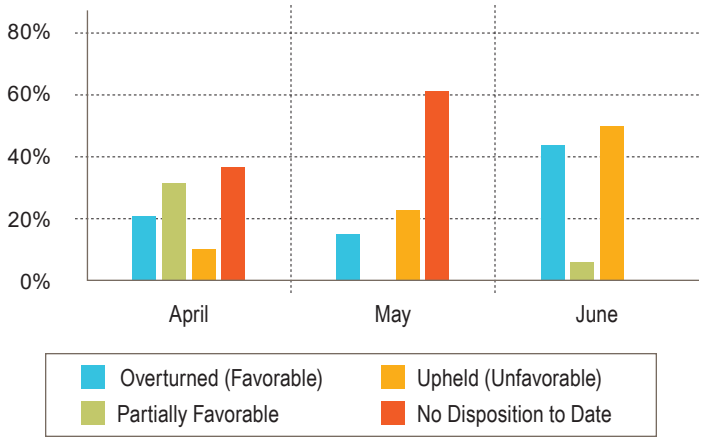
Dispositions Overturned, Upheld, or Parially Upheld by QIC: June 2020



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

Dispositions: April - June Overturned, Upheld, or Partially Overturned



The bar graph are a comparison of decisions for the months of April, May, and June that were either overturned (favorable), upheld (unfavorable), or partially favorable

DISCLAIMER

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