Minimizing Denials: Practicing Effective Home Care Compliance

Objectives:
- Recognize critical role of home health managers in agency compliance
- Apply practical tips for day to day management of compliance effectiveness
- Review effective approach for monitoring denials and filing appeals

Background
- Additional documentation requirements including Therapy Re-assessments and Face to Face documentation
- Need to document to the Coverage Criteria - Chapter 7
- Quality Assurance / Compliance Verification Process required
Background

- Federal Deficit, Medicare Growth, and Home Health Profits Concerns
- Increased Scrutiny by MACs, RACs, and ZPICs
- Few ADRs in prior years led to complacency by some Agencies

Risk

- Risk is in the Medical Record – Quality of the documentation of the Clinical Notes, Face to Face, Orders, etc.
- Complete understanding by staff of Skilled Services and Homebound Requirements
- Need to document to the Coverage Criteria – Chapter 7

Risk

- Quality Assurance / Compliance Verification Process required
- Whistle Blower concerns
- Staff turnover without formal processes can lead to breakdown of control systems
**Establish Compliance Monitoring Processes/Tracking**
- Establish documentation controls
- Assign compliance responsibilities to appropriate personnel
- Implement compliance with billing
- Establish tracking of individual personnel & process compliance
- Review tracking to identify compliance trends

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**Work Flow and Process Improvement**
- Compliance requirements include:
  - Marketing
  - Intake and Insurance Verification
  - Admission
  - Visit Documentation
  - Billing

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**Work Flow and Process Improvement**
- Quality Assurance / Compliance Verification Process required
  - Frontload OASIS and Care Plan verification (60%)
  - Clinical Note and Physician Orders and Face to Face (40%)
  - Include compliance items as part of case conference
Work Flow and Process Improvement

- Pre-Billing Audits – Should be done before the claims are sent to billing
- Orientation and ongoing staff training

Prebilling Audit

- Audit 100% of Charts
  - Catch Compliance Issues
  - Catch Issues Associated w/PPS
  - Avoid unnecessary denials
- Who should conduct these audits?
  - Billing or Clerical Staff are sufficient – it is not a clinical audit

Prebilling Audit

- When do we conduct these audits?
  - End of episode – no need to audit prior to end of episode or discharge
- What do you need for audit?
  - Patient Chart
  - Audit Tool
  - Trial Bill (Pre-bill)
**Supplies on Final Claim**

- Billing Medical Supplies
  - Revenue Code 0270 – Non-Routine Medical Supplies – not related to wound care
  - Revenue Code 0623 – All Supplies related to wound care
  - Bill supplies at CHARGES not COST
  - These charges should not include things like enteral nutrition, etc. that can be billed by a medical supply company
  - Supplies should be on list provided by CMS

**NON-ROUTINE SUPPLIES (NRS)**

- Supply Reporting
  - Two reactions:
    - Report the supplies that were overlooked
    - Change the 5th position of the HIPPS code to the corresponding number that says supplies were not provided.
  - Medicare systems will be revised to only use the first 4 positions of the HIPPS code to match final claims to their corresponding RAP

**Monitoring Denials**

- Update contact information and mailing address
- Utilize on-line services to identify ADRs timely
- Monitor RA Edits on website & results of audits
### Recovery Auditor (RA) Edits

**Issue Name:** Hospice related services billed with Condition code 07-0106
- **Home Health:** C000802012

**Description:** Services related to a Hospice terminal diagnosis provided during a Hospice period are included in the Hospice payment and are not paid separately.

- **Provider Type Affected:** Home Health
- **Date of Service:** Within Three Years prior to demand date
- **States Affected:** Region C
- **Additional Information:**
  1. CMS Pub 100-04, Chapter 11, section 504
  2. Medicare Benefit Policy 100-02, Chapter 9, sections 10 and 40.1.9

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### Incorrect Billing of HH PEP

**Issue Name:** Incorrect billing of Home Health Partial Episode Payment claims
- **CMS Issue Number:** C002022011

**Description:** Incorrect billing of Home Health Partial Episode Payment (PEP) claims identified with a discharge status 06 and another home health claim was not billed within 60 days of the claim from date. Additionally, MCO effective dates are not within 60 days of the PEP claim.

- **Provider Type Affected:** HHA
- **Date of Service:** Within Three Years prior to demand date
- **States Affected:** Multiple States
- **Additional Information:**
  "Additional information can be found in the following manuals/publications:

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### RAP without Final

**Issue Name:** RAP claim without corresponding home health claim
- **CMS Issue Number:** C000682011

**Description:** Home health billing requires that the home health agency (HHA) submit a Request for Anticipated Payment (RAP), for determination of home health PPS payment, in addition to a home health final claim. Payment was made in response of the RAP claim bill, with expectation that a home health claim was billed. After data research of Medicare claims database, RAP claims were identified without a corresponding home health final claim.

- **Provider Type Affected:** HHA
- **Date of Service:** Within Three Years prior to demand date
- **States Affected:** Numerous
- **Additional Information:** Additional information can be found in the following manuals/publications:
  1. Medicare Claims Processing Manual Publication 100-04 Chapter 10 Home Health Agency Billing
  2. Medicare Benefit Policy Manual Chapter 7 - Home Health Services
Possible LUPAs

**Issue Name:** Home Health Services for 5 to 9 Visits: D0004220103

**Description:** Medical documentation will be reviewed to determine that services for only 5 to 9 services within a 60-day episode were medically reasonable and necessary and not subject to the LUPA adjustment.

**Provider Type Affected:** HHA

**Date of Service:** Within Three Years prior to demand date

**States Affected:** Numerous

**Additional Information:**
- CMS Publication 100-02 Medicare Benefit Policy Manual: Chapter 7, Section 10.7 - Low Utilization Payment Adjustment (LUPA)
- Chapter 7, Section 20 - Conditions To Be Met for Coverage of Home Health Services
- Chapter 7, Section 20.1 - Reasonable and Necessary Services
- Chapter 7, Section 40.1 - Skilled Nursing Care
- CMS Publication 100-04 Medicare Claims Processing Manual: Chapter 10, Section 10.1.17 - Low Utilization Payment Adjustment (LUPA)
- Social Security Act: 1862A(1)a and 1862A(1)i - Exclusions from Coverage and Medicare as Secondary Payer (42 U.S.C. 1395y)

Filing Appeals

- Requires coordinated effort to avoid missing response deadlines
- Consider obtaining outside review if expertise in not available in house
- Utilize MAC information on submitting responses

Take Home Tools

- Home Health Billing Compliance Audit Tool
- Face to Face Compliance Checklist used by Palmetto GBA for their ADR process
Questions and Answers

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Home Health Face to Face Checklist

General:
- □ Is the face to face document labeled and dated?
- □ Is it performed within the time frame (90 days before - 30 days after)?
- □ Is it legible?
- □ Is it signed and dated prior to the submission of the claim for billing?
- □ Does it contain the date of the encounter?

Clinical Findings:
- □ Does it describe the patient's condition and symptoms, not just a list of diagnoses?
- □ Is this a new problem or an exacerbation of a previous problem?

If this is a post operative patient:
- □ How long ago was the surgery?
- □ Were there any complications?
- □ If pain is documented, how severe is the pain?

Skill Need:
- □ Is there evidence that skilled Physical Therapy (PT) is needed? (Note this is not an all-inclusive list.)
  - □ Assessment of functional deficits and home safety evaluation
  - □ Therapeutic Exercises
  - □ Restore joint function for post joint replacement patient
  - □ Gait Training
  - □ ADL Training
- □ Is there evidence that Speech Therapy is needed? (Note this is not an all-inclusive list.)
  - □ Therapeutic exercise to improve swallowing
  - □ Therapeutic exercise to improve language function
  - □ Therapeutic exercise to improve cognitive function
- □ Is there evidence that Nursing is needed? (Note this is not an all-inclusive list.)
  - □ Assessment and observation for
  - □ Teaching and training for
  - □ Complex wound assessment and care
  - □ Management of new/changed medications
  - □ Direct nursing care for
Homebound Status:

☐ Description is not limited to weakness, considerable and taxing effort, poor endurance

☐ Does it contain a description of the patient's condition and symptoms, not just a diagnosis and not just the need for an assistive device?

If shortness of breath is applicable, describe the severity (severe at rest, with minimal exertion, etc.)

Weakness as evidence by: 

☐ Does the patient exhibit symptoms when attempting to walk (increase pain, shortness of breath, etc.)

The patient has medically restricted the patient to the home due to: 

☐ Patient is homebound due to a psychiatric condition/symptoms
# Home Health Billing Compliance Audit Tool

## Admission Forms and Insurance Verification

<table>
<thead>
<tr>
<th>Audit Indicator</th>
<th>Findings</th>
<th>Action Steps</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Required Consents/Financial Agreements Signed &amp; Dated</td>
<td></td>
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<tr>
<td>2 Insurance Coverage Verified</td>
<td></td>
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<tr>
<td>3 PECOS verified for Physician</td>
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<td></td>
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<tr>
<td>4 Prior Authorization Obtained</td>
<td></td>
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</tbody>
</table>

## Physician Orders

<table>
<thead>
<tr>
<th>Audit Indicator</th>
<th>Findings</th>
<th>Action Steps</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 Verbal Order on POC/485 is Signed &amp; Dated</td>
<td></td>
<td></td>
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<tr>
<td>6 POC/485 is Complete (Goals, Interventions)</td>
<td></td>
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<tr>
<td>7 Interim/Supplemental Orders are Complete</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>8 All Orders are Complete and Signed prior to Final Claim submission</td>
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<tr>
<td>8a POC/485 is Signed by the Physician</td>
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<tr>
<td>8b POC/485 is Dated by the Physician</td>
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<tr>
<td>8c Interim/Supplemental Orders are Signed by the Physician</td>
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<td></td>
</tr>
<tr>
<td>8d Interim/Supplemental Orders are Dated by the Physician</td>
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</tbody>
</table>

## Face to Face (F2F) Encounter

<table>
<thead>
<tr>
<th>Audit Indicator</th>
<th>Findings</th>
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</thead>
<tbody>
<tr>
<td>9 Physician F2F Narrative documentation includes the required elements:</td>
<td></td>
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<tr>
<td>9a Timing: within 90 days prior to SOC or within 30 days after SOC</td>
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<tr>
<td>9b Separate, distinct and clearly titled section or addendum to the 485/POC</td>
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<tr>
<td>9c Date of in person visit by certifying physician or NPP</td>
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<tr>
<td>9d F2F is signed by certifying physician</td>
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<tr>
<td>9e F2F is dated by certifying physician</td>
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<tr>
<td>Certified physician documents clinical findings that include the following:</td>
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<tr>
<td>9f Related to primary reason for home care</td>
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<tr>
<td>Patient is homebound</td>
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<tr>
<td>Patient’s medical condition requires Medicare covered home health services</td>
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## OASIS Assessment

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<th>Action Steps</th>
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<tbody>
<tr>
<td>10 ICD-9 Codes are Supported in Documentation &amp; Comply with Coding Regulations</td>
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<tr>
<td>11 Diagnosis Codes are Consistent on OASIS, POC, &amp; Claim</td>
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<tr>
<td>12 HHRG Related M0 Answers are Supported in Documentation</td>
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## Visit Notes and Therapy Re-assessment Documentation

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<thead>
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<tbody>
<tr>
<td>13 Orders Cover Visits Billed</td>
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<tr>
<td>14 Visits Billed Equal Visits Documented</td>
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<tr>
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<tbody>
<tr>
<td>SN Ordered</td>
<td>Documented</td>
<td>Billed</td>
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<td>PT</td>
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<td>OT</td>
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<td>SP</td>
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<td>MSS</td>
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<td>HHA</td>
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## Payment

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<tr>
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</thead>
<tbody>
<tr>
<td>15 Visit Notes Reflect Medical Necessity of Skilled Care</td>
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<tr>
<td>16 Therapy: Services are Reasonable &amp; Necessary to the treatment of the Patient’s illness or injury or to the restoration or maintenance of function affected by the patients illness or injury</td>
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<tr>
<td>17 Documentation supports the Patient Meets Homebound Eligability Requirements</td>
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</tr>
<tr>
<td>18 Qualifying Services met for OT, MSS &amp; HHA</td>
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<table>
<thead>
<tr>
<th>Audit Indicator</th>
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<tbody>
<tr>
<td>Anticipated Payment Amount</td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>RAP Payment</td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>Final Payment</td>
<td></td>
<td></td>
<td>$</td>
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<tr>
<td>Total Payment with change explained</td>
<td></td>
<td></td>
<td>$</td>
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