FUTURE HH PPS PAYMENT RATES

- Sequestration: 2% reduction on claims with through date of 4/1/13 and later
  - Attention to discharge date when end of service prior to 4/1
    - No adjustments to RAPs
    - RA will balance
  - 2014 rebasing
    - May result in varied rates
    - Awaiting proposed rule
  - CMS study on vulnerable populations continues
    - Physician and home health agency surveys underway
  - Case mix weight change adjustment analysis ongoing
  - MedPAC case mix adjustment model: goal to drop therapy threshold element
MEDICARE RATE/PAYMENT FORECAST

• 2014- minus 4% from 2013 (plus 2.5% MB update, minus 3.5% rebasing, minus 1% case-mix creep, minus 2% sequestration).
• 2015- minus 3%
• 2016- minus 3%
• 2017- minus 3%

POTENTIAL MEDICARE HOME HEALTH CHANGES

• Copayments
  ▪ Ongoing risk, but previous success in stopping
• Payment/benefit restrictions
  ▪ May be alternatives to copay, e.g. episode payment caps
• Program integrity measures
  ▪ Market entry restrictions and/or moratorium
  ▪ Oversights
• New case mix adjustment model
  ▪ Elimination of any therapy thresholds???
2013 REGULATORY CHANGES

- Face-to-face encounter
- Therapy assessments and documentation
- Alternative CoP violation sanctions
- Case-mix diagnosis code changes

FACE-TO-FACE: POLICY AND ENFORCEMENT

NPP Revisions 2013
- Allow facility-based NPP to perform encounter
- Require communication with the physician with whom collaborating (i.e. inpatient or community)

Documentation title and date
- Allow any party to title and date F2F documentation
REQUIREMENTS FOR HOME HEALTH SERVICES

Certification
- Physician attestation of eligibility for home health services
- Includes F2F attestation

Plan of Care
- Physician detailed plan of care developed in consultation with home health agency personnel

WHO ARE F2F INPATIENT PHYSICIANS

Physicians caring for patient during:
- Acute care stay
- Post acute inpatient stay
- ED visit
- Observation stay at an acute care facility

Includes
- Residents (however documentation and communication via supervising physician)
ENCOUNTERS: DOCUMENTATION

Who must document the encounter?

- The physician who certifies that the patient qualifies for home health (i.e. is homebound and requires intermittent nursing or therapy)
- Regardless of whether encounter by that physician, an inpatient physician, or an NPP

QUESTION with CMS: Will certifying physician’s “sign off” on NPPs clinical notes meet documentation requirements?

INPATIENT F2F ENCOUNTER ONLY:

NO DOCUMENTATION AND CERTIFICATION

- Communication of clinical information from medical record to community physician (i.e. verbal, clinical notes, discharge summary, referral, etc.)
- Clinical documentation must support eligibility (i.e. homebound, medical necessity)
- Information compilation may be by inpatient support staff
- Community physician may obtain supplementary information via phone, email, if needed
- Inpatient physician documentation must be signed/dated by community physician
- Note: Inpatient physician or NPP signature not required
OTHER IMPORTANT CONSIDERATIONS

• Checkboxes created by the physician are acceptable
• Standardized language prohibited (e.g., considerable and taxing effort)
• New starts of care resulting from inpatient on day 60, 61 do not require new F2F
• Home health agencies may not create, transcribe, add to, or alter F2F documentation
• F2F samples may not be patient specific
• Start of Care may be revised if late encounters
  ▪ Realignment of SOC: may use original OASIS, updated
  ▪ Realignment of SOC due to late F2F requires realignment of therapy 13 and 19

LATE F2F ENCOUNTER

• Count back 30 days
• New SOC is the first billable visit from that date
• Use an existing OASIS assessment to generate another OASIS for the new SOC date
• If the original OASIS assessment had already been submitted to the State, it should be deleted
CMS ENCOUNTER RESOURCES

Regulation 42CFR §424.22

Resources:

Q&As (updated May 2012): [http://cms.gov/Center/Provider-Type/Home-Health-Agency-HHA-Center.html](http://cms.gov/Center/Provider-Type/Home-Health-Agency-HHA-Center.html)


Manual revisions underway

MEDICARE COMPLIANCE

• Medical review
  • Aberrant patterns outside the norm
  • Statistical deviation
  • Percent increase billing, payment, number visits/services
  • High utilization services/items
  • High cost services/items

• OIG home care efforts
  • New report alleges widespread fraud and abuse (overlapping inpatient stays and after death, questionable billing)
  • Report is weak on facts and methodology, strong on hyperbole
  • Extensive home health issues on OIG work plan (e.g. OASIS, F2F, criminal background, S&C, etc.)

• Unlawfully present denials

• Medicaid home care: Services, time of visit, staff credentials, etc.
RAC APPROVED HH ISSUES

Region C: Connolly, Inc.
States: AL, AR, CO, FL, GA, LA, MS, NM, NC, OK, SC, TN, TX, VA, WV, Puerto Rico and U.S. Virgin Islands

- Home Health Agency - Medical Necessity and Conditions to Qualify for Services: Complex
- RAP claim without corresponding home health claim: Automated
- Incorrect billing of Home Health Partial Episode Payment claims: Automated
- Validation of late episode timing: Automated
- Core-based statistical area: Automated
- OASIS not completed timely: Semi-automated (on hold)
- Hospice related services billed with Condition code 07- Home Health: Automated
- Non-Routine Medical Supplies and Home Health Consolidated billing: Automated

OTHER INITIATIVES

- **ZPIC**
  - Automated denials for homebound
  - Problem: 1+ year delay in issuance of decisions
- **Supplemental Medical Review Contractor**
  - Lower improper payments
  - HHAs targeted
  - Implications unclear
- **Comparative Billing Reports**
  - Second round
  - 5000 agencies with top per beneficiary charges (1/11-12/11)
  - Visit count per beneficiary
  - PT, OT, SLP visits per beneficiary that received therapy
JIMMO LAWSUIT (IMPROVEMENT STANDARD)

- Settlement: focused on illegal “improvement” standard
  - Permit coverage of skilled maintenance therapy
  - Permit coverage of chronic care/terminal patients
  - Clarify existing guidelines
  - Provider and contractor education will follow
  - Ongoing oversight of claim determinations
- Qualifying and coverage rule unchanged
  - Skilled, medically necessary care
- Existing guidelines recognize such coverage, but MACs changed the “rules”
- Documentation is key
  - Need for care
  - Provision of services that require skills of nurse, therapist

HIPAA: NEW PROVISIONS

- Who: Any health care provider that transmits an electronic “transaction”
- What: Protects individually identifiable health information
- Provisions of 2013 HIPAA final rule
  - Expands the definition of business associate, includes subcontractors
  - Clarifies direct liability of business associates, limits covered entity liability
  - Requires business associate disclosures to Secretary, to individual
  - Breach evaluated based on: nature, extent, history of compliance, financial state, probability of use of PHI, level of mitigation
  - Breach penalties up to $3M
  - Excludes transmission via paper, fax, phone
  - Requires individual authorization for marketing
  - Expands notice of privacy requirements
  - Addresses individuals rights to limit use of PHI, access to PHI
  - Effective 9/23/13, 1 year transition period for static contracts
ICD-10

- CMS Resources:
  - http://www.cms.gov/Medicare/Coding/ICD10/ProviderResources.html
- Identify current systems and work processes that use ICD-9
- Talk with your vendor about accommodations for ICD-10 codes
  - Ask your vendor what updates they are planning to make
  - Ask your vendor when they expect to have it ready to install
  - Check your contract to see if upgrades are included
- Discuss implementation plans with clearinghouses, billing services, and payers
- Identify potential changes to work flow and business processes.
- Consider changes to processes: e.g. clinical documentation, quality reporting
- Educate coders and other staff

ICD-10 TRANSITIONING AND TESTING

- **March 1, 2013 – December 31, 2013:** Conduct high-level training on ICD-10 for clinicians and coders to prepare for testing (e.g., clinical documentation, software updates) (ongoing)
- **April – June 2013:** Start testing ICD-10 codes and systems with your practice’s coding, billing, and clinical staff (ongoing)
- Use ICD-10 codes for diagnoses your practice sees most often
- Test data and reports for accuracy
- Monitor vendor and payer preparedness, identify and address gaps (ongoing)
- **October 2013 – January 2014:** Begin testing claims and other transactions using ICD-10 codes with business trading partners such as payers, clearinghouses, and billing services (10 months minimum)
- **January 1, 2014 – April 1, 2014:** Review coder and clinician preparation; begin detailed ICD-10 coding training (6-9 months)
- Work with vendors to complete transition to production-ready ICD-10 systems
- Complete Transition/Full Compliance
- **October 1, 2014**
  - Complete ICD-10 transition for full compliance
  - ICD-10 codes required for services provided on or after October 1, 2014

...
SURETY BONDS

- **OIG Position**
  - Recommended that CMS implement the iced rule (on hold 16 years)
  - Home health expenditures and the number of HHAs has increased
  - Tool for keeping fraudulent providers out of the system and provides a
    process for Medicare to recoup some overpayments
- **NAHC Position**
  - System checks and safeguards that prevent overpayments and fraud now in place
  - Criminal conduct won’t be prevented by a surety bond of $50,000 or $100,000
  - Value must be reexamined
  - Consider for new agencies only
- **CMS Position**
  - With volume, cost won’t be prohibitive
  - Continue to evaluate options
  - Implementation date unknown

MEDICAID HOME CARE

Rebalancing of LTC spending continues
PPACA incents home care
States increasing Medicaid home care audits and oversight
  - Big focus on caregiver qualifications by OIG
  - Documentation weaknesses on care plans ad authorizations
Major movement to managed care Medicaid
Agency model vs. Self-directed care (or both)
MEDICAID MANAGED CARE

Nationwide shift to managed Medicaid Long Term Services and Supports (MLTSS)

- CMS supports move with some caution
- Dual-eligible demo programs are the big wave
  - Various approaches
    - May target a population, e.g. elderly vs. disabled
    - Managed care is the primary approach
  - New plans emerging
    - Concern: Limited plan experience with LTC
    - Passive enrollment in plan
    - Opportunity to opt out with Medicare
    - Gradual shift to network providers
      - 6-12 months
      - Medicaid rates at the start

CMS DIAGNOSIS REPORTING

“Enhancement” of grouper

- Restrict M1024 to only permit fracture (v-code) diagnosis coding
- Pair fracture with appropriate diagnosis codes in primary and secondary

Revise HHRG logic to permit equivalent scoring when reported immediately following V code

- Diabetes, Skin 1, Neuro 1
IMPACTED DIAGNOSTIC CATEGORIES

Drop offs due to limit of six primary & secondary
- Diabetes
- Skin
- Neuro

Orphan codes: no plan by CMS
- Post surgical care
- Resolved but treating residual affects
  - Cancers
  - Gastrointestinal
  - Orthopedic
  - Neurological

THERAPY REASSESSMENT

- For late assessments, the visit on which the reassessment is conducted will be covered
- The visit prior to the late reassessment will not be covered
  - Reassessment conducted on visit 14
  - Visit 14 will be covered but not visit 13
- In single therapy cases reassessment must be conducted on the 13th / 19th therapy visit
THERAPY REASSESSMENT

In multi-discipline cases:

- Each discipline must conduct a reassessment on therapy visits 11, 12, or 13.
- Each discipline must conduct the reassessment on therapy visits 17, 18, or 19 for each discipline.
- Non-coverage will apply only to the discipline that fails to conduct the reassessment on time.
- Reassessments may be conducted on the visit closes to, but no later than the 13/19th therapy visit, if there is no scheduled visit for that discipline within the required time frame.

EXAMPLE:
The patient is receiving PT and OT.

- OT completes the reassessment on visit 12, PT makes visit 13 but misses the reassessment, makes visit 14 and completes the reassessment.
- OT makes visit 15, PT makes visit 16, OT makes visit 17 and completes the reassessment.
- OT Visit 12 - Medicare-covered, OT reassessed patient within 11-13 timeframe.
- PT Visit 13 - Non-covered as the PT missed reassessing the patient between the 11-13 visits.
- PT Visit 14 - covered since he PT reassessment was conducted, however, it becomes the 13th covered visit.
- OT Visit 15 - This becomes the Medicare-covered 14th visit.
- PT Visit 16 - This becomes the 15th Medicare-covered visit.
- OT Visit 17 - This becomes the Medicare-covered 16th visit, but now places OT out of compliance with the reassessment for the 17/19th threshold.
THERAPY REASSESSMENT

Revised therapy reassessment FAQs
http://www.cms.gov/Center/Provider-Type/Home-Health-Agency-HHA-Center.html

ADDITIONAL CLAIMS DATA

Effective JULY 1, 2013

Place of service code
- Q5001: Hospice or home health care provided in patient’s home/residence
- Q5002: Hospice or home health care provided in assisted living facility
  - Licensed facilities?
- Q5009: Hospice or home health care provided in place not otherwise specified (NO)
ADDITIONAL CLAIMS DATA

- Report changes / additions to the POC
  
  “HHAs must report when there are changes/additions to the plan of care by a physician other than the certifying physician. HHAs must use a modifier to indicate changes/additions to the plan of care by a physician other than the certifying physician.....”

- Certifying physician or physician who signs the POC?
- Any change in the POC or only additional visits?
- Will agencies be able to comply by July 1, 2013?

PECOS

- ACA and regulation requires all home health certifying and ordering physicians be enrolled in Medicare
- Medicare requires an approved enrollment record in PECOS
- Physician name and NPI as they appear in PECOS on the claim
- Edits will be activated May 1, 2013
- Claims with a “From” date on or after May 1 will be subject to the edit.
- Claims will be denied

PECOS

**Outstanding issues**

- Certifying physician is the physician to be listed on the claim
  - Impact on Inpatient and community physicians
- RAPs will be subjected to edit
  - RAPS can’t be denied
- Edit to be applied to dates of service
  - Must the physician be enrolled in PECOS on the date of the orders, the date of the certification, or the first visit date? Or will the edits be applied based whether the physician is in PECOS on the date of the submission of the RAP/Claim
- Accuracy of the data base
  - Over 20,000 physicians in pending status
  - # of physicians enrolled in Medicare but not in PECOS
PECOS

- physician terminates enrollment before the end of an episode

- *Federal Register* states that RAPS and final claims may be cancelled, corrected and resubmitted... is this true?

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PECOS

Check "ordering referring report "
https://www.cms.gov/MedicareProviderSupEnroll/06_MedicareOrdering
andReferring.asp#TopOfPage

- Listed by physician name and last four digits of the NPI
- Updated weekly

MLM article

http://www.cms.gov/Outreach-and-Education/Medicare-Learning-
Network-MLN/MLNMattersArticles/Downloads/SE1305.pdf
ALTERNATIVE SANCTIONS

- April 1, 1989 deadline for implementation under the law
- Medicare issue a proposed rule on August 2, 1991
- OIG issued report on Medicare's failure to promulgate intermediate sanction consistent with OBRA 1987 law on March 2, 2012

ALTERNATIVE SANCTIONS

Applies to condition level deficiencies
  ▪ In lieu of termination

Sanctions include:
  ▪ Temporary management of the HHA
  ▪ Suspension of payment for new admissions
  ▪ Civil money penalties
    ▪ $500-$10,000 Per diem/per instance
  ▪ Directed plan of correction
  ▪ Directed in-service training

Informal dispute resolution possible

Appeal rights w/o penalty suspension
ALTERNATIVE SANCTIONS

The basis for choice of sanctions will be based on:
(a) The extent to which the deficiencies pose immediate jeopardy
(b) The nature, incidence, manner, degree, and duration of the
(c) The presence of repeat deficiencies and compliance history.
(d) The extent to which the deficiencies are related to failure to
   provide quality care.
(e) The extent to which the HHA is part of a larger organization with
   performance problems.

Immediate Jeopardy
- CMS takes immediate action to remove the jeopardy and
  correct the deficiency
  - Sanctions and/or termination
- 2 day notice (except CMPs)
- Termination unless deficiency resolved within 23 days of
  survey
- Termination “no later than “ 23 days after survey
- If terminated, patients must be transferred w/in 30 days
In 2011, there were 11 IJ terminations out of 5500 surveys
ALTERNATIVE SANCTIONS

Condition-Level Deficiencies w/o Immediate Jeopardy
- 15 day notice of sanctions
- Termination and sanctions can be combined
- Sanctions continue until compliance or termination
- 6 month termination cycle
- Patient transfers w/in 30 days of termination

ALTERNATIVE SANCTIONS

Problems
- Limited insight as to which sanction(s) and how many would be imposed
- Lack of clarity of effective date of sanctions
- Failure to discuss the protracted time it now takes for surveyors to conduct a revisit when an agency has condition level deficiencies
- Interpretive guidance to be developed
ALTERNATIVE SANCTIONS

July 1, 2013
- Directed plan of correction
  - CMS directs the HHA on specific actions and outcomes to achieve within specific time frames
- Directed in-service training
  - HHA training by a CMS or stated approved entity
  - Agency responsible for all associated costs
- Temporary management
  - CMS approved entity
  - Agency responsible for all associated costs

July 1, 2014
- Civil money penalties
- Suspension of payment for new admissions
- Informal dispute resolution

HHABN

Under revision
- No change in policy

ABN CMS-131 for financial liability protection
- Replaces Option Box 1

Home Health Change of Care Notice (HHCCN)
- prior to reducing or discontinuing care related HHA reasons
- Prior to reducing or discontinuing care related to physician orders
- New form replaces Option BOX 2 and Option Box 3
HOME HEALTH NATIONAL QUALITY IMPROVEMENT CAMPAIGN

CMS Funded
West Virginia Medical Institute
http://www.homehealthquality.org/
- Education
- Networking
- Data Support
- Best Practice Packages