Ingredients for Survival & Success with CGS: Clinical & Billing Updates

Missouri Alliance for Home Care

April 29, 2015

CGS
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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Home Health Clinical Updates

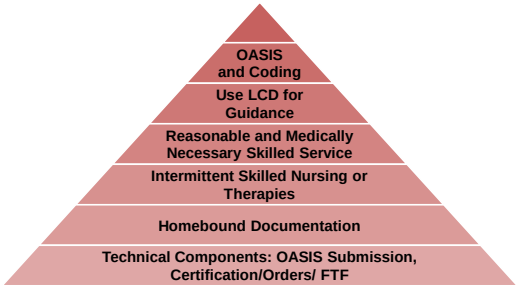
Top 5 Reasons for Home Health Clinical Claim Denials

Denials by Medical Review

Top HH Medical Review Denial Reasons

Denial Reason Code	Denial Reason	# Claims Denied (Jan – Dec 2014)
5FFTF	Missing/incomplete/untimely face-to-face documentation	1,917 (42%)
5HMED	Medical necessity of services not supported	1,680 (36%)
56900	No/untimely response to ADR	609 (13%)
5HPLN	Missing/incomplete/untimely plan of care	228 (5%)
5HHBD	Homebound status not supported	202 (4%)

Essential Home Health Documentation



Home Health Coverage Resources

CMS "Medicare Benefit Policy Manual" (CMS Pub. 100-02)

Chapter 7; Home Health

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

CGS "Home Health Coverage Guidelines" Web page

- www.cgsmedicare.com/hhh/coverage/Home_Health_Coverage_Guidelines.html

Face-to-Face (5FFTF)
(*and Physician Certification (5PCER)*)

Denial Reason #1 (5FFTF)

MLN Matters® SE1436

"Certifying Patients for the Medicare Home Health Benefit" SE1436.

Important information plus document examples

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

Denial Reason #1: 5FFTF Face-to-Face Documents

To be eligible for Medicare home health services, a patient must have Medicare Part A and/or Part B and:

1. Be confined to the home;
2. Need skilled services;
3. Be under the care of a physician;
4. Receive services under a plan of care established and reviewed by a physician; and
5. Had a face-to-face encounter performed by:
   - **Certifying physician** (must be Medicare enrolled)
   - **Non-physician practitioner** (NPP) in collaboration with the certifying physician
   - **Physician who cared for the patient** in an acute/post-acute facility during a recent stay and has privileges in that facility

Denial Reason #1: 5FFTF Face-to-Face Documents

Per the regulations at 42 CFR 424.22(c), certifying physicians and acute/post-acute care facilities **must provide**, upon request, the medical record documentation that supports the certification of patient eligibility for the Medicare home health benefit to the home health agency, review entities, and/or CMS.

http://www.cms.gov/Outreach-and-Education/Outreach/NPC/Downloads/2014-12-16-HHBenefit-HL.pdf

MLN Connects National Provider Call,
"Certifying Patients for the
Medicare Home Health Benefit"

Denial Reason #1: 5FFTF Face-to-Face Documents

- **Information from the HHA** can be incorporated into the certifying physician's and/or the acute/post-acute care facility's medical record for the patient.
- Information from the HHA **must be corroborated** by other medical record entries and align with the time period in which services were rendered.
- The **certifying physician must review and sign off** on anything incorporated into the patient's medical record that is used to support the certification of patient eligibility.

Denial Reason #1: 5FFTF Face-to-Face Documents

The certifying physician's medical record must contain information that **justifies the referral** for Medicare home health services. Including:

1. The need for the skilled services; and
2. Homebound status

AND must contain the **actual clinical note for the face-to-face** encounter visit which demonstrates the encounter:

3. Occurred within the required time frame;
4. Was related to the primary reason the patient requires home health services; and
5. Was performed by an allowed provider type.

Denial Reason #1: (5PCER Physician Certification)

The Recertification document must:

1. Be **clearly signed and dated** by the certifying physician who reviewed the plan of care
2. Indicate the **continuing need** for skilled services

NEW

3. **Estimate how much longer** the skilled services will be required

Denial Reason #1: 5FFTF

Electronic Code of Federal Regulations: Title 42 CFR 424.22; Requirements for home health services

- **http://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=c86654e32a4f36f15d70fab390124c29&n=pt42.3.424&r=PART&ty=HTML#se42.3.424_122&rgn=div8**

Denial Reason #1: 5FFTF When?

For initial certifications only

- **Recertifications do not require** a face-to-face encounter

Certifying physician must document FTF took place within

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

Reminder:

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

Denial Reason #1: 5FFTF Face-to-Face

The physician who cared for the patient in an **acute or post-acute facility** may choose to use documentation from the patient's medical record, (such as **a discharge summary**) to inform the certifying physician of the clinical findings from the face-to-face encounter.

IF

The compiled documentation is **reflective of the clinical findings** of the face-to-face encounter

AND

Serves as that physician's communication **to the certifying physician**

Denial Reason #1: 5FFTF Face-to-Face Signatures

The document from the acute or post acute facility record

- Must be signed and dated by the **certifying physician**,
- Must indicate the certifying physician **received the information** from the physician who performed the face-to-face encounter, and
- Must show the certifying physician is **using that documentation** as his/her documentation of the face-to-face encounter

Denial Reason #1: (5PCER Physician Certification)

Physician certification documentation requirements:

- The patient needs intermittent SN care, PT, and/or SLP services
- The patient is confined to the home
- A plan of care has been established and will be periodically reviewed by a physician
- Services will be furnished while the individual was or is under the care of a physician
- A face-to-face encounter (if initial certification)

Denial Reason #1: 5FFTF Documentation

Does the documentation clearly answer "why home health and why now?"

Reminder: Good documentation should address:

- Objective **clinical evidence** of patient's individual need for care
- Progress or lack of progress
- Medical condition
- Functional losses

Denial Reason #1: 5FFTF Readmission

If the patient is discharged, then readmitted with the same diagnosis, the same FTF document can be used if:

- The **timeframe** still meets requirements, **AND**
- There is **not a 60 day or greater gap** between episodes

Examples of FTF Documentation "Don'ts"

Insufficient documentation – Miscellaneous

- Diagnoses/clinical findings on FTF not related to home care ordered
- Altered documentation without **acceptable** notations for changes
- FTF **signed** by Non Physician Practitioner (NPP) **only**
- No date of FTF encounter
- **Not clearly titled** as face-to-face encounter

FTF Documentation: Important Reminders

FTF is requirement for Medicare payment

Missing/incomplete documentation results in **entire claim being denied**

As the billing entity, the home health agency's (HHA's) **responsibilities** include:

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

Medical Necessity (5HMED)

Denial Reason #2

Denial Reason #2 5HMED Medical Necessity

All services (even skilled) must be reasonable and medically necessary **related to the patient's condition.**

Does the documentation clearly answer "why home health and why now?"

Reminder: Good documentation should address:

- *Objective clinical evidence of patient's individual need for care*
- *Progress or lack of progress*
- *Medical condition*
- *Functional losses*
- Treatment goals
- Discharge planning

Denial Reason #2 5HMED
Medical Necessity - "Do's"

Identify skilled service, and **reason** skilled service is necessary for beneficiary in objective terms

Examples of **good documentation**:

- "Wound care completed per POC to left great toe. No s/s of infection, but patient remains at risk due to diabetic status."
- "Range of motion (ROM) is tolerated to lower extremities. Unsafe to teach caregiver ROM due to displaced fracture."

Denial Reason #2 5HMED
Medical Necessity – "Do's"

Demonstrate **medical necessity** of skilled observation and assessment by documenting complexity of beneficiary's condition and co-morbidities affecting outcomes.

Examples of **good documentation**:

- "Lungs sound coarse throughout. Patient finished antibiotic therapy today for pneumonia, and seeing pulmonologist tomorrow for follow up to due to COPD and emphysema."
- "Stasis wound on LLE continues to show 50% granulation and moderate serous drainage. Instructed patient on need to elevate legs and exercises related to peripheral vascular disease."

Denial Reason #2 5HMED
Medical Necessity – "Don'ts"

Skilled nursing **fables.** These are **NOT TRUE!**

- "As long as you document teaching, it is a billable visit."
- "As long as you document assessment, it is a billable visit."

Denial Reason #2 5HMED
Medical Necessity – "Don'ts"

Medicare Benefit Policy Manual (CMS Pub. 100-02) Ch. 7, §40.1 and §40.2 lists requirements in order for a service to be covered by Medicare as "skilled." The service must:

- Require the skills of a nurse or qualified therapist
  - Service is **NOT** skilled because it is performed by a nurse or qualified therapist
  - Service does **NOT** become unskilled because it is taught
- Be reasonable and necessary to treat patient's illness or injury
  - Patient's condition warrants the skilled care
  - **MUST BE evident in documentation**

No Response to Additional Development Request (ADR) (56900)

Denial Reason #3

Denial Reason #4: 56900
No Response to ADR

http://cgsmedicare.com/hhh/education/materials/pdf/ADR_QRT.pdf

- Quick resource tool
- Chart of how claim is processed
- List of how to check for ADRs using FISS
- Recommendations
- Checklist
- Preferred order of document submission

Plan of Care (5HPLN)

Denial Reason #4

Denial Reason #4: 5HPLN Plan of Care

Common denial reasons include:

- Dates: Verbal order, date of physician signature
- Incomplete orders/POC
- Timeliness: must be **SIGNED** and **DATED** by physician prior to billing
- Missing dates: "Received date" NOT accepted

CGS: "Physician Orders, Plan of Care and Certification" Web page

www.cgsmedicare.com/hhh/coverage/HH_Coverage_Guidelines/1B.html

Homebound Status (5HHBD)

Denial Reason #5

Denial Reason #5: 5HHBD Homebound Criteria

Medicare Benefit Policy Manual (CMS Pub. 100-02) Ch. 7, §30.1.1 defines "confined to home" (homebound)

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

CGS Homebound Web page

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

Denial Reason #5: 5HHBD Homebound Criteria

Two criteria are used to determine homebound status

Criteria-One:

The patient must **either**:

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

OR

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

Denial Reason #5: 5HHBD Homebound Criteria

Two criteria are used to determine homebound status (continued)

Criteria-Two:

- There must exist a normal inability to leave home

AND

- Leaving home must require a considerable and taxing effort

Denial Reason #5: 5HHBD Homebound Criteria

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

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

Denial Reason #5: 5HHBD Homebound Criteria

Documentation must support **homebound status** throughout

Beware of vague descriptions: "taxing effort", "unable to leave home"

Utilize **objective, measurable language**

Examples of **good documentation**:

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

CGS Home Health Denial Fact Sheets

Available from Home Health Quick Resource Tools webpage
http://www.cgsmedicare.com/hhh/education/materials/HH_QRT.html

- 5HHBD – Homebound Status
  http://www.cgsmedicare.com/hhh/education/materials/pdf/hh_5hhbd_factsheet.pdf
- 5HMED – Medical Necessity
  http://www.cgsmedicare.com/hhh/education/materials/pdf/HH_5HMED_FactSheet.pdf

CGS Home Health Denial Fact Sheets

- 5HNOA – No OASIS
  http://www.cgsmedicare.com/hhh/education/materials/pdf/hh_5hnoa_factsheet.pdf
- 5HPLN/5HORD – Missing Plan of Care or Orders
  http://www.cgsmedicare.com/hhh/education/materials/pdf/HH_5HPLN-5HORD_FactSheet.pdf

Home Health Billing Updates

Home Health Final Rule: Overview of Changes

Final rule includes:

- Revised face-to-face encounter requirements
- Revised therapy assessment rules
- Revised rates
- Home health quality reporting program updates
- Revised conditions of participation for speech-language pathologists

Home Health Final Rule: Overview of Changes

Changes to reduce administrative burden, allow HHA greater flexibility

- Elimination of narrative requirement for face-to-face encounter
- If home health claim is denied, corresponding physician claim for certifying/recertifying patient eligibility is considered non-covered
- Clarification that FTF encounter is required for certification, rather than initial episodes
  - i.e. Anytime a new start of care assessment is completed to initiate care, a FTF encounter is required
- Therapy reassessments revised to every 30 calendar days
  - Must be performed by qualified therapist (not an assistant)

Home Health Final Rule: CMS Resources

CMS Home Health Agency Center webpage, http://www.cms.gov/Center/Provider-Type/Home-Health-Agency-HHA-Center.html

Calendar Year 2015 HH PPS Final Rule, http://www.gpo.gov/fdsys/pkg/FR-2014-11-06/pdf/2014-26057.pdf

CMS Fact Sheet for HHAs for 2015, http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2014-Fact-sheets-items/2014-10-30.html

Once CGS receives final instructions from CMS on policy changes, additional education will be done

- CGS Calendar of Events webpage, http://www.cgsmedicare.com/hhh/education/Education.html

Change Request 8443

"Review Timeliness Requirements for Prepay Review", http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R568PI.pdf

- Effective for claims received on/after March 1, 2015
- CR changes number of days MACs have to conduct complex review from 60 to 30 days

Change Request 8581

"Automation of the Request for Reopening Claims Process", http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8581.pdf

- Effective for claims received on/after October 1, 2015
- CR8581 implements system changes that allow providers/vendors to electronically request reopenings of claims

Reopening

- Remedial action to change final decision that resulted in overpayment or underpayment, even if decision was correct based on evidence of record
- Differ from adjustments
- Subject to timeframes
  - Only allowed after normal timely filing period has expired
  - May be reopened within one year of initial determination for any reason; or
  - Within one to four years of the date of initial determination if good cause

Change Request 8699

"Preventing Duplicate Payments When Overlapping Inpatient and Home Health Claims are Received Out of Sequence", http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8699.pdf

- Effective for dates of service on/after January 1, 2015
- Current edits reject a HH claim with service dates that overlap a posted inpatient stay
  - Claim can be adjusted to remove overlapping line item dates of service
- CR 8699 will implement additional edits:
  - To recoup HH PPS payment when inpatient stay billed after paid HH episode
  - To include swing bed (type of bill 18X) as an inpatient claim

Change Request 8710

"Preventing Payment on Requests for Anticipated Payment (RAPs) When Home Health Beneficiaries are Enrolled in Medicare Advantage (MA) Plans", http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8710.pdf

- Effective for dates of service on/after January 1, 2015
- Implements edits to prevent RAP payments when final claim not payable due to MA plan
- Requirements of CR8710 ensure RAPs process but not paid when
  - "FROM" date falls on/after start of MA plan enrollment
  - "FROM" date falls before end of MA plan enrollment
- Remittance advice remark code N360 applied

Change Request 8813

"Diagnosis Reporting on Home Health Claims", http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8813.pdf

- Effective for dates of service on/after January 1, 2015
- Implements edits to prevent manifestation codes as primary diagnosis on home health claims
- Principal diagnosis on HH claim should be ICD-9 code most related to current HH plan of care (POC)
- RAPs and claims reporting a manifestation code as principal diagnosis will be returned to provider (RTPd)

Definitions of Medicare Code Edits, https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Downloads/FY_14_Definition_of-Medicare_Code_Edits_V_31_Manual.pdf

Change Request 9027

"Preventing Inappropriate Payments on Home Health Low Utilization Payment Adjustment (LUPA) Claims", http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9027.pdf

- Effective for dates of service on/after July 1, 2015
- CR9027 notifies providers of new edits ensuring LUPA payments under HH PPS are made appropriately
- No new policy created by CR9027
- New edits improve enforcement of existing payment policies

Special Edition Article (SE) 1504

"Payment Codes on Home Health Claims Will Be Matched Against Patient Assessments", http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1504.pdf

- Beginning April 1, 2015, Medicare will compare Health Insurance Prospective Payment System (HIPPS) code on home health claim to HIPPS generated by OASIS before claim is paid
- If HIPPS differs from OASIS assessment, Medicare will use OASIS-calculated HIPPS code for payment
- At this time, if no corresponding OASIS assessment found, claim will process normally

Billing Reminder: Home Health Ordering/Referring Edits

"Certifying Physicians and the Phase 2 Ordering and Referring Denial Edits for Home Health Agencies (HHAs)", http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1413.pdf

"Home Health Agency Reporting Requirements for the Certifying Physician and the Physician Who Signs the Plan of Care", https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8441.pdf

- New Resource: Ordering/Referring Checklist for Home Health Agencies, http://www.cgsmedicare.com/hhh/education/materials/pdf/ord_ref_phys_checklist_hha.pdf

Billing Reminder: Home Health Ordering/Referring Edits

"Full Implementation of Edits on the Ordering/Referring Providers in Medicare…Home Health Agency Claims"

- http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1305.pdf
- Effective January 6, 2014, claims will be denied if claim fails ordering/referring edit
  - 37236 – home health claim (type of bill 329)
  - 37237 – home health adjustment (type of bill 327)

Billing Reminder: Home Health Ordering/Referring Edits

If appropriate, may "appeal" claim denials for ordering/referring edits

- Ex: NPI /name mis-keyed or PECOS file was incorrect and has been corrected

To "appeal," must submit:

- Reopening Request Form, http://www.cgsmedicare.com/hhh/appeals/pdf/hhh_reopening_form.pdf

and

- Adjustment claim on hardcopy UB-04

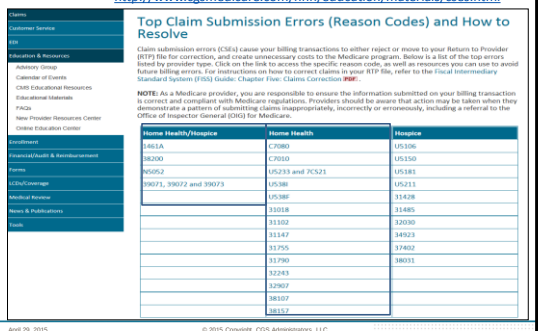
See "Ordering/Referring Denial Reopening" on 'Reopenings' webpage, http://www.cgsmedicare.com/hhh/appeals/Reopenings.html

Top Home Health Billing Errors

Top Home Health Billing Errors: January 1, 2014 – December 31, 2014	
Reason Code	Description of Error
1. 38107	FISS can't find matching RAP
2. 38157/38200	Duplicate billing – same beneficiary/same dates of service/same billing provider
3. U538I	RAP or home health claim overlaps an existing episode with a different provider number
4. 31018	Episode "TO" date not 60 days greater than "FROM" date
5. 31790	HCPC Q5001, Q5002, or Q5009 is not present

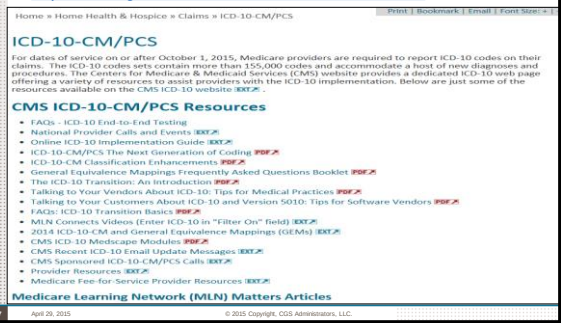
Top Claim Submission Errors (CSE) Page

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



ICD-10 Reminder: October 1, 2015 Compliance Date

http://www.cgsmedicare.com/hhh/claims/5010.html



CGS HH&H Website

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

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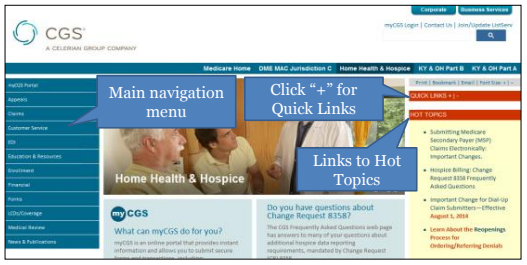

CGS HH&H Website: Education & Resources

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

CGS HH&H Website: Educational Materials

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

Questions?

1.877.299.4500 CGS

Provider Contact Center: Option 1

Electronic Data Interchange (EDI): Option 2

Provider Enrollment: Option 3

Overpayment Recovery: Option 4

Thank You!

Please complete the

Event Evaluation

Attendance Form

Post-Test