

# 2011 PPS Updates

## Efficiencies Ensure Jungle Survival

### Missouri Alliance for Home Care Annual Conference

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## Objectives



- Provide a critical review of the diverse 2011 PPS initiatives;
- Detail the 2011 PPS changes that impact current agency processes and outcomes;
- Identify Best Practices that meet the challenges of the 2011 PPS revisions, including therapy requirements and associated documentation needs;
- Discuss agency strategies to ensure effective integration of the 2011 PPS updates.

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# Another Adventurous Year

G Code Updates


Visit Efficiencies



C Clarifications





Face to Face



What Next?

PPS Updates

Enhanced Audits

Therapy Requirements

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# Agency Efficiencies

- Lean To Programs
  - Efficiency Priorities: 2011 PPS Updates
    - Clinical Efficiencies: OASIS Visits; Coding; Referrals; Other
    - Eliminate Redundancies: Oversight & Process; Audits
    - Refine Roles and Outcomes
- Global Operational Reviews
  - Identify & Merge Processes
  - Modify Roles
- Process Modifications
  - Infrastructure Supports
  - Accountability Cultures
- Second Peel: More to Come

Creativity

EFFECTIVENESS

Coaching

OPEN

Emotional Intelligence

Innovation

BUILDING Co-Creation

COMPLEXITY

Leadership

DECISIONS

Strategic

TRUST

TEAM

Conflict

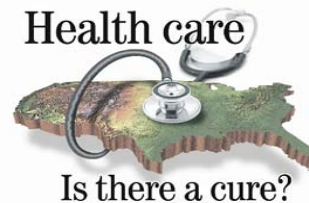
Collaboration

## Easy Money for CMS

- **Compliance Issues**
  - Orders; RAPS's & Final Claims
    - F2E; Physician signatures & dates; Therapy Reassessments & Supervisions
  - CoP's
    - Timeliness; DRR; Physician orders; OASIS
- **Survey Issues**
  - Care Planning
    - Addresses every identified risk or potential risk
  - Look Back Documentation
    - Have you implemented the POC?
- **Audit Issues**
  - OASIS-C supports medical necessity & services
  - OASIS-C supports therapy utilization
  - Consistent clinical documentation
- **Quality & Reimbursement Issues: More To Come**

## HCR (ACA) Paves the Way

- **Consumer is King**
- **Medicare Pilots Detailed**
  - ACO's
  - Bundling
  - Medical Homes
- **Medicare Value Based Purchasing (P4P)**
- **Physician Engagement & Accountability**
- **Focus on Chronic Care Management**
- **CMS Center for Innovation**
- **Enhanced Fraud and Abuse Initiatives**
  - ZPICS; Integrity Audits; MAC's; Heat Teams; RACS



## Leadership Priorities

- **Regulatory**
  - Compliance processes
    - 485's; F2E; Physician signature & dates; G Codes; HHABN's
    - Verbal orders; physician communication; therapy documentation
- **Operational**
  - Outcomes Data; Process Best Practices; HH-CAHPS
  - Efficiencies: Clinical & Operational
  - Episode Management; Visit Utilization
  - Expansion: Medicare PPS
- **Strategic = Survival in Health Care Reform**
  - Marketing; Outreach; Innovation; Partnerships
  - Be At the Table on Pilot Programs

## Patient Protection & Affordable Care Act

- **CMS Implementation of New Health Reform Act**
  - Changes Physician Certification Requirements
    - New Requirement: Face to face encounters for HH & Hospice
- **Market Basket Provisions**
  - 1% reduction 2011-2013
  - 2015: Annual Productivity Adjustment
- **Rebasing Home Health to begin in 2014**
  - Phased in thru 2017
  - MedPac to Recommend System to Congress by 2012
- **Section 6405: Claim Changes**
  - CMS Audit for compliance; Enhanced audit initiatives

## 2011 PPS Updates

- Case Mix Creep
- Case Mix Diagnoses Changes: To Be Studied in 2011
- Therapy Services: Assessment & Documentation
- Physician Face to Face (F2) Encounters
- HH-CAHPS
- P4P
- Outliers; Rural
- Other
  - Ownership; Capitalization
  - Claim Submissions & Calculations
  - Oversight & Monitoring: Audit Initiatives

## Bottom Line

- CMS Final Rule
  - Affordable Care Act (ACA) Mandates
    - 1 point reduction Market Basket Index
    - 2.5% reduction Outlier Budget
  - 3.79% Case Mix Creep Reduction
  - No Action on Case Mix Codes
    - Hypertension diagnoses remain case mix in 2011
  - LUPA & NRS Rates not impacted by reductions
- MedPac to Recommend Case Mix Model Changes in 2013
- CMS to Study Hypertension Diagnoses Status
  - Resource utilization in home health

## Future PPS Rate Changes

- **PPS Re-Basing by 2014 (Maybe Escalated to 2013)**
- **CMS to Study Case Mix Weight Changes for 2013**
  - Delayed 3.79% 2012 reductions for further study
- **MedPac to Develop Case Mix Adjustment Model**
  - To report to Congress in 2013
- **Other Considerations**
  - ICD-10 October 1, 2013
  - Assessment Tool Changes: CARE Tool?????
  - Bundling: 2014
- **Expanded Program Reforms (Pilots: 2012; 2013; 2014)**
  - Prevention Models; Chronic Care; Wellness Programs +++

## MedPac 2011



- **Reported to Congress 3/2011**
- **Five Key Home Health Recommendations**
  - Payment Rates
  - Payment Accuracy
  - Patient Safeguards
  - Beneficiary Incentives to Control Utilization
  - Program Integrity
- **MedPac Data**
  - HH Grows to 11,400 Providers
  - Medicare User increased 3.3 million
  - Home Health is now 9.4% ALL FFS
    - 6.5 million episodes; Average 1.9 episodes per user

## More on MedPac Data

- **Increase in number of community referrals**
  - 64% admissions = Community admitted patients
  - 36 % admissions = Facility based referrals
  - **Let's check your *current* Case Mix Profile**
- **Home Health Margins**
  - 17.7% All Free Standing
    - For Profit = 18.7% margin
    - Non-profit=14.4% margin
  - Average Home Health Margins=17.5%
    - **Excludes Hospital Home Health** = -5.4% margin
- **MedPac Data**
  - Basis for 2011 Congressional Recommendations

## MedPac Recommendations

- **Payment Changes: Highest MedPAC HH Priority**
  - Eliminate 1% inflation rate in 2012: Freeze rates
  - Accelerate case mix rebasing to 2012 (2 year phase in)
  - **Proposed Revise PPS Payment Model: 2013**
    - **Eliminate Therapy Thresholds**
    - **Therapy based on Patient Characteristics**
- **Other Payment Considerations**
  - **Cost-Sharing: Non Facility Based Beneficiary Referrals**
    - Excludes patients discharged from facilities
    - Excludes dually eligible
  - **Proposed Home Health Co-Payment = \$150.00 (per episode)**
    - Access Issues for low income beneficiaries
    - Medigap use prohibited

## More on MedPac Recommendations

- **Institute Efforts to Address Fraud & Abuse**
  - ACA details new Fraud & Abuse Initiatives
    - MedPac supports ACA rule
  - Home Health High Risk Areas: **Identify Aberrant Counties**
    - Moratorium on New Providers
    - Payment Suspension Authority
      - ➔ Lack of protection for due process
  - Physician Roles in Home Health
    - **Expand F2F for all Recertification in 2012**
- **Other Audit Considerations**
  - RAC Audits Mandated for Medicaid (April, 2011)
  - **F2F for Medicaid (April, 2011: State Specific)**
  - **Mandatory Compliance Programs for ALL Providers**

## Other ACA & PPS Updates

- **Claim Submission**
  - ACA: one calendar year
  - Through Date on 485
- **PECOS: Enforcement Delayed Indefinitely**
  - Deny payments if MD not on PECOS System
- **Physician Signatures: 1/1/11**
  - Sign & Date ALL orders
  - No Date Stamps
- **Claim Denial: If OASIS not in repository**
- **Revised HHABN: 4/1/2011 Mandatory**
  - CMS Transmittal 361: Change Request 6988

## Additional Billing Requirements

- **Expanded G Codes: Implementation: January 1, 2011**
  - G0151: Qualified PT
  - G0152: Qualified OT
  - G0153 Qualified SLP
  - G0154: Skilled licensed nurse
  - G0157: PTA
  - G0158: OTA
  - G0159: Maintenance therapy by qualified PT
  - G0160: Maintenance therapy by qualified OT
  - G0161: Maintenance therapy by qualified SLP
  - G0162: Skilled RN for Management & Evaluation
  - G0163: Skilled licensed nurse for Observation & Assessment
  - G0164: Skilled licensed nurse for Training & Education
- **[www.cms.gov/transmittals/downloads/R824OTN.pdf](http://www.cms.gov/transmittals/downloads/R824OTN.pdf)**

## Why G Code Changes?

- **CMS Manual System Update 100-20**
  - Effective 1/1/11
  - Change Request 7182
- **Additions and Revisions to G Codes**
- **MedPAC recommended that CMS improve data assessment of agencies to ascertain the provision of unnecessary services**
  - Need for more data to differentiate qualified therapist *versus* a therapy assistant
  - Need to differentiate skilled nurse for direct services *versus* indirect services
- **Bottom Line: Data to Direct Medical Review**

## More on G Codes

- **1 G Code per Visit (Final Claim)**
  - Reported in 15 minute intervals
  - Select G Code that represents the **Primary Reason for Visit**
- **Primary Reason for Visit**
  - Typically would be the service the clinician spent the most time
- **On Admission**
  - Not billable unless a skilled service is provided
  - **Select G Code for the skilled service provided**
- **[www.cms.gov/transmittals/downloads/R8240TN.pdf](http://www.cms.gov/transmittals/downloads/R8240TN.pdf)**
  - CR7182

## One FAQ

- **G Code Use:**
- **What is the difference between G0154 Skilled Licensed Nurse and G0164 Skilled licensed nurse training and education patient or family?**
- ***CMS intends for home health agencies to use new G codes to report patient/family education and training, observation and assessment, and management and evaluation. Reporting all other nursing services (ex: injections, wound care, infusion, catheter changes, etc.) will be reported with G0154. What is the primary reason for this skilled nursing visit?***

## Manual G Code Instructions

- In cases where nursing or therapy provides more than one service in a visit, the **HHA must report the G-code which reflects the service for which the clinician spent most of his/her time.**
- **Manual Examples:**
  - **Nursing:** Provides both direct care and education. Report the G code that reflects the service the clinician spent most of their time during that visit
  - **Therapy:** Performs a therapy service and establishes a maintenance program during the same visit. Report the G code which reflects the service for which most of the time was spent during that visit.
- **Provide General Staff Guidelines on G Code Use**

## Maintenance Therapy

- **Restorative Therapy: Based on reasonable expectation of material improvement**
- **Exception:** Maintenance therapy by a *qualified* therapist
  - Design an effective maintenance program
  - Specific to illness or injury
  - Requires skills of therapist
  - Identifies program design, instruction, re-evaluation
- **409.44 Maintenance Therapy**
  - Amount, frequency and duration of services must be reasonable

## More on Maintenance

- **PPS Updates Details (Page 124)**
  - *Maintenance therapy will continued to be covered in the HH setting when the unique condition of the patient requires complex services, which can only be provided effectively and safely by a qualified therapist. The maintenance therapy G codes are defined as provided by a “qualified therapist”.*
- **Maintenance therapy**
  - *Repetitive services are required to maintain function; and require the skills and knowledge of a qualified therapist*
- **Therapy assistants cannot provide maintenance therapy**

## Maintenance Example

- **Parkinson’s Patient with RA**
  - *Requires services to determine present level of function and design program to maintain capacity and tolerance for treatment. Re-evaluations will occur to assess patient condition , instruct patient and caregivers on required program to maintain function.*
- **Documentation is Critical**
  - Level of function & disabilities
  - Maintenance goals
  - Treatment objectives related to function
  - Collaboration with physician
- **Billing G Codes to Designate Maintenance**

## Bottom Line on G Codes

- **Clinician Education Critical** *Clinician Guide*
  - CMS Benefit Policy Manual: Chapter 7
    - CMS Defines Each Skilled Service
      - ➔ Direct; O & A; Maintenance; M & E
- **Documentation Guidelines**
  - Homebound
  - Reasonable & Medically Necessary
  - Management & Evaluation
- **Agency Oversight**
  - High Risk Issues
  - Proactive Monitoring
  - Specific Clinician Feedback

## Your MAC Transitions

- **Cahaba to CIGNA (Jurisdiction 15)**
  - Electronic Notification: 3/11/11 (EFT)
- **CIGNA communicates with all providers on transition**
  - CMS MedLearn SE1017
- **Other Transitions**
  - No delays in payments
  - No Complaints in Transition Process
- **CIGNA: [www.cignagovernmentservices.com](http://www.cignagovernmentservices.com)**
  - Listserve
  - WebSite
  - Teleconferences: 4/19/11 (MAHC)

## 2011 PPS Process Changes

- **Physician Face to Face (F2F) Encounters**
  - **CMS: No further Enforcement Delays**
  - **Process Changes**
  - **Documentation**
  - **Oversight**
  - **Additional Education Initiatives**
  - **Tracking/Billing Oversight**
- **Therapy Services & Clinical Documentation**
- **HH-CAHPS: Report on Home Care Compare 2012**
- **Other**
  - **Claim Submissions: G Codes & Clinical Documentation**
  - **Oversight & Monitoring: Audit Initiatives**

## Face-to-Face (F2F) Encounters

- **ACA Mandates**
  - **Prior to initial certification only for home health**
    - Does **NOT** apply to home health re-certifications
  - **Physician; NP; CNS; PA**
    - Non physician F2F must be communicated to physician who certifies patient for home health
  - **Hospitalist may perform F2F**
    - Must indicate community physician in discharge plan
    - Plan must be updated by community physician
- **F2F Timeframes**
  - **Up to 90 days prior to the home health SOC OR**
  - **Up to 30 days after the home health SOC**
- **RAP NOT Effected by F2F BUT.....**

## F2F Documentation

### ■ CMS to Update Medicare Manual

- Physician to document
  - Clinical findings(s) to support eligibility
  - Homebound Status
  - Nursing or therapy need(s)
- Physician to sign & date F2F encounter onto the certification (or Addenda)
- Documentation must be separate and distinct OR an addendum to the certification
  - Clearly titled & signed/dated by the physician
- No Standardized Language Allowed for F2F
- Certification cannot occur by
  - Physicians NOT registered on PECOS

*Who Reviews for Completion?*

## F2F Documentation

### ■ CMS Written Guidance

- Specific clinical documentation findings
- Non-physician documentation (NP; CNS; PA)
- Encounter Related to Home Care

### ■ Documentation Oversight

- Program Integrity Audits
- Agency responsible only for F2F encounters and documentation in certification
  - Physician certifying MUST document F2F
  - Patient F2F related to primary reason for Home Care
- Billing; Survey Oversight & Audits
  - MAC Oversight Guidance ; Surveyor Oversight

*Your Percent Compliance?*



Not to be correlated by diagnosis

## Quick Check on Face to Face

- **The facility case manager can complete the Face to Face document from the medical record, and have the hospitalist sign and date this document to meet this requirement.**
  - True
  - False
- **If the patient goes home without the Face to Face documentation, the agency must wait to admit this patient.**
  - True
  - False
- **The agency cannot bill the final claim unless the agency receives the completed Face to Face documentation.**
  - True
  - False

## What's It Mean to Agency Ops?

- **Where are You With.....**
- **Policies & Protocols for PPS Changes**
  - **F2F Encounters: Agency Requirements**
  - **Admission Protocols**
  - **Admission Packet/Patient Notification Materials**
  - **F2F Encounter Tracking Protocols**
- **Physician Education**
  - **Physician Letter/Kit**
- **Other Education**
  - **Agency staff; Contractors; Referral Sources**

### **Oversight Processes**

## Patient Notifications

### ■ Key Elements

- Update on new requirements 1/1/11
- Detail critical elements of new F2F encounter
- Cannot Use Notice of Potential Liability for Charges
  - If F2F not documented or does not occur in required timeframe
- Notice of Non-Acceptance
  - If F2F does not occur as indicated
- HHABN: Option Box 2 (Updated March 7, 2011)

### ■ Amend Admission Packet & Protocol

- Patient Responsibilities
- Patient Letter & Face to Face Info Provided on Admission

## Physician Contact Information

### ■ Key Elements

- Clarity regarding certifying physician role for F2F encounter and required documentation
- Detail PPS Final Rule and physician responsibilities regarding F2F encounter, care plan, additional documentation requirements

### ■ Sample F2F Encounter Documentation

- On initial certification (POC or 485) or an addendum to the initial certification
- Timing
- Clinical data to support home care needs
- Home bound status & specific care needs

*Fast Facts Card*

## Referral Sources Needs

- **Key Elements**
  - PPS Final Rule F2F Encounter Requirements
  - Who, What, Where, When & How
  - Sample Documentation Template
    - Include instructions for patient specific clinical data, homebound status and specific need for intermittent skilled home health services (nursing, therapy)
    - **My Favorite: Assessment; Considerable & Taxing**
- **Clarify FAQ's**
  - Provide simple guide
- **Provide contact data for further discussion**
  - Office visits to key referring sources

## Staff Education

- **Can Your Staff Explain the F2F to Physicians & Office Staff?**
- **Revised Admission Packet & Protocols**
  - Patient Letter
  - Patient Education Guide
  - Patient Admission Review Process
    - Patient Responsibilities
- **Agency Practices**
  - Clinician: Patient Physician Appointment
  - Form to Physician (Fax & Send in with Patient)
- **Encounter Tracking Protocol: Percent Compliance Now**

## Implementation & Tracking

- **System Affiliations**
  - Case Managers
  - Discharge Planners
  - Hospitalists: Electronic
- **Considerations**
  - Intake
  - Clinical Tracking
  - Medical Records
- **Models**
  - 485 Trackers/ Face to Face Monitoring
- **What Works for You?**



## Bottom Line on Face to Face

- **Agency Protocols Involve Clinicians from the Get Go**
  - **Fast Fact:** Best Practice to Have Patient See Physicians within 5-7 days of facility discharge
- **Engage Physician Office Staff**
- **Continue to Tackle from Intake thru Admission**
  - Educate all referral sources; Simple Format Card
- **Agency Decisions**
  - Admission with Physician Appointment Clarity
- **NAHC Determinations**
  - Litigation Considerations
  - Continued Lobby Efforts

## Therapy Practices

- **New Criteria for Home Therapy**
  - Benefit Defined
  - Restoration versus Maintenance Therapy
- **New Assessment/Reassessment Requirements**
  - 13<sup>th</sup> & 19<sup>th</sup> Visit = Qualified Therapist
- **Physician Collaboration**
  - Goal Progress & Rehab Potential
- **G Code Assignment for Final Claim Billing**
  - Capture Mix of Therapy Providers
  - Identifies Therapy Assistants
  - M&E; Training & Education; Observation & Assessment

## Best Practices in Therapy

- **Regulations:** New PPS 2011 rules requiring functional reassessments on the 13<sup>th</sup>, 19<sup>th</sup> day, at least every 30 days by a Qualified Therapist
- **Assessments/reassessments:** Comparison of measurements in assessing function, effectiveness of therapy, measurable treatment goals
- **Objective Documentation:** Standardized and validated tools
- **Communication:** Between multidisciplinary, paper, EMR, contract and per diem staff
- **Scheduling:** Ensure 13<sup>th</sup> & 19<sup>th</sup> visit by qualified therapist

## Documentation

- **Adhere to Standards of Practice**

*“Notes must reflect progress towards goals, which incorporate functional assess/reassess which justify medical necessity.”*

- **Functional-assess/reassess 13<sup>th</sup>, 19<sup>th</sup> or 30 days**
- **Goals-expectations that condition will improve**
- **Variable factors that influence patient condition**
- **Objective-Standardized, and continued need for therapy to ensure progress to goals**
- **Does Your Agency have Therapy Documentation Standards?**

## Therapy Remains an Audit Focus

- **CMS Therapy Focus**

*“Does the Plan of Care for the Medicare payment period for which this assessment will define a case mix group, indicate a need for therapy (physical, occupational, or speech) that is reasonable and medically necessary?”*

- **Areas of Concern**

- **OASIS scores support therapy utilization**
- **Diagnosis codes support therapy utilization**
- **Visit notes support therapy Plan of Care**
- **All visits are reasonable and medically necessary**

## Therapy Documentation

- **MUST REFLECT**
- *Prior level of function*
- *Current deficits*
- *Progress toward goals*
- *Restoration to a previous level*
- *Goals – MUST be tied to function*
- **Medical review is often performed by non therapists**
  - **Document deficits**
  - **Modify goals**



## Documentation

- **Therapy goals** – **MUST** be tied to function  
(what were the M items specific to functional status on admission?)
  - M1810-M1860: Functional Items
  - M1100-2100: Caregiver Needs (Teaching)
- What were the prior M items on the functionals?
- **Do other skilled visit notes support therapy needs?**
  - Nursing; OT; ST

**Check Profile**

## Quick Check

- If a patient is hospitalized on visit 9 and each therapist completes an evaluation for ROC, does this assessment re-set the clock on the number of visits?
  - Yes
  - No
- Does the physician have to certify all reassessments?
  - Yes
  - No
- If all disciplines do not do their reassessments by the 13<sup>th</sup> and 19<sup>th</sup> visit, is it appropriate to hold visits until that therapist completes their assessment?
  - Yes
  - No

## Agency Policies & Protocols

- Enhance agency policies of supervision of therapy assistant visits
- Documentation using Best Practices of objective standardized and validated tools
- Reassessments using objective documentation for functional reassessments, progression towards goals (or lack of), skilled continued need of therapy services
- Scheduling Practices
  - Multi-therapy patients

## How About Rehab Risks?

- Patient complexity does NOT indicate need for therapy or high level of therapy
    - OASIS assessment does NOT support therapy needs (M2200)
  - OASIS & therapy evaluations do NOT indicate consistency in assessments and POC
  - Therapy notes do NOT indicate reasonable and medical necessity
  - Therapy disciplines overlap in goals and interventions are considered duplicitous by your MAC
- Proactive Review?**

## Are the Services Reasonable?

- Does the frequency & duration of therapy support the patient's condition & diagnosis – as reflected in the OASIS & other evaluations
- Red Flags
  - Delay in Therapy SOC
  - High frequency – low HHRG (case mix)
  - Same therapy POC for all agency patients
  - Low frequency for duration of POC
- Is the POC consistent with the other the clinical documentation (OASIS & Therapy Evals)?
  - SNV; therapies

## Does This Seem Consistent?

- **Every patient has a frequency of two visits times four weeks**
- **Same therapy POC for every Rehab patient**
  - Same frequency of visits
  - Same goals
- **Therapy evaluations are inconsistent with nursing assessments and other documentation**
  - Therapy indicates patient can independently transfer, but therapy POC includes transfer training
  - Other examples

## Have You Seen This?

- RN M1860 = 2, but narrative indicates “unsteady gait”
- RN Ambulation score = 2, but therapy evaluation
  - “Patient uses wheeled walker for ambulation and transfers but requires close supervision due to poor balance.”
- RN scores a “0” for Transfer items, but PT eval indicates
  - “Patient needs close supervision to transfer safely”
- RN scores OASIS functionals as safe, but PT eval
  - “Patient staggers, catches self when ambulating”

## Therapy Challenges

- **Medical reviewers and the OIG detail audit concerns**
- **Reasonable and Necessary – does the therapy frequency and duration of visits reflect patient diagnosis, goals and treatment plan?**
- **Does the POC address the need for skilled therapy?**
- **Are therapy goals individualized to patient needs?**
  - **Objective Evidence that Patient's will Improve**
  - **Objective, measureable evidenced based tools**
    - **Detail your Objective Tools**

## Potential Risk Areas



- **Lack of Implementation of Required Elements**
- **Lack of Systemic Implementation Plan**
- **Lack of supporting physician documentation for initial certification**
  - **Documentation does not meet CMS standards**
- **Therapy Practices Do Not Meet Regulatory Requirements**
  - **Reassessment visits (13<sup>th</sup> & 19<sup>th</sup>) or at least every 30 days**
  - **Clinical documentation**
  - **Physician oversight: Collaboration as needed**
  - **Timely documented Therapy Assistant Supervisions**

## Other Therapy Practice Questions

- Visit Protocols
  - Low & High Therapy Practices
- Practice Standards
  - Disease Specific
- Single Visit Patterns
- Referral to Initial Assessment Threshold
  - Data Needs
- Front Load Therapy Visits
  - Monitoring & Dashboard (Scorecard)
- Episode Management: Case Conferences?
- Therapy Requirements: Oversight Processes

## Bottom Line on Therapy Changes

- Not Really A Change (MR Perspective)
  - Documentation and Evaluation Standards
- Agency Protocols
  - Size and Automation Tracking Capabilities
  - Therapy Responsibilities
- Oversight/Accountability
  - Calendars
  - Scheduling
- NAHC Considerations
  - Audit & Billing Considerations
    - SOC's & Recerts 4/1/11
  - Unanswered CMS questions



## Other Related Updates

- **State Surveyor Manual (SOM) Updated**
  - [http://www.cms.gov/Surveycertificationgeninfo/downloads/SCLetter11\\_11.pdf](http://www.cms.gov/Surveycertificationgeninfo/downloads/SCLetter11_11.pdf)
    - Effective May 1, 2011
  - **Surveyor Worksheets are Posted**
- **Appendix B: Part 1**
  - Revised Standard Protocols directly related to patient care processes
  - Expanded Pre-Survey Document Review
- **Appendix B: Part 2**
  - OASIS Submission: Timely Recertifications
  - Therapy Requirements

## Pre-Survey SOM Updates

- **Surveyor Worksheets**
  - Potentially Avoidable Events (PAE)
  - OBQI Outcome Reports
  - Patient/Agency Characteristics Report
  - Submission Statistics by Agency Report
  - Error Summary Report by HHA
- **Tier 1 PAE**
  - Emergent Care for injury caused by fall at home or
  - Emergent care for wound infections, deteriorating wound status
  - Select patient records & home visits based on PAE identified on report

## More on Pre-Survey Report Review

- **Tier 2 PAE**
  - Select closed patient records based on current agency incidence rate of equal to or greater than twice the national reference rate
- **OBQI Outcome Report**
  - Review Most Recent Risk Adjusted Outcome Report
  - Select two (2) for focus during on site survey
  - At least thirty reported cases
  - **Large and unfavorable difference (10%)** between the agency and the national reference rates
  - Statistical significance equal to or less than 0.10 as depicted by 1 or 2 asterisks (\*)

## More on Pre-Survey Report Review

- **Patient/Agency Characteristic Report**
  - Same timeframe as OBQI report
  - Focus on acute conditions and home care diagnoses that are statistically significant and are equal to or greater than 15 % higher than reference mean
  - Choose three conditions or diagnoses that meet the criteria
  - Select one or two records of patients with diagnoses that meets the criteria review
- **Submission Statistics**
  - Investigate compliance with OASIS submission
    - Submitting data less often than monthly
    - Has greater than 20 % of records rejected

## More on Pre-Survey Report Review

- **Error Summary Report by HHA**
  - **Inconsistent M090: Identify percent of recertifications done on 60 day cycle**
    - Investigate if error rate over 20%
  - **Data Sequence Error Rate**
    - Investigate if error rate over 10%
  - **Investigate compliance with OASIS Reporting Requirements**
- **Survey Integrates OASIS-C Data**
  - **High Risk Data Focuses On Site Surveys**
    - Access and review your data on a regular basis
    - Review your data in Performance/Quality Processes
    - Focus Education on Problematic C Data

## Summary of Audit Focus

- **Detect & Prevent Fraud and Abuse: Data Mining**
  - Cross reference claim & survey data bases
- **Collect Medicare Overpayments**
  - Appeal Process (\$858 million in 2007)
- **Surveillance of High Risk Areas for HH Providers**
  - **Eligibility: Homebound Status**
  - **Physician orders**
  - **Documentation of services: stand alone; medical necessity**
  - **Legible clinician signatures**
    - Updated CMS Transmittal 327 (3/16/10)
  - **Matching claim and clinical record data**
  - **Therapy, Therapy, Therapy**

## Health Care Reform Updates

### ■ HR 3590: PPACA

- Expands Tools to Fight Fraud & Abuse
  - New Rules for Criminal Sentences
  - Enhanced Enrollment Requirements
  - New Government Resources: HEAT Teams
  - Shared Databases (Care/CAID/Survey/MACs/Enforcement)
  - Enhanced Surety Bonds
  - Expanded Recovery Efforts (RACS)
  - Enhanced Penalties

### ■ Provider Disclosure Protocols

- Stark Enforcement

### ■ Compliance Program Requirements

- Regulation Expansion: Provider Specific

## Congress Questions Audits

### ■ HHS OIG & Senate Finance Committee

- Question Effectiveness of Watchdog Auditors

### ■ OIG Reports to Congress

- ZPICS Collect only 7% of overpayments
- 93% of Challenged Overpayments are reversed in favor of providers (ALJ)

### ■ Congress Requests from CMS (10/15/10)

- Data to determine audit effectiveness
- Requests amounts paid to audit contractors & explanation of Award Fees

### ■ CMS Acknowledges Need for Greater Oversight

- CMS indicates Audits are Protected Information

## Specific Audit Integrity

- **MAC/RAC Electronic Data Warehouses**
  - Shared Data Banks for AutoBot Review
  - 6 months post Black-out Period Post MAC Transition
- **RAC's to Approve & Post Home Health Issues**
  - RAC identifies HH vulnerabilities
  - CMS Approves Audit Priorities & Posts on RAC Sites
  - RAC audits via CMS Protocols
- **RAC's: Hired Guns**
  - Paid on Commission
  - Follow same protocols as MAC
- **Home Health Issues not yet Identified**

## Compare RAC to ZPIC

- **Common Goals**
  - Identify & Deter Medicare & Medicaid Fraud, Abuse & Waste
  - CMS Oversees Audit Protocols/Appeal Processes
- **Differentiate Audit Entities**
  - **RAC's: Hired Guns** (Paid on Commission)
  - **ZPICS: Paid Program Integrity Auditors (Medicare)**
- **ZPICS in Force Now**
  - Enforcement Heavy in Florida & Texas
- **Home Health Issues Identified**
  - Regulatory based; Reasonable Medical Necessity

## RAC Audit Details & Updates

- Congress expands RAC Audits to Home health
- Recovery Audit Contractor (RAC)
  - Detect & correct past improper payments
  - Lower CMS error rate – 2008 Error rate = 3.6% (↓.3%)
  - Protect future Medicare beneficiaries
- Three year retrospective
- Recovered \$860 Million in three states
  - Focus on Hospitals
  - Expanded to Home Health
- Focus on Medical Necessity
  - Aberrant Billing Practices

[www.racsummit.com](http://www.racsummit.com)

## RAC Audits: Not High Risk

- Limit RAC Look Back to 3 years
  - Will NOT be able to review claims paid prior to 10/1/2007
- Limits number of medical record requests - HH
  - 1% of the average monthly Medicare services (max 200) per 45 days per NPI
- RAC reviews claims on a post payment basis
- RAC uses same Medicare policies as MAC's
  - NCD's; LCD's; CMS Manuals
- Two types of review
  - Automated (no medical record needed)
  - Complex (medical record requested)

## Tips to Prevent Loss

- **Audit all claims for coding and medical necessity**
  - Proactive review of clinical documentation
  - Focus on: Progress toward goals
  - Medical Necessity
  - Accurate ICD-9-CM Code Assignment
- **76% of all overpayments, even after appeals, were due to erroneous codes & lack of medical necessity**
- **Appeal if Necessary**
  - 35% of appeals were reversed to providers

## Prepare Now

- **Designate one person to respond to RAC audits**
- **Identify RAC address & contact person**
  - Use RAC Web Site: [www.racinfo.healthdatainsights.com](http://www.racinfo.healthdatainsights.com)
  - **Call RAC: 866-376-2319**
- **Check RAC Status on a periodic basis**
- **Track & trend RAC results on Web Sites**
- **Appeal Process**
  - Same as appeals for MAC (Cahaba/CIGNA)
- **Other Contacts: Region D Health Data Insights**
  - [www.cms.hhs.gov/RAC](http://www.cms.hhs.gov/RAC)
  - [RAC@cms.hhs.gov](mailto:RAC@cms.hhs.gov)

## ZPICS (PSC's)

- **Zone Program Integrity Contractor**
  - 5 Year Scope of Work (SOW)
- **Goals: Identify Potential Fraud, Abuse, & Waste**
  - Data Analysis (Automated Data Mining)
  - Referrals to Law Enforcement
  - Fraud Alerts
  - Referrals to MAC's
- **Support Law Enforcement During Investigations & Prosecution**
  - Medical Review; Expert Witness
- **Training for MAC Staff**

## ZPIC Priorities

- **Implement Medicare Fraud for DME, Home Health & Hospice (Integrated Approach)**
  - Identity Theft (Beneficiary & Providers)
  - Infusion Therapy
  - DME
  - Benefits related to Psychiatric Services
  - **Claim Data Analysis: Variations/Discrepancies**
- **Implement Care/CAID Fraud Initiatives in Zone**
  - Proactive Claim Data Analysis
  - OIG, FBI, DEA, IRS Priorities (Steering Committee)
- **High Risk Zones: Designated by CMS**

## ZPIC Authority

- **Administrative Contractors for CMS**
  - Conducts prepay and post pay medical review
  - Conducts announced and/or unannounced **onsite visits**
  - Determines actual and/or extrapolated recoupment
  - Suspends provider payments
  - Refers for Law Enforcement
  - Conducts Beneficiary Interviews
  - Refers providers for exclusion from Medicare Programs
- **Providers are Guaranteed Appeal Rights for All Overpayment Determinations**
- **Advance Med Contact: Deputy Zone Program**  
**Director\_watkinsc@admedcorp.com**

## CMS to Remain Aggressive on Audits

- **ZPIC (PSC) Audit Trends (Majority RN Reviewed)**
  - **Clinical Documentation**
    - Medical Necessity
    - Eligibility: Homebound Status
  - **Operational Requirements**
    - Occupancy Permits
    - Contracts: Vendor & Staff
    - Employee Licensure & Updated Personnel Files
  - **On Site Visits**
    - Verify Legitimate Identities (HIPAA)
    - Post Required Data (Certificates; OSHA; Other)
    - Access Records & Data
- **On Site Management Staff Audit Oversight**



## How Does A ZPIC Audit Occur?

- **Announced or Unannounced**
  - Letter or Fax
- **Remote or On Site**
  - Sample clinical records or
  - Review claims before provider contact
- **Prepayment or Post Payment**
- **Interviews**
  - Beneficiary & Provider Employees
- **Data Analysis Drives Audits AND**
- **Complaints**

## ZPIC Triggers

- **Claim Variances: Billing Trends**
  - Lower or higher claim adjustments
  - Higher downcodes and/or denials
- **Data Mining: Compare to National & Regional Benchmarks**
  - Average Episodic Payments Variations
  - Length of Stay
  - Utilization Variances (Higher or lower staff use)
    - Therapy utilization
- **Complaints**
  - MAC's
  - OIG

## ZPIC Audit High Risk Areas

- **Billing Services Not Provided**
- **Billing for Medically Unnecessary Services**
  - Not Homebound
  - Not reasonable and medically necessary
- **Over utilization and under utilization of services**
- **Knowingly billing for *substandard care***
- **Billing for services provided by an unqualified or unlicensed clinical personnel**
- **Billing for untimely or lack of physician orders**
- **Billing for services with insufficient documentation**

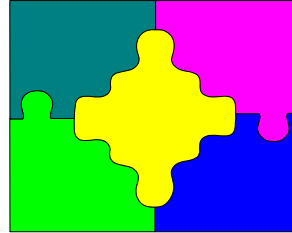
## Bottom Line on Audits

- **Robust Corporate Compliance Plan is Critical**
  - Policies & Procedures to Meet OIG Recommended Plan
- **ACA Requires Corporate Compliance Program**
  - Regulations to Detail
- **Update Audit Formats to Meet High Risk Issues**
- **Ongoing Staff Education on High Risk Areas**
  - Homebound
  - Medical Necessity
  - G Code Standards
- **Specific Clinical Documentation Competencies**
  - Job Descriptions & Annual Evaluations

## Leadership Considerations

### ■ Agency Policies & Protocols

- Intake/Referral (F2F)
- Admission Packet Updates
- Supervisory/Clinician (F2F)
- F2F Encounter Tracking Protocol
- Therapy Standards & Documentation
- Billing Audit Processes (F2F)
- Other Audit Protocols (High Risk Items)



### ■ Staff Education

- Regulatory Overview & Agency Policies & Protocols

### ■ Physician & Referral Education

### ■ Corporate Compliance Program

- Agency Oversight: Audit Processes

## Agency Actions Now

### ■ Best Practices

- Care and Quality Outcomes
- Policies & Protocols: Efficiencies
- Enhanced Clinical Documentation

### ■ Face-to-Face Encounter Requirements: Tracking

- Physician Education
- Required Documentation for Admission/Billing

### ■ Therapy Requirements: Tracking

- Agency documentation standards

### ■ Episode Management: Who & How?

- Visit Utilization
- Resource & Supply Utilization

## Successful Agencies

- **Innovate 360°**
  - MWA
- **Involve Staff**
  - All Levels
  - Deep Dives
- **Pilot**
  - Efficiencies
  - Select Champions
- **Create Cultures of**
  - Accountability
  - Service



**Jungle Parable**

## Resource Web Sites

[www.cms.hhs.gov](http://www.cms.hhs.gov)

Centers for Medicare & Medicaid Services  
Home Health Regulations

[www.apta.org](http://www.apta.org)

American Physical Therapy Association  
Guide to Physical Therapy Practice

[www.aota.org](http://www.aota.org)

American Occupational Therapy Association  
Guide to Occupational Therapy Practice

[www.oig.hhs.gov](http://www.oig.hhs.gov)

Office of Inspector General

[www.cms.hhs.gov/MLNGeninfo/](http://www.cms.hhs.gov/MLNGeninfo/)

CMS Medicare Learning Network (MLN) Website



[www.nahc.org](http://www.nahc.org)

National Association for  
Home Care & Hospice

## Therapy Requirements Fact Sheet

While changes to Publication 100-02, Chapter 7, Home Health Services are pending, the following information related to therapy requirements contained in the Calendar Year 2011 Final Home Health Rule is being provided to assist HHAs and therapists with these requirements that are effective April 1, 2011.

### **Assessment, Measurement and Documentation of Therapy Effectiveness**

To ensure therapy services are effective, at defined points during a course of treatment, for each therapy discipline for which services are provided, a qualified therapist (instead of an assistant) must perform the ordered therapy service. During this visit, the therapist must assess the patient using a method which allows for objective measurement of function and successive comparison of measurements. The therapist must document the measurement results in the clinical record. Specifically:

#### **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.

#### **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.
- Where more than one discipline of therapy is being provided, at least once every 30 days, a qualified therapist from each of the disciplines 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. In multi-discipline therapy cases, the qualified therapist would reassess functional items (and measure and document) those which correspond to the therapist's discipline and care plan goals.

### **Reassessment prior to the 14th and 20th therapy visit**

- If a patient's course of therapy treatment reaches 13 therapy visits, for each therapy discipline for which services are provided, a qualified therapist (instead of an assistant) must provide the ordered 13th therapy service, functionally reassess the patient, and compare the resultant measurement to prior 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.
- Similarly, if a patient's course of therapy treatment reaches 19 therapy visits, a qualified therapist (instead of an assistant) must provide the ordered 19th therapy service, functionally reassess, measure and document effectiveness of therapy, or lack thereof.
- When the patient resides in a rural area or when documented circumstances outside the control of the therapist prevent the qualified therapist's visit at exactly the 13th visit, the qualified therapist's visit can occur after the 10th therapy visit but no later than the 13th visit. Similarly, in rural areas or if documented exceptional circumstances exist, the qualified therapist's visit can occur after the 16th therapy visit but no later than the 19th therapy.
- Where more than one discipline of therapy is being provided, a qualified therapist from each of the disciplines must provide the ordered therapy service and functionally reassess, measure, and document the effectiveness of therapy or lack thereof close to but no later than the 13th and 19th therapy visit. The 13th and 19th therapy visit timepoints relate to the sum total of therapy visit from all therapy disciplines. In multi-discipline therapy cases, the qualified therapist would reassess functional items and measure those which correspond to the therapist's discipline and care plan goals.
- Therapy services provided after the 13<sup>th</sup> and 19<sup>th</sup> visit (sum total of therapy visit from all therapy disciplines), are not covered until:

The qualified therapist(s) completes the assessment/measurement/documentation requirements.

The qualified therapist(s) determines if the goals of the plan of care have been achieved or if the plan of care may require updating. If needed, changes to therapy goals or an updated plan of care is sent to the physician for signature or discharge.

If the measurement results do not reveal progress toward therapy goals and/or do not indicate that therapy is effective, but therapy continues, the qualified therapist(s) must document why the physician and therapist have determined therapy should be continued.

## Home Health “G” Tags and Abbreviated Identifiers \*

### Subpart B - Administration

- G100 §484.10 Condition: Patient rights**  
**G101 Inform, promote & protect patient rights**  
**Standard: Notice of rights**  
 G102 Written notice of rights in advance of care  
 G103 Documentation showing patient was informed  
 G104 **Standard: Exercise rights/respect for property**  
 Patient, family & guardian exercise rights  
 G105 Property treated with respect  
 G106 Voice grievances without reprisal  
**G107 Investigate & document complaints & resolutions**  
**Standard: Right to be informed and participate in planning**  
**G108 Advance notice of care & changes to plan of care**  
**G109 Participate in planning of care & treatment**  
 G110 Inform & distribute advance directives info  
**Standard: Confidentiality of medical records**  
**G111 Confidentiality of the clinical records**  
 G112 Clinical records disclosure policies/procedures  
**Standard: Patient liability for payment**  
 G113 Advise of payment sources & liability prior to care  
**G114 Oral & written notice**  
 G115 Notification of changes within 30 days  
 G116 **Standard: Home health hotline**
- 
- G310 §484.11 Condition: Release of patient identifiable OASIS information**
- 
- G117 §484.12 Condition: Compliance with Federal, State & local laws, disclosure, ownership information, accepted professional standards & principles**  
**Standard: Compliance with laws & regulations**  
 G119 **Standard: Disclosure of ownership & management information**  
 Must comply with, Part 420, Subpart C  
 G120 Disclose ownership information to State  
**Standard: Compliance with accepted professional standards & principles**  
**G121 Comply with professional standards & principles**
- 
- G122 §484.14 Condition: Organization, services, and administration**  
**G123 Identifiable lines of authority**  
**G124 Administration/supervisory functions not delegated**  
**G125 Monitor & control non-direct services**  
 G126 Administrative records maintained for each subunit  
 G127 **Standard: Services furnished**  
 Nursing & therapeutic services available in patient’s residence; and one service provided directly, in its entirety.  
**Standard: Governing body**

- G128 Legal authority/responsibility for operations  
 G129 Qualified administrator  
 G130 Professional advice as required  
 G131 Adopts and reviews written bylaws  
 G132 Oversees management and fiscal affairs  
**Standard: Administrator**  
**G133 Organizes & directs the agency’s functions**  
 G134 Qualified personnel & staff education/evaluations  
 G135 Accuracy of public information materials/activities  
 G136 Effective budgeting/accounting system  
**G137 Qualified person in absence of administrator**  
**Standard: Supervising physician or Registered Nurse (RN)**  
**G138 Physician or RN direct & supervise**  
**G139 Available at all times during operating hours**  
 G140 Participates in all relevant professional services  
**Standard: Personnel policies.**  
 G141 Practices/care supported by written policies  
**Standard: Personnel under hourly or per visit contract.**  
 G142 Written contract between personnel and home health agency (HHA)  
**Standard: Coordination of patient services**  
**G143 Maintain liaison & support plan of care objectives**  
**G144 Documentation shows effective care coordination**  
 G145 Summary to physician at least every 60 days  
**Standard: Services under arrangement**  
 G146 Written contract  
**Standard: Institutional planning**  
 G147 Annual budget & capital expenditure plan  
 G148 **Standard: Plan & budget prepared**  
 G149 **Standard: Plan & budget reviewed/updated**  
**Standard: Laboratory services**  
**G150 Certified for level of testing performed**
- 
- G151 §484.16 Condition: Group of professional personnel**  
 G152 One Physician, one RN & other disciplines  
 G153 Establish and annually review policies. One member neither owner or employee  
**Standard: Advisory and evaluation function**  
 G154 Meets frequently to advice on professional issues  
 G155 Documented by dated minutes
- 
- G156 §484.18 Condition: Acceptance of patients, plan of care & medical supervision**  
**G157 All patients’ needs adequately met in residence**  
**G158 Care follows written plan/reviewed by physician.**  
**Standard: Plan of care**  
**G159 Plan of care covers all pertinent diagnoses**  
**G160 Physician approves additions and modifications**  
 G161 Specific orders for therapy services  
**G162 Personnel participate in development**

- G163 Reviewed at least every 60 days or more frequently**  
**G164 Alert physician of changes in condition**  
**Standard: Conformance with physician orders**  
**G165 Administer drugs/treatments ordered by doctor**  
**G166 Verbal orders put in writing/signed/dated**  
 G300 Verbal orders accepted by authorized personnel
- 
- G320 §484.20 Condition: Reporting OASIS information**  
 Electronically report all data collected per §484.55  
**G321 Standard: Encoding OASIS data.** HHA must encode & transmit OASIS data within 30 days of assessment  
**G322 Standard: Accuracy of encoded OASIS data. Standard: Transmittal of OASIS data.**  
 G324 Transmit all completed assessments  
 G325 Transmission of test data  
 G326 Transmit data using electronics communications software  
 G328 Transmit data that includes branch identification number  
**G327 Standard: Data format.**  
 Encode/transmit data using specified software
- 
- ### Subpart C - Furnishing of Services
- 
- G168 §484.30 Condition: Skilled nursing services**  
**G169 Skilled nursing by or supervised by RN**  
**G170 In accordance with the plan of care**  
**Standard: Duties of the registered nurse**  
 G171 Makes the initial evaluation visit  
 G172 Regularly re-evaluates the patient’s nursing needs  
 G173 Initiates the plan of care and necessary revisions  
 G174 Services requiring specialized nursing skill  
 G175 Preventive/rehabilitative nursing procedures  
 G176 Prepares clinical & progress notes, coordinates services, informs physician of changes  
**G177 Counsels patient/family in meeting all needs**  
 G178 Participates in in-service programs, supervise/teach  
**Standard: Duties of the licensed practical nurse**  
**G179 Furnishes services in accordance with policies**  
 G180 Prepares clinical and progress notes  
 G181 Assists physician/RN with specialized procedures  
 G182 Observes aseptic technique  
 G183 Assists patient to learn appropriate self-care
- 
- G184 §484.32 Condition: Therapy services**  
 G185 Services are performed by qualified therapist  
**G186 Assists physician in evaluating/developing plan of care**  
 G187 Prepares clinical and progress notes  
**G188 Advises/consults with family/personnel**

## Home Health “G” Tags and Abbreviated Identifiers \*

G189	Participates in in-service programs <b>Standard: Supervision of PT &amp; OT assistants</b>	Provides services ordered by physician in the plan of care.	G333	Initial assessment of rehabilitation therapy services when that is the only service ordered and it establishes program eligibility	
G190	Supervised by a qualified PT/OT	G226	Aide duties include hands-on personal care, etc.	G334	<b>Standard: Completion of the comprehensive assessment</b>
G191	Assists in preparing clinical notes and reports	G227	Aide services provided by a qualified HH aide <b>Standard: Supervision</b>		Assessment must be completed no later than 5 calendar days after the start of care date
G192	Participates in patient education and in-services <b>Standard: Supervision of speech therapy Services</b>	G228	Supervised by appropriate professional	G335	RN must conduct a complete assessment and for Medicare patients determine eligibility & homebound status
G193	Provided by or under a qualified SLP/Audiologist	G229	On-site visits every 2 wks	G336	PT/ST/OT may complete comprehensive assessment if only service ordered. The OT may complete if OT establishes eligibility.
<b>G194 §484.34 Condition: Medical social services</b>		G230	Non-skilled patient; RN onsite visit every 60 days	G337	<b>Standard: Drug regimen review</b>
G195	Provided by qualified social worker	G231	Services provided by non-direct employees must be provided under arrangement/contract		Comprehensive assessment must include review of all meds the patient is currently taking
G196	Participates in the development of the plan of care	G232	Ensure quality of contracted services		<b>Standard: Update of the comprehensive assessment</b>
G197	Prepares clinical and progress notes	G301	Supervision of aides under arrangement	G338	Comprehensive assessment must be updated & revised
G198	Works with the family	G302	Contract employees meet training requirements <b>Personal care attendant: evaluation requirements</b>	G339	Follow up assessment conducted within last 5 days of every 60 days beginning with start of care date, transfer, change in condition, or discharge and return during 60 day episode
G199	Uses appropriate community resources	G233	Competent to perform tasks assigned	G340	Within 48 hrs of the patient return home after 24 hr or more hospital stay other than diagnostic tests
G200	Discharge planning/in-service programs	<b>G234 §484.38 Condition: Qualifying to furnish outpatient PT/SPS</b>		G341	At discharge
G201	Consultant to other agency personnel	<b>G235 §484.48 Condition: Clinical records</b>			<b>Standard: Incorporation of OASIS data items</b>
<b>G202 §484.36 Condition: Home health aide services</b>		G236	Maintain in accordance with professional standards	G342	OASIS data must be incorporated into HHA’s own assessment
G203	Selected on basis of specific factors <b>Standard: Home health aide training</b>	G303	Inform attending physician of discharge summary <b>Standard: Retention of records</b>		
G204	<b>Standard: Content and duration of training</b>	G237	Retained for 5 years or as required by state law		
G205	Complete 16 hours of classroom training	G238	Record or abstract is sent with transferred patient <b>Standard: Protection of records</b>		
G206	Specific training requirements	G239	Safeguarded against loss/unauthorized use		
G207	<b>Standard: Conduct of Training</b>	G240	Written procedures on use/removal of records & release of information		
	Offered by any organization except HHA with Condition of Participation out of compliance, etc.	G241	Patient’s written consent required for release of information not authorized by state law		
G208	Instructor qualifications	<b>G242 §484.52 Condition: Evaluation of the agency’s program</b>			
G209	Other trainers under supervision of RN	G243	Written policies requiring annual evaluation		
G210	<b>Standard: Documentation of training</b> <b>Standard: Competency evaluation and in-service training</b>	G244	Consists of policy/administrative/clinical review		
G211	<b>Standard: Provide services after completing a competency evaluation program</b>	G245	Evaluates appropriate/adequate/effective/efficient		
G212	Aides meet competency requirements	G246	Results are reported & acted upon		
G213	Evaluation and in-service training requirements	G247	Maintained separately as administrative records <b>Standard: Policy and administrative review</b>		
G214	Performance review every 12 months	G248	Review of policies & administrative practices		
G215	12 hours of in-service each 12 month period	G249	Mechanisms in writing for collection of data <b>Standard: Clinical record review</b>		
G216	<b>Standard: Organizations that can conduct competency evaluation and training</b>	G250	Quarterly review of active/closed clinical records		
G217	Competency evaluation by/in-service under RN	G251	Continuous 60 day review of clinical records		
G218	Subject areas to be evaluated	<b>G330 §484.55 Condition: Comprehensive assessment of patients</b>			
G219	<b>Standard: Competency determination</b>	G331	RN nurse must conduct an initial assessment visit		
G220	Satisfactory rating in all required areas	G332	Initial assessment within 48 hours or upon start-of-care date		
G221	<b>Standard: Document competency evaluation</b>				
G222	<b>Standard: Effective date</b>				
	<b>Standard: Assignment &amp; duties of the HH aide</b>				
G223	<b>Standard: Assignment</b>				
	Assigned to a specific patient by the RN				
G224	Written Instructions by the RN or Therapist				
G225	<b>Standard: Duties</b>				