



## Two Sides of the Coin (or Making Heads or Tails of Home Health Medical Review)

NAHC 2011  
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## Why Was My Agency Denied?

- Loving Home Health sent their ADR on day 45 after receiving the letter from their MAC...after all that work of providing care, then making copies- they still get a denial?!



## Automated Denial

- Day 46- when records have not yet been received, FISS denies automatically



## What is Medical Review?

- **Record reviews** to ensure appropriate payment for services
- Performed by **Medicare Administrative Contractors** (MAC) or Regional Home Health Intermediaries (RHHI)
- Triggered through the Additional Development Review (**ADR**) process
  - Small percentage of claims selected

## Who Directs ADRs?

- CMS mandates ADRs through Progressive Corrective Action (PCA)
  - Program Integrity Manual – CMS Publication 100-8  
[www.cms.gov/Manuals/iom/list.asp](http://www.cms.gov/Manuals/iom/list.asp)
- MAC/RHHI carry out PCA based on their own data from providers


## Don't be late!

- Provider **mails** all documentation relevant to the request **within 30 days** from date of ADR.



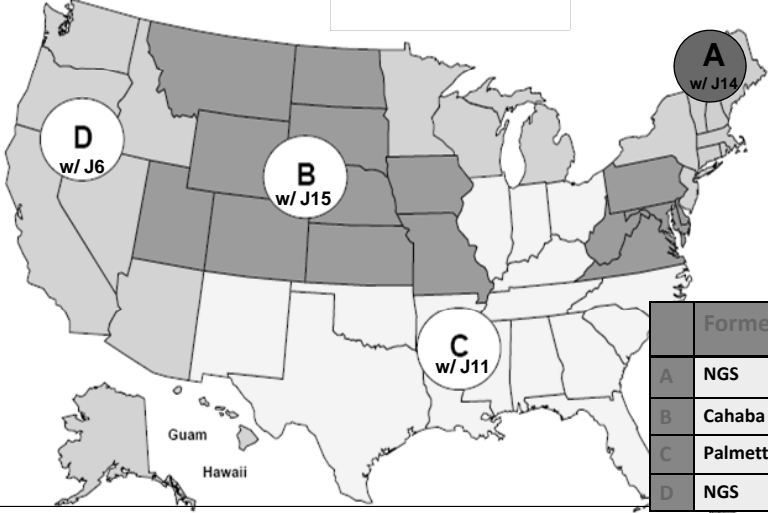
## Review Outcomes

- **Paid**
  - Moved to P B9997
- **Partially Paid**
  - Line items, therapy downcode, or HIPPS
  - FISS page 04 or on Remittance Advice (RA)
- **Denied**
  - Moved to D B9997



## Medicare Contractor Reform

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



	Former	New
A	NGS	NHIC
B	Cahaba	CGS
C	Palmetto	Palmetto
D	NGS	TBD

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## Contacting Your MAC

- NHIC, Corp
  - [www.medicarenhic.com](http://www.medicarenhic.com) or 866-289-0423
- National Government Services (NGS)
  - [www.ngsmedicare.com](http://www.ngsmedicare.com) or 800-338-6101 or [clinical.education@wellpoint.com](mailto:clinical.education@wellpoint.com)
- Palmetto GBA
  - [www.palmettogba.com](http://www.palmettogba.com) or 866-801-5301
- CGS
  - [www.cgsmedicare.com](http://www.cgsmedicare.com) HH: 877-299-4500

## What triggers ADRs?

- Progressive Corrective Action
  - Each MAC/RHHI **must** follow process:
    - **Data** must drive claim review selection.
    - **Notification required** for widespread issues and provider-specific issues.
    - **Education** must be the focus.
  - Outlined in Program Integrity Manual (100-8) [www.cms.gov/Manuals/IOM/list.asp](http://www.cms.gov/Manuals/IOM/list.asp)



## Why an ADR?

- Widespread or provider-specific vulnerabilities
- Focus on proven problem areas
- Focus on payment
- Feedback and education for providers

## Widespread Edits

- **Data or vulnerability** identified
- **Widespread probe** completed
  - 100 claims total
- If effective (↑denials), becomes **widespread edit**
  - MAC/RHHI may publish probe edit results
  - Evaluate Quarterly for effectiveness

## Widespread Edits

- Current examples of Widespread Edits:
  - Therapy utilization
  - Chronic diseases + 2 Recerts
  - Five-visit threshold episodes
  - Case-mix diagnoses
- Providers alerted of record reviews through ADRs

## Widespread Edits

- Speak up!
  - Ask **your** MAC to make widespread edit information more accessible to providers.
  - Remind them to **focus on education!**



## Provider-Specific Edits

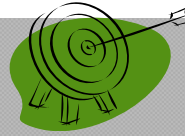
- ADRs cued by
  - Outliers:
    - E.g. high therapy utilization, ↑ length of stay
- Referrals
- Letter notifies provider of **probe edit**
- MAC/RHHI evaluates error rates
  - High provider denials = targeted review
  - Low provider denials = no targeted review

## Targeted Review



- Results typically from provider-specific probe review
  - Agency receives a letter
    - Denial detail
    - Education resources/contacts
  - Provider is on targeted review for at least three months

## Targeted Review



- Effectiveness of all edits evaluated quarterly
  - Based on claims error rate (CER)
- Agency receives letter each quarter
  - Edit discontinued
  - Continue on targeted review
  - May request a Corrective Action Plan (CAP)

## What is an Error Rate?

- Claim error rates (CER)
  - Total \$ billed/actual \$ paid for claims reviewed
  - Example: 10 claims, each \$1000.00
    - 7 claims paid as billed= \$7000.00
    - 1 claim paid at reduced rate= \$500.00
    - 2 claims denied= \$0.00
- Total denied = \$2500 of \$10,000 = 25% denial

## How Are Results Analyzed?

- MAC sets own error threshold
- An error rate >10-20% may trigger continued review
  - While **education** takes place
  - Until **error rate falls** to acceptable level
  - May impose **additional corrective actions** based on the problem's severity

## Corrective Action

- Provider specific results letter
  - Providers who are on TMR or provider-specific probes
- Web articles
  - Results from widespread probes
- Education referral
- Corrective action plan (CAP)
- Benefit integrity

## Beneficiary-Specific Edit

- Based on previous medical review findings of non-covered service
- May stem from a prior widespread or provider-specific edit
- Claim suspended for medical review by beneficiary's identification

## Who ADRs Impact

- You!
- Everyone at your agency and in the home health industry...
- "We've always done it this way..."
- No news is not always good news

## ADR Teamwork

- **When ADRs hit – everyone at the agency is involved**
  - Billing
  - Administrative
  - Clinicians
  - QI
  - Cash flow



## ADR Teamwork

- **Use checklist**

2.           Verbal Orders signed by M.D. for audit period. (Be sure to check if any V.O. prior to audit period affects the current audit period) Be sure to include any therapy orders that have M.D. signature.  
 Attached, date:          and / from:         

3.  **SOC OASIS Assessment**  
 All OASIS that are applicable for each period, and previous if applicable.  
 Attached:         

4.  **Attach service notes for all disciplines including Admin Progress Notes.** Please record notes dates by discipline in the appropriate treatment week. (2 weeks dates if G.O.) Treatment weeks are from Mon. (or SOC) to Sat. be sure 485 and V.O.s support the visits that were made. Leave blank any treatment weeks that are not included in the audit period. Tx week 1 should be first week of care/evaluation or re-evaluation period. Review notes to assure completeness (esp. Auto Notes) for medical necessity and appropriateness.

Initial and current visits for all current and archival disciplines	SH	TMA	PT	OT	ST	MSW
Week 1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Week 2	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



## ADR Process

- Provider submits a claim for payment
- FISS processing begins
  - Claim matches an edit, is pulled for review
  - FISS moves the claim to S B6001
  - ADR message is generated in the FISS

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## ADR Received

- Clock begins...
  - Some MACs send letters to notify
  - Agency must **monitor** the FISS system for ADRs
    - Recommended weekly process
  - Suspended claims - HH location
    - S B6001

## Provider Response

- Receives and responds to ADR.
  - Collects and copies requested documentation.
  - **Bundles each ADR separately.**
  - Attaches claim page 07 to the top of the record.

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## Provider Response

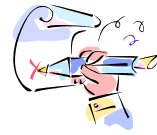
- **Clinician reviews** documentation
  - Ensure it is **complete** and **supports services provided.**
  - Include **documentation outside of claim dates** if needed to support.
  - Request **further documentation** from physician or inpatient facility if necessary.



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## Letter Writing Campaign

- Letters are always “Secondary documentation”- can not pay claim based on this...
  - Still can be helpful to direct and highlight



## Provider Responds

- When it's a denial or adjustment
  - **Checks record** for key points related to denial reason
  - **Identifies why** denial occurred
    - Documentation doesn't support services billed
    - Not all documentation submitted in response to ADR



## Process Improvement

- Identifies **action plan** to prevent further denials
  - Documentation errors- education
  - Certification technical errors- QA process
  - Missed information in ADR- refine process
- Implements plan
- Submits a **request for redetermination**, if appropriate

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## Avoiding Denials...

## How Are ADRs Reviewed?

- Focus is on payment
  - Medicare Benefit Policy Manual guidelines for coverage
  - CMS Publication 100-2, Chapter 7 for HH LCDs, if applicable
  - Focus is **NOT** on CoPs
    - But can refer acute concerns to state agencies

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## Scope of HH Medical Review

- Technical components and eligibility
  - Certifications, including FTF
  - Plan of care, and additional orders
  - Intermittent /part-time if nursing
  - OASIS submission to state

## Scope of HH Medical Review

- Illegible = Denied

UNIT NO. / PATIENT NAME / DATE	UNIT NO. / PATIENT NAME / DATE	UNIT NO. / PATIENT NAME / DATE
GAT TRAINING (yes/no) _____	GAT TRAINING (yes/no) _____	GAT TRAINING (yes/no) _____
ADMIT DATE _____	ADMIT DATE _____	ADMIT DATE _____
ADMIT TIME _____	ADMIT TIME _____	ADMIT TIME _____
TRANSFER TRAINING (yes/no) _____	TRANSFER TRAINING (yes/no) _____	TRANSFER TRAINING (yes/no) _____
BALANCE (yes/no) _____	BALANCE (yes/no) _____	BALANCE (yes/no) _____
MODALITIES (yes/no) _____	MODALITIES (yes/no) _____	MODALITIES (yes/no) _____
HOME PROGRAM/CAREGIVER INSTRUCT (yes/no) _____	HOME PROGRAM/CAREGIVER INSTRUCT (yes/no) _____	HOME PROGRAM/CAREGIVER INSTRUCT (yes/no) _____
OTHER TX _____	OTHER TX _____	OTHER TX _____
PAIN (yes/no) _____	PAIN (yes/no) _____	PAIN (yes/no) _____
ADDITIONAL _____	ADDITIONAL _____	ADDITIONAL _____
PHYSICIAN _____	PHYSICIAN _____	PHYSICIAN _____
PHYSICIAN NO. _____	PHYSICIAN NO. _____	PHYSICIAN NO. _____
Widely assessed if progress towards goals (check by unit) _____	Widely assessed if progress towards goals (check by unit) _____	Widely assessed if progress towards goals (check by unit) _____
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## Scope of HH Medical Review

- Medical necessity components
  - Homebound documentation
  - Qualifying skilled services and need
    - Keep in mind how HH PPS is paid
- Review of OASIS vs. HIPPS billed

## No OASIS Submission= No \$\$

- Instructs reviewers to deny claims when OASIS is not submitted
- Directs medical review, CERT and ZPIC reviewers
- Provides more detail about written POC needed for home health & hospice
- CR 6982
  - [www.cms.gov/transmittals/downloads/R343PI.pdf](http://www.cms.gov/transmittals/downloads/R343PI.pdf)

## Complete Orders

Chapter 7, Section 30.2.4

- A POC that differs at all from the referral:
  - Requires proof of verbal OK received *prior* to providing care.
  - Otherwise all services not on referral, provided before the date the MD signed the POC are non-billable.
  - “PT to eval and treat” covers only evaluation
  - Signed/dated prior to final billing

28. Physician's Name and Address

GRYGLA, DAVID  
168 N 100 E  
ST GEORGE UT 84770  
Phone: 435 868 3665 UPIIN#:

*[Handwritten Signature]*  
Attending Physician's Signature and Date Signed

29. I verify / recertify that this patient is confined to his / her home and needs intermittent skilled nursing care, physical therapy and / or speech therapy or continues to need occupational therapy. This patient is under my care and I have authorized the services on this plan of care and will periodically review the plan.

28. Anyone who misrepresents, falsifies, or conceals crucial information required for payment of federal funds may be subject to loss, suspension or civil penalty under applicable Federal laws.

## Complete Orders

- Orders must be in order
  - Discipline
  - Modalities
  - Frequency
  - Duration
    - *Medicare Benefit Policy Manual, Publication 100-2, Chapter 7, Section 30.2.2*

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## Orders Denial

- Shining Sun HHA receives signed orders for PT to eval and treat on 9/10 after Mr. Gordon had an ORIF
- Therapy provided skilled intervention for 3 weeks, patient met goals and discharged
- Dr. signed eval on 10/1, prior to billing
- Received ADR and sent in full chart
- Why was there a denial?



## Orders Denial

- PT to Eval and Treat was the initial signed order- covers eval
- No further verbal orders noted in chart
- PT eval contained frequency, goals, modalities and duration- which was signed after care was complete- 20 days later

## Homebound

- Patient must be homebound
  - “However, occasional absences from the home for nonmedical purposes... would not necessitate a finding that the patient is not homebound if the absences are undertaken on an infrequent basis, or are of relatively short duration..”
    - *Medicare Benefit Policy Manual, Publication 100-2, Chapter 7, Section 30.1*
- What are the patient's limitations?
  - Mobility
  - Respiratory status
  - Pain
  - Delusional, active psychoses
  - Activity tolerance restrictions
    - Ambulates 10 feet and rests due to SOB

## Homebound Denials

- Patient has extreme taxing effort, is a quad, but leaves home almost daily after assisted into chair with hoyer.
- Patient is 87 years old, uses a cane safely, but never leaves home because she is most comfortable there, and does not drive.
- “Patient does not want to be homebound any longer”

## Other Qualifying Criteria

- Intermittent care if nursing
- Patient has skilled need
  - SN, PT or SLP at SOC, or ongoing OT

## Other Qualifying Criteria

- Medical Necessity documentation a must for all care
  - Patient has diagnoses, changes and risks that warrant this level of care

[redacted] medical history identified significant comorbidities that effected his plan of care and response to therapy. Most significant of those comorbidities was the effects he suffered from cerebral ataxia. He also had a history of Afib, HTN, and UTI with urinary retention.

Once discharged from rehab, [redacted] sent home and home health services were reinstated. For that certification period therapy interventions were successful with partial goal achievement. Due to patients interruption in course of care with hospital admission and his effects from the cerebellar ataxia recertification was necessary.

## Top Home Health Denials

- SN-Observation/assessment:
  - Diagnoses, changes and risks to justify
- Homebound
  - Taxing effort not clear
- Therapy Downcodes
  - Documentation becomes repetitive-unclear if skilled



## Wound Care Denial

- Happy Home Care has a patient with a wound on her lower leg, which she can not reach. The nurse cleanses the wound and applies a clean hydrocolloid dressing every 3 days.
- Why was this denied? The patient can't reach it!



## Wound Care Denials

- The wound care was not “skilled level of care”
- Could've been paid for assessment if there had been comorbidities documented raising risks
  - DM, PVD, incontinence, etc



## Top Home Health Denials

- Therapy:
  - Functional changes, need for maintenance program, requires skills of therapist
    - Anyone could take the patient for a walk

Patient ID: <u>277</u>	Time: <u>08:16:33</u>
<b>Skilled Services Performed</b>	
<b>GAIT TRAINING (note assist needed)</b>	
distance	<u>2x 60'</u>
assistive device	<u>PWW</u>
stair training	

- Therapies drive payment, are under focus
  - New assessment requirement at least every 30 days
    - Visit 13 and 19 therapies combined
  - All therapies must complete

OASIS-C...  
Still Changing...

## Clinician's Tools for OASIS-C

- OASIS-C Guidance Manual 2010
- Chapter One- Conventions, Chapter 3 Individual M Items
  - [www.cms.hhs.gov/HomeHealthQualityInits/14\\_HHQIOASISUserManual.asp](http://www.cms.hhs.gov/HomeHealthQualityInits/14_HHQIOASISUserManual.asp)
- CMS OASIS Q&As- Updated 2011
  - [www.qtso.com/hhdownload.html](http://www.qtso.com/hhdownload.html)
- Quarterly CMS OASIS Q&As
  - [www.oasiscertificate.org](http://www.oasiscertificate.org)

## Clinician's Tools for OASIS-C

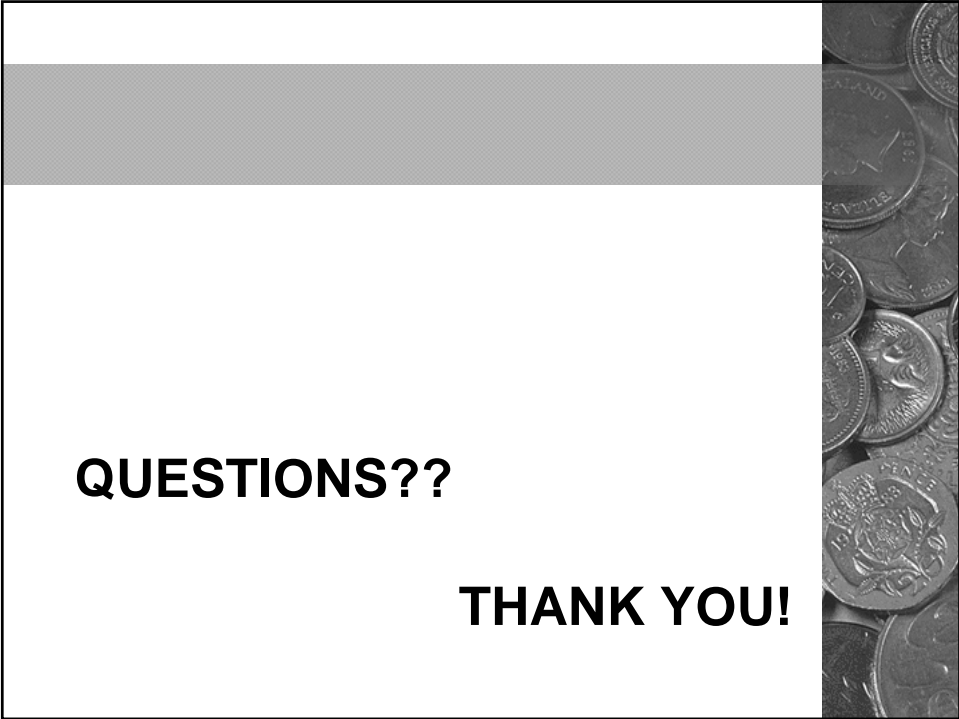
- Your OASIS Education Coordinator (OEC)  
[www.cms.hhs.gov/OASIS/Downloads/OASISeducationalcoordinators.pdf](http://www.cms.hhs.gov/OASIS/Downloads/OASISeducationalcoordinators.pdf)
- Each state has a designated OEC to assist in:
  - Training in using the OASIS data set to assess patients
  - Training and technical support in integrating the OASIS items in the agency's record keeping system
  - Technical support in answering questions on the clinical aspects of OASIS

## Do We Stand Out?

- Understanding what makes your agency or claims “stand out” can aide in judgments, and avoid audits
- Audit/ADR doesn't = something wrong

## On the Same Page??

- **Information is Power!!**
  - Provide staff with the rules
  - Guide decisions and empower clinicians with coverage criteria
  - Educate on coverage and documentation standards
- Oversee documentation
- Check up on technical pieces



**QUESTIONS??**

**THANK YOU!**

# Additional Development Request (ADR) Checklist Home Health

## **Administrative/Billing Staff**

Print page seven of claim with identifying information

Copy all documentation for dates of service requested:

- Plan of care
- Additional orders
- OASIS supporting HIPPS code for this episode (Will be prior to dates of service if recertification)
- All visit notes for all disciplines during dates of service requested
- Coordination of care notes
- All documentation supporting referral or resumption, such as H&P, discharge orders, physician documentation or other facility documentation

## **Clinician Review**

Review dates requested and ensure proper dates of documentation copied, including the POC and OASIS that are completed prior to requested dates on recertification.

Review all signatures.

- If handwritten, are they legible?
- If not, is there an authenticating typed signature, signature log or attestation statement?
- If signature not clear, and author not on your signature log, obtain an attestation statement.

Review POC and additional service orders.

- Complete orders with discipline, modalities, frequency and duration?
- Signed by physician and dated (by physician or a "received on" date) prior to billing claim? (remember, no stamped signatures allowed)

Compare visit notes to billed visits.

- Is there a note for each billed visit?

## Additional Development Request (ADR) Checklist

### Home Health

- Each visit supports the patient's conditions/needs coupled with the interventions provided.
  - If not, are additional pieces of documentation that help support why patient needed visit included?
  - Five payable visits for episode? (if less than five visits billed, each will be reviewed-are all billed visits supported?)

All billed therapy visits supported.

- Is the patient's condition clear?
- Is descriptive language used? (re: quality of gait, balance, exercises, etc.) Avoid repetitive documentation—build on each visit.

Review OASIS payment items.

- Do the responses to these items "fit" in the context of the medical record at that timeframe?
- Is additional narrative needed to explain?

### Writing a Summary

- Write a summary of the patient conditions/needs, highlighting the recent changes precipitating referral, or recertification.
- Highlight specific visits, by date, when documentation is clearest regarding the skilled level of interventions.
- Note the additional orders changing services or treatments/medications
- Show a "roadmap" through the course of care, and the impact of home health on patient conditions

### Send Records

- Send copy of records in, with summary and claim page seven (contact MAC for address if ADR, and fax with bar coded cover sheet if CERT review)
- Ensure records will be received by due date, and monitor results

Reviewed by: \_\_\_\_\_

Date: \_\_\_\_\_