Reimbursement Challenges

Melinda A. Gaboury - Healthcare Provider Solutions, Inc.
2015 Proposed Regulation

- 2015 Home Health Prospective Payment System rates that reduce rates under the 4-year rebasing
- Face-to-Face Physician Encounter rule modifications including the elimination of the physician narrative requirement
- Significant change to the requirement for professional therapy reassessments, dropping the 13th and 19th visit requirements and instituting a 14 day reassessment standard

2015 Proposed Regulation

- A new numerical standard for the submission of OASIS to avoid payment rate reductions
- Modifications of the standards for qualification of speech-language pathologists under the CoPs
- The introduction of possible new, restrictive coverage standards on the administration of insulin injections
2015 Proposed Regulation

- The unveiling of a likely model for Value Based Purchasing that would be mandatory in 5-8 undesignated states
- Clarifications of the requirements for imposition of alternative Civil Money Penalty sanctions for CoP violations
- Changes to recertification requirements

FINAL 2013 Payment Rates Home Health

- Base rate of $2,137.73 (decrease from $2,138.52)
  - 2.3% Market Basket Increase (MBI) (2.5 was proposed)
  - 1 point reduction (Affordable Care Act Mandate)
  - 1.32% case mix weight change adjustment in 2013
- Labor Rate Increase from 77.082 to 78.535 percent changing the non-labor rate from 22.918 to 21.465 (good for agencies whose wage index is 1.0 or greater)

- 2% sequestration deduction in 2013 as a result of the deficit reduction law did go into effect on April 2013 – All episodes ending April 1, 2013 and later. No word on whether or not this will be renewed in 2014.
FINAL 2014 Payment Rates Home Health

Base rate of $2,869.27 (increase from $2,137.73 -- 2013)

- CMS FINALIZED rebasing changes are the most complex factor of the new rule. As stated in the regulation: “rebasing must be phased-in over a four-year period in equal increments.” Starting with the 2014 HHPPS rule, CMS has chosen to begin this four-year process with a -3.45% rebasing adjustment in 2014. This 3.45% reduction is based on CMS projection of an average home health margin of 13.09% in 2013 (the difference between the average national episode revenue in home health and the average national episode cost) using 2011 Cost Report Data. This data appears to be skewed and is under intense review.

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Case Mix Weight - Final Changes 2014

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Low Utilization Payment Adjustment (LUPA)

- 4 or fewer visits in a 60 day episode
- Paid on the National Standardized per Visit rate (wage adjusted for your CBSA)
- Doesn’t require a RAP
- Has less than $2.00 per Episode built into rates for Non-Routine Supplies.

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**LUPA Add-On Calculation**

THIS AMOUNT SHOULD BE THE AMOUNT PAID FOR THE DISCIPLINES BELOW FOR AN INITIAL VISIT IN AN EPISODE THAT IS A START OF CARE EPISODE FOR THE AGENCY AND IS CONSIDERED TO BE FIRST IN A SERIES OF ADJACENT EPISODE OR THE ONLY EPISODE FOR THE PATIENT

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CBSA: 35380 .8752

LUPA Calculation

- **HHRG = C1F2S2 (6 therapy)** 1<sup>st</sup> Episode = 3<sup>rd</sup> NRS Level = $2,384.04
- Patient receives 1 SN & 2 HHA visits in episode
- Payment =
  - SN - $109.23 per visit = $109.23
  - SN - $201.54 (due to add-on)
  - HHA - $49.47 per visit x 2 visits = $98.94
  - Payment before Add-on = $208.17
  - $300.48
- If 5 visits had been provided the payment would have been the full amount.
**Occupational Therapy Clarification**

In response to the commenter who requested further clarification regarding when occupational therapy must be followed by a skilled nursing, physician therapy, or speech therapy service, we clarify that the initial occupational therapy service must be followed by another qualifying service to be covered. Subsequent occupational therapy services, however, do not require another qualifying service to follow them. Specifically, we are clarifying that once a beneficiary’s eligibility for home health services has been established by virtue of a prior need for an intermittent skilled service (that is, skilled nursing care, physical therapy, or speech language pathology therapy), and the beneficiary also meets each of the criteria specified in §409.44(c), the first occupational therapy service provided to the patient is considered a dependent service.

**Therapy Clarifications**

- **EFFECTIVE DATE APRIL 1, 2011**

- Requires that:
  - Qualified therapist assess, establish goals and reassess patient
  - Measurable treatment goals be described:
    - Plan of care
    - Clinical record
  - Methods used to assess a patient’s function include:
    - Objective measurement
    - Successive comparison of measurements
  - There must be objective measurement of progress toward goals and/or therapy effectiveness.
Therapy Clarifications

- Documentation requirements
  - Evaluation and goals
  - Describe correlation between
    - Treatment for illness/injury to professional standards
    - Measurable goal related to illness/injury
  - Objective measures of function (e.g. swallow, bathing, dressing, walking, stairs, use of devices)

Therapy Clarifications

- Professional (qualified) therapist assessment
  - Functional assessment for therapy provided by qualified therapist from EACH discipline
  - Documentation
    - Results of therapy
    - Effectiveness of (or lack of) therapy

- Qualified therapist (vs. assistant) visits to functionally assess and treat
  - At least every 30 days by each discipline, and
  - On 13th and 19th visit
### Orders = PT2w1, 3w2, 2w2

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The following is effective for all episodes BEGINNING 1/1/2013 and later:

- CMS finalized that if a qualified therapist missed a reassessment visit, therapy coverage would resume with the visit during which the qualified therapist completed the late reassessment, not the visit after the therapist completed late reassessment.
- CMS finalized that if multiple therapy disciplines are involved, if the required reassessment visit was missed for any one of the therapy disciplines for which therapy services were being provided, therapy coverage would cease only for that particular therapy discipline.
- CMS finalized to revise the assessment timing for individuals receiving more than one type of therapy. The reassessment could occur during the 11th, 12th, or 13th visit for the required 13th visit reassessment and on the 17th, 18th, or 19th visit for the required 19th visit reassessment.

Final Claim - Form Locators

- FL76**- NPI for physician

Medicare allows a physician (such as a hospitalist) who attends to hospitalized patients, but does not follow them into the community to:

1) Certify the need for home health care based on their face to face contact with patients in the hospital;
2) Initiate the orders and a plan of care for home health services, and
3) “hand off” the patients to their community-based physicians to review and sign the plan of care.
Reporting Physician on Claim

- CR 8441, requires that, for claims with episodes that begin on or after July 1, 2014, home health agencies (HHA) must:
  - Report the National Provider Identifier (NPI) and name of the physician who certifies/re-certifies the patient's eligibility for home health services, if this physician is different than the physician who signs the patient's plan of care ("attending physician"); and
  - Continue to report the NPI and name of the physician who signs the patient's plan of care.

Questions
AN OVERVIEW

NAHC Financial Management Conference & Exposition

Pre-Conference 2 - 701
Home Health Summer Camp 2014

Sunday, July 13, 2014

Thomas E Boyd
Vice President of Reimbursable Services
Simione Healthcare Consultants

How to Best Use the Medicare Cost Report as a Management Resource Tool

Interpret the proven techniques for maximizing the Medicare cost report as a financial management tool.
Overview of Flow of Cost Report

Why is proper cost reporting important?
What is the intent of the cost report

Information is submitted annually to the Medicare Contractor (MAC) for settlement of costs relating to health care services rendered to Medicare beneficiaries.
Avoid a false claim act

Cost Report Certification

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ______________________(Provider Name(s) and Number(s)) for the cost reporting period beginning __________________________ and ending __________________________ and that to the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services and that the services identified in this cost report were provided in compliance with such laws and regulations.
Cost Report Certification

I further certify that I am familiar with the laws and regulations regarding the provision of health care services and that the services identified in this cost report were provided in compliance with such laws and regulations.

Reimbursement rules have not changed, only the payment methodology!

RULES
1. YOU CAN....
2. YOU CAN'T...
ZPIC REQUESTS COST REPORT INFORMATION FROM HOME HEALTH AGENCY

Rebasing the Rates

- Required by Affordable Care Act
- Adjust payment rates to reflect average cost of episodes today
  - Phased in over a four-year period beginning in 2014
  - Max cut of 3.5% per year (14% total)
- Used 2011 Medicare costs to arrive at costs
  - Could only use 6,252 out of 10,327 after “trimming”
  - Audited 98 cost reports from 2010 to assess accuracy
    - Suggest costs overstated by 8%
    - Eight agencies were turned over to ZPICS
# Impact of PPACA rebasing on payments for 60-day episodes

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**Note:** PPACA (Patient Protection and Affordable Care Act of 2010). Data are based on 2013 third-quarter forecast of home health market basket. Annual and cumulative impacts of payment changes are multiplicative. Data do not include impact reduction in 2014 due to changes to the home health grouper.

**Source:** MedPAC analysis based on data from CMS.
# Medicare margins for freestanding home health agencies

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MedPAC March 2014
Medicare margins for freestanding home health agencies

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MedPAC March 2014

Preparation of the HHA Medicare Cost Report

WHO HAS TO FILE?

➢ Medicare Certified:
  ✓ Provider-Based
  ✓ Freestanding
  ✓ Is an LMU for you?
Home Health and Hospice (HH+H) Jurisdictions (Administered by A/B MACs) as of October 2013

NGS J6 - Puerto Rico and US Virgin Islands

NGS J6 - Alaska, American Samoa, Guam, Hawaii, and Northern Mariana Islands

Medicare Contractors

CGS SM, LLC –
www.cgsmedicare.com

National Government Services –
www.NGSMedicare.com

Palmetto GBA (PGBA) –
www.palmettogba.com/medicare
Cost reporting is sloppy

Preparation of the HHA Medicare Cost Report

1. Deadlines
2. Rejection
3. ECR Disks
4. Software
5. Signature
6. Medicaid
7. PS&R
What is to be filed with the cost report?

- Financial Statements (Internal)
  Audit / Review / Compilation

- Working Trial Balance
  Should be sufficient in detail to facilitate crosswalk from trial balance to Medicare cost report

- Supporting schedules for reclasses and adjustments

- CMS Form 339

- Original signatures (blue ink)

Cost Report Software

- Health Financial Systems  [www.hfssoft.com](http://www.hfssoft.com)
- KPMG  [www.KPMG.com](http://www.KPMG.com)
- Manis & Ryan  [www.manisandryan.com](http://www.manisandryan.com)
- Optimizer Systems  [www.optimizer.com](http://www.optimizer.com)
- Progressive Provider Services of Colorado  [www.ppsassistant.com](http://www.ppsassistant.com)
CMS Form 339 Questionnaire
Sections that apply to Home Health

A. Provider organization and operation
B. Financial data and reports
E. Approved education activities
I. Medicare bad debts
J. Bed complement
K. PS&R data

Uniform Chart of Accounts

The Uniform Chart of Accounts provides for all product lines that are to be included under Home Care and Hospice.

Also included suggested formats for Hospice, Private Duty, Pharmacy and Infusion Therapy.

Updated: HHFMA - Chart of Accounts with Account Explanations

http://www.hhfma.org/Accounts.htm
§ 2302.1 Accrual Basis of Accounting

Under the accrual basis of accounting, revenue is recorded in the period when it is earned, regardless of when it is collected, and expenditures for expense and asset items are recorded in the period in which they are incurred, regardless of when they are paid. Section 2305ff sets forth special rules regarding recognition of expenses under the Medicare program relating to liquidation of liabilities.

Provider Reimbursement Manual (CMS-Pub. 15-1)

Medical Supplies
Routine vs. Non Routine

Routine (non billable) (line 5)
- Small quantities – not patient specific

Non Routine (billable) (line 12)
- Patient specific illness or injury
- Separately identifiable in patient records (POC)
- Must be ordered by the physician
- Separate charge

Notes: All payments for Medicare PPS episodes includes NRS Add-On
Many agencies still not billing for NRS
Examples of Non Routine Medical Supplies

- Dressings / Wound Care
- I.V. Supplies
- Ostomy Supplies
- Catheter and Catheter Supplies
- Syringes and Needles

Consolidated Billing List
http://www.cms.gov/HomeHealthPPS/03_coding_billing.asp

Links

Provider Reimbursement Manual (PRM 15-1)

Medicare Cost Report Forms and Instructions (PRM 15-2)

CMS Form 339 – Chapter 11

Home Health CMS Form 1728-94 – Chapter 32

Freedom of Information Act

Management information
Management Use of Cost Report

The MCR is NOT just a “compliance” requirement that must be filed with CMS but can be a valuable tool to assist in budgeting, pricing and strategic analysis.

When looking at total cost, you should add back non allowable expenses (marketing, donations, etc.)

Management Use of Cost Report

✓ Direct and indirect costs by discipline (per hour and per visit)
✓ Fixed and variable costs
✓ Non-routine medical supplies
✓ Cost per episode / Medicare margin
✓ Cost, revenue and margin by payer
✓ Service utilization per episode
The Medicare Cost Report can be used for Benchmarking Data

A COMPLETED AND ACCURATE MEDICARE COST REPORT will permit an organization to benchmark their PPS data against the information provided by their prior history and the cost reports for the nation and for their state.

Direct Cost Per Visit

<table>
<thead>
<tr>
<th></th>
<th>2012</th>
<th>2011</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>SN</td>
<td>$59.31</td>
<td>$50.70</td>
<td>$51.94</td>
</tr>
<tr>
<td>PT</td>
<td>$86.47</td>
<td>$81.56</td>
<td>$67.77</td>
</tr>
<tr>
<td>OT</td>
<td>$80.69</td>
<td>$73.45</td>
<td>$59.44</td>
</tr>
<tr>
<td>ST</td>
<td>$110.64</td>
<td>$97.42</td>
<td>$72.84</td>
</tr>
<tr>
<td>MSW</td>
<td>$85.54</td>
<td>$75.98</td>
<td>$53.66</td>
</tr>
<tr>
<td>HHA</td>
<td>$26.42</td>
<td>$23.77</td>
<td>$21.63</td>
</tr>
</tbody>
</table>

Salaries of worksheet A, column 1, lines 6-11, divided by the visits of worksheet S-3 Part 1, column 5, lines 1-6
## Computation of Cost per Visit

<table>
<thead>
<tr>
<th></th>
<th>Direct</th>
<th>Indirect</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>SNC</td>
<td>$ 59.31</td>
<td>$ 54.34</td>
<td>$ 113.65</td>
</tr>
<tr>
<td>PT</td>
<td>$ 86.47</td>
<td>$ 79.23</td>
<td>$ 165.70</td>
</tr>
<tr>
<td>OT</td>
<td>$ 80.69</td>
<td>$ 73.93</td>
<td>$ 154.62</td>
</tr>
<tr>
<td>ST</td>
<td>$ 110.64</td>
<td>$ 101.37</td>
<td>$ 212.01</td>
</tr>
<tr>
<td>MSW</td>
<td>$ 85.54</td>
<td>$ 78.36</td>
<td>$ 163.90</td>
</tr>
<tr>
<td>HHA</td>
<td>$ 26.42</td>
<td>$ 24.21</td>
<td>$ 50.63</td>
</tr>
</tbody>
</table>

## Total Cost Per Visit

<table>
<thead>
<tr>
<th></th>
<th>2012</th>
<th>2011</th>
<th>2010</th>
<th>Nevada</th>
<th>National</th>
</tr>
</thead>
<tbody>
<tr>
<td>SN</td>
<td>$ 113.65</td>
<td>$ 116.44</td>
<td>$ 123.33</td>
<td>$ 147.38</td>
<td>$ 130.81</td>
</tr>
<tr>
<td>PT</td>
<td>$ 165.70</td>
<td>$ 187.34</td>
<td>$ 160.90</td>
<td>$ 193.70</td>
<td>$ 137.11</td>
</tr>
<tr>
<td>OT</td>
<td>$ 154.62</td>
<td>$ 168.72</td>
<td>$ 141.13</td>
<td>$ 180.60</td>
<td>$ 135.22</td>
</tr>
<tr>
<td>ST</td>
<td>$ 212.01</td>
<td>$ 223.77</td>
<td>$ 172.95</td>
<td>$ 198.97</td>
<td>$ 147.80</td>
</tr>
<tr>
<td>MSW</td>
<td>$ 163.90</td>
<td>$ 174.51</td>
<td>$ 127.41</td>
<td>$ 209.35</td>
<td>$ 201.54</td>
</tr>
<tr>
<td>HHA</td>
<td>$ 50.63</td>
<td>$ 54.59</td>
<td>$ 51.37</td>
<td>$ 78.50</td>
<td>$ 60.71</td>
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</table>

Worksheet C, Part 1, column 4, lines 1-6
### Statistics – Average Visits Per Episode

<table>
<thead>
<tr>
<th></th>
<th>2012</th>
<th>2011</th>
<th>2010</th>
<th>Nevada</th>
<th>National</th>
</tr>
</thead>
<tbody>
<tr>
<td>SN</td>
<td>11.12</td>
<td>11.58</td>
<td>11.51</td>
<td>9.8</td>
<td>9.9</td>
</tr>
<tr>
<td>PT</td>
<td>4.18</td>
<td>4.18</td>
<td>3.07</td>
<td>3.2</td>
<td>4.1</td>
</tr>
<tr>
<td>OT</td>
<td>1.35</td>
<td>1.35</td>
<td>0.98</td>
<td>0.8</td>
<td>0.7</td>
</tr>
<tr>
<td>ST</td>
<td>0.17</td>
<td>0.04</td>
<td>0.07</td>
<td>0.1</td>
<td>0.1</td>
</tr>
<tr>
<td>MSW</td>
<td>0.23</td>
<td>0.24</td>
<td>0.21</td>
<td>0.2</td>
<td>0.1</td>
</tr>
<tr>
<td>HHA</td>
<td>2.57</td>
<td>2.44</td>
<td>2.6</td>
<td>2.7</td>
<td>3.9</td>
</tr>
</tbody>
</table>

Worksheet S-3 Part IV, visits column 7, divided by total episodes of lines 45 & 46 column 7

---

### Visits Per Full Episode

<table>
<thead>
<tr>
<th></th>
<th>2012</th>
<th>2011</th>
<th>2010</th>
<th>Nevada</th>
<th>National</th>
</tr>
</thead>
<tbody>
<tr>
<td>SN</td>
<td>10.49</td>
<td>10.50</td>
<td>10.41</td>
<td>8.40</td>
<td>8.30</td>
</tr>
<tr>
<td>PT</td>
<td>4.67</td>
<td>4.62</td>
<td>4.14</td>
<td>3.60</td>
<td>4.70</td>
</tr>
<tr>
<td>OT</td>
<td>1.47</td>
<td>1.47</td>
<td>1.07</td>
<td>0.90</td>
<td>0.80</td>
</tr>
<tr>
<td>ST</td>
<td>0.16</td>
<td>0.05</td>
<td>0.08</td>
<td>0.10</td>
<td>0.10</td>
</tr>
<tr>
<td>MSW</td>
<td>0.25</td>
<td>0.26</td>
<td>0.22</td>
<td>0.20</td>
<td>0.20</td>
</tr>
<tr>
<td>HHA</td>
<td>2.83</td>
<td>2.61</td>
<td>2.77</td>
<td>3.00</td>
<td>4.10</td>
</tr>
<tr>
<td>Total</td>
<td>19.87</td>
<td>19.50</td>
<td>18.69</td>
<td>16.10</td>
<td>18.20</td>
</tr>
</tbody>
</table>

Worksheet S-3 Part IV
visits column 1 divided by total episodes column 1 line 45
### Episode By Type

<table>
<thead>
<tr>
<th></th>
<th>Full w/o Outliers</th>
<th>Full with Outliers</th>
<th>LUPA</th>
<th>PEP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your Agency</td>
<td>84.83%</td>
<td>3.27%</td>
<td>8.97%</td>
<td>2.65%</td>
</tr>
<tr>
<td>Nevada</td>
<td>82.91%</td>
<td>3.22%</td>
<td>10.24%</td>
<td>2.71%</td>
</tr>
<tr>
<td>National</td>
<td>80.59%</td>
<td>4.00%</td>
<td>11.38%</td>
<td>2.29%</td>
</tr>
</tbody>
</table>

### Average Per Episode

<table>
<thead>
<tr>
<th></th>
<th>2012</th>
<th>2011</th>
<th>2010</th>
<th>Nevada</th>
<th>National</th>
</tr>
</thead>
<tbody>
<tr>
<td>Revenue</td>
<td>$3,095.84</td>
<td>$3,138.47</td>
<td>$2,734.15</td>
<td>$2,764.84</td>
<td>$2,527.78</td>
</tr>
<tr>
<td>Cost</td>
<td>$2,369.85</td>
<td>$2,544.17</td>
<td>$2,326.04</td>
<td>$2,149.91</td>
<td>$2,007.20</td>
</tr>
<tr>
<td>Profit</td>
<td>$725.99</td>
<td>$594.30</td>
<td>$408.11</td>
<td>$614.93</td>
<td>$520.58</td>
</tr>
<tr>
<td>Visits</td>
<td>19.63</td>
<td>19.83</td>
<td>19.07</td>
<td>16.70</td>
<td>19.00</td>
</tr>
</tbody>
</table>
Payment Per Full Episode

<table>
<thead>
<tr>
<th></th>
<th>2012</th>
<th>2011</th>
<th>2010</th>
<th>Nevada</th>
<th>National</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$ 3,382.38</td>
<td>$ 3,366.64</td>
<td>$ 2,967.26</td>
<td>$ 3,009.68</td>
<td>$ 2,752.65</td>
</tr>
</tbody>
</table>

Worksheet D Part II line 12.01, total of columns 1 & 2 divided by Worksheet S-3 Part IV, column 1 line 45

Cost Report Indicators

<table>
<thead>
<tr>
<th>Profit By Episode Type</th>
<th>Full w/o Outliers</th>
<th>Full with Outliers</th>
<th>LUPA</th>
<th>PEP</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Revenue</td>
<td>$600,270</td>
<td>$26,195</td>
<td>$14,789</td>
<td>$8,353</td>
<td>$649,607</td>
</tr>
<tr>
<td>Cost</td>
<td>$444,324</td>
<td>$35,096</td>
<td>$12,822</td>
<td>$5,755</td>
<td>$497,997</td>
</tr>
<tr>
<td>Profit</td>
<td>$155,946</td>
<td>($8,901)</td>
<td>$1,967</td>
<td>$2,598</td>
<td>$151,610</td>
</tr>
</tbody>
</table>
### Cost Report Indicators

#### Cost Analysis

<table>
<thead>
<tr>
<th>Category</th>
<th>Amount</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capital</td>
<td>$55,500</td>
<td></td>
</tr>
<tr>
<td>Plant Operation / Maint</td>
<td>$10,400</td>
<td></td>
</tr>
<tr>
<td>Administration</td>
<td>$464,218</td>
<td>26.48%</td>
</tr>
<tr>
<td>Total Overhead Costs</td>
<td>$530,118</td>
<td>30.24%</td>
</tr>
<tr>
<td>Direct Costs</td>
<td>$1,222,646</td>
<td>69.76%</td>
</tr>
<tr>
<td>Total Costs</td>
<td>$1,752,764</td>
<td></td>
</tr>
<tr>
<td>Total Patient Revenue</td>
<td>$1,809,392</td>
<td></td>
</tr>
<tr>
<td>Admin Costs as % of Revenue</td>
<td>25.66%</td>
<td></td>
</tr>
</tbody>
</table>

All Costs from Worksheet A Column 10

### Medicare Profit Margin

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare PPS Reimbursement</td>
<td>$649,607</td>
</tr>
<tr>
<td>Medicare PPS Cost</td>
<td></td>
</tr>
<tr>
<td>Visit Cost</td>
<td>$491,437</td>
</tr>
<tr>
<td>NRS Cost</td>
<td>$6,560</td>
</tr>
<tr>
<td>Total Cost</td>
<td>$497,997</td>
</tr>
<tr>
<td>Medicare Profit Margin</td>
<td>$151,610</td>
</tr>
<tr>
<td>Medicare Margin %</td>
<td>23.3%</td>
</tr>
</tbody>
</table>

PPS reimbursement from Worksheet B Part II total of lines 28 columns 1 & 2
PPS costs from Worksheet C Part IV line 19 column 6
NAHC has compiled the data from over 12,000 HHA Medicare Cost Reports.

The information, existing by state and national averages, can be used to benchmark information vital to the organization.

**NAHC Cost Report Data Compendium (All States)**

**Item Number:** M-083, **All States**

The NAHC COST REPORT DATA COMPENDIUM is an in-depth analysis of Medicare cost reports filed by home health agencies since the beginning of the HH PPS payment system in October 2000. NAHC has acquired over 20,000 filed cost reports to develop this Compendium. Cost reports contain a wealth of data. For purposes of this compendium, NAHC used data on per unit costs, supply costs, service utilization, and Medicare PPS episodes. In addition, overall HHA cost and revenue data is used to calculate overall financial margins. The geographic location of the HHA and its categorizations also is utilized. The Compendium is a valuable tool for providers of services, consultants, health policy planners, home care advocates, investors, and trade associations looking to gain an understanding of the financial status of home health agencies.
Preparation of the HHA Medicare Cost Report

NAHC Cost Report Data

Cost & Revenue Trends by State and Year 2001 – 2012
   All Cost Reports
   Free Standing
   Hospital Based

Cost & Revenue Trends by Year
   All Cost Reports
   Free Standing
   Hospital Based

Preparation of the HHA Medicare Cost Report

NAHC Cost Report Data

- Revenues & Expenses – National Summary
  - All Cost Reports
  - Free-Standing
  - Free-Standing Rural
  - Free-Standing Urban
Preparation of the HHA Medicare Cost Report

NAHC Cost Report Data

- Revenue & Expenses
- Categorized Profit Margins – National
- Categorized Profit Margins – by State
- State Profit Margin Summary
- National Profit Margin Detail
- State Profit Margin Detail
- Visits per Episode – National
- Visits per Episode – Detail by State

Preparation of the HHA Medicare Cost Report

The following five pages compare a Home Health Agency's data to that made available by NAHC for national averages and to that existing for the state.

Disclosure of total average cost per visit [includes cost report allocated overhead].

Average PPS visits per Medicare episode and average PPS visits per full Medicare episode.

PPS data including cost and payment per episode.
### Cost Report Data - Average Cost Per Visit

<table>
<thead>
<tr>
<th>Item</th>
<th>National</th>
<th>State</th>
</tr>
</thead>
<tbody>
<tr>
<td>SNC</td>
<td>$108.41</td>
<td>$142.69</td>
</tr>
<tr>
<td>PT</td>
<td>$173.40</td>
<td>$126.45</td>
</tr>
<tr>
<td>OT</td>
<td>$140.41</td>
<td>$128.31</td>
</tr>
<tr>
<td>ST</td>
<td>$175.32</td>
<td>$142.56</td>
</tr>
<tr>
<td>MSW</td>
<td>$120.24</td>
<td>$308.04</td>
</tr>
<tr>
<td>AIDE</td>
<td>$83.69</td>
<td>$71.28</td>
</tr>
</tbody>
</table>

### Visits Per Episode

<table>
<thead>
<tr>
<th>Item</th>
<th>National</th>
<th>State</th>
</tr>
</thead>
<tbody>
<tr>
<td>SNC</td>
<td>10.97</td>
<td>9.15</td>
</tr>
<tr>
<td>PT</td>
<td>2.95</td>
<td>4.04</td>
</tr>
<tr>
<td>OT</td>
<td>1.07</td>
<td>0.73</td>
</tr>
<tr>
<td>ST</td>
<td>0.05</td>
<td>0.14</td>
</tr>
<tr>
<td>MSW</td>
<td>0.22</td>
<td>0.17</td>
</tr>
<tr>
<td>AIDE</td>
<td>2.46</td>
<td>4.31</td>
</tr>
</tbody>
</table>
### Visits Per Full Episode

<table>
<thead>
<tr>
<th>Item</th>
<th>National</th>
<th>State</th>
</tr>
</thead>
<tbody>
<tr>
<td>SNC</td>
<td>12.00</td>
<td>8.7</td>
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<tr>
<td>PT</td>
<td>3.27</td>
<td>4.7</td>
</tr>
<tr>
<td>OT</td>
<td>1.19</td>
<td>0.8</td>
</tr>
<tr>
<td>ST</td>
<td>0.05</td>
<td>0.2</td>
</tr>
<tr>
<td>MSW</td>
<td>0.21</td>
<td>0.2</td>
</tr>
<tr>
<td>AIDE</td>
<td>19.51</td>
<td>19.3</td>
</tr>
</tbody>
</table>

### Average Per Episode

<table>
<thead>
<tr>
<th>Item</th>
<th>National</th>
<th>State</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reimbursement</td>
<td>$2,558.99</td>
<td>$2,225.59</td>
</tr>
<tr>
<td>Cost</td>
<td>$2,137.25</td>
<td>$1,977.66</td>
</tr>
<tr>
<td>Profit</td>
<td>$421.74</td>
<td>$247.93</td>
</tr>
<tr>
<td>Visits</td>
<td>17.72</td>
<td>18.5</td>
</tr>
<tr>
<td>Payment Per Full Episode</td>
<td>$2,776.62</td>
<td>$2,547.48</td>
</tr>
<tr>
<td>% Profit Margin</td>
<td>16.5</td>
<td>1.53</td>
</tr>
</tbody>
</table>
Preparation of the HHA Medicare Cost Report

PPS Episodes

<table>
<thead>
<tr>
<th>Item</th>
<th>National</th>
<th>State</th>
</tr>
</thead>
<tbody>
<tr>
<td>% Full w/o Outliers</td>
<td>85.56</td>
<td>78.51</td>
</tr>
<tr>
<td>% Full with Outliers</td>
<td>2.13</td>
<td>2.71</td>
</tr>
<tr>
<td>% LUPA</td>
<td>10.02</td>
<td>13.76</td>
</tr>
<tr>
<td>% PEP only</td>
<td>2.05</td>
<td>2.38</td>
</tr>
<tr>
<td>% SCIC within PEP</td>
<td>-</td>
<td>0.08</td>
</tr>
<tr>
<td>% SCIC</td>
<td>0.25</td>
<td>2.56</td>
</tr>
<tr>
<td>Supply Cost Per Episode</td>
<td>$132.55</td>
<td>$41.00</td>
</tr>
</tbody>
</table>

Additional Information

2. How To Hire A Business Consultant
3. Medicare & Accrual Basis Accounting
4. Medicare PPS Rates & The Medicare HHA Cost Report
5. The Yes But. Financial requirements of surveyors

http://www.simione.com/news-events

Select Cost Reporting from the News & Events Menu Board
Simione Healthcare Consultants provides solutions for your core home care and hospice challenges – organizational, financial, sales & marketing, technology, and mergers & acquisitions. Over 1000 organizations use our practical insight and tools to reduce costs, mitigate risk and improve efficiencies to steward the way they conduct business.

Thomas E. Boyd, MBA, CFE
Vice President of Reimbursable Services
50 Professional Center Drive, Suite 200
Rohnert Park, CA 94928
707 585.9317
877.424.6527
tboyd@simione.com
MEDICARE MARGINS, FREESTANDING

Per BKD study of Medicare freestanding cost reports with fiscal years ended in 2012

2008  2009  2010  2011  2012
15.2%  15.3%  15.8%  12.2%  12.0%
MEDICARE MARGINS, HOSPITAL-BASED

2008 2009 2010 2011 2012
-5.3% -5.8% -5.2% -12.1% -14.9%

Per BKD study of Medicare hospital-based cost reports with fiscal years ended in 2012

OVERALL MARGINS, FREESTANDING

2008 2009 2010 2011 2012
4.0% 5.3% 4.8% 2.8% 2.7%

15.2% 15.3% 15.8% 12.2% 12.0%

Medicare

Per BKD study of Medicare freestanding cost reports with fiscal years ended in 2012
OBJECTIVES

// Review essential home health (HH) benchmarking data
// Analyze key performance indicators necessary for effective management
KEY PERFORMANCE INDICATORS

- Margins & cash flow
- Quality
- Compliance
- Volume
- Expenses
- Revenues
Quality

Outcomes
• Outcome & Assessment Information Set (OASIS) data

Patient perception & satisfaction
• HH Consumer Assessment of Healthcare Providers & Systems (CAHPS) data

KEY PERFORMANCE INDICATORS

HH CAHPS | Outcomes
---|---
How often team gave care in professional way? | How often did patients got better at walking or moving around?
How well did team communicate with patients? | How often patients got better at getting in & out of bed?
Did team discuss medicines, pain & home safety with patients? | How often patients got better at bathing?
How do patients rate overall care? | How often patients had to be admitted to hospital?
Would patients recommend agency to friends & family? | How often patients needed urgent, unplanned care?
### KEY PERFORMANCE INDICATORS

#### Margins & cash flow

> “…no margin, no mission…”
> “…no cash, no hope…”

<table>
<thead>
<tr>
<th>Metric</th>
<th>SHP/BKD¹</th>
<th>All Others²</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Median</td>
<td>Best 25%</td>
</tr>
<tr>
<td>Gross margin</td>
<td>48.0%</td>
<td>55.0%</td>
</tr>
<tr>
<td>Medicare margin</td>
<td>22.3%</td>
<td>30.5%</td>
</tr>
<tr>
<td>Overall margin</td>
<td>8.9%</td>
<td>16.3%</td>
</tr>
<tr>
<td>Days in receivables</td>
<td>50.3</td>
<td>41.0</td>
</tr>
</tbody>
</table>

¹Per BKD study of 2012 Medicare freestanding cost report data of SHP Benchmark Leaders
²Per BKD study of all Medicare freestanding cost reports with fiscal years ended in 2012

#### Volume

<table>
<thead>
<tr>
<th>Metric</th>
<th>SHP/BKD¹</th>
<th>All Others²</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Median</td>
<td>Best 25%</td>
</tr>
<tr>
<td>Net revenues</td>
<td>$5,320,904</td>
<td>$10,175,002</td>
</tr>
<tr>
<td>Visits</td>
<td>25,039</td>
<td>51,760</td>
</tr>
<tr>
<td>Total patients</td>
<td>1,209</td>
<td>2,204</td>
</tr>
<tr>
<td>Medicare patients</td>
<td>68.2%</td>
<td>90.2%</td>
</tr>
<tr>
<td>Medicare episodes</td>
<td>1,119</td>
<td>1,967</td>
</tr>
<tr>
<td>Medicare revenues</td>
<td>$2,954,580</td>
<td>$5,457,919</td>
</tr>
</tbody>
</table>

¹Per BKD study of 2012 Medicare freestanding cost report data of SHP Benchmark Leaders
²Per BKD study of all Medicare freestanding cost reports with fiscal years ended in 2012
### Key Performance Indicators

#### Revenues

<table>
<thead>
<tr>
<th>Metric</th>
<th>SHP/BKD</th>
<th>All Others</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Median</td>
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</tr>
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<td>25,039</td>
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</tr>
<tr>
<td>Medicare visits</td>
<td>69.3%</td>
<td>89.2%</td>
</tr>
<tr>
<td>Medicare episodes</td>
<td>1,119</td>
<td>1,967</td>
</tr>
<tr>
<td>LUPAs</td>
<td>8.6%</td>
<td>5.7%</td>
</tr>
<tr>
<td>Episodes per patient</td>
<td>1.4</td>
<td>1.6</td>
</tr>
<tr>
<td>Case-mix weight</td>
<td>1.0382</td>
<td>1.1310</td>
</tr>
<tr>
<td>Therapy visits per episode</td>
<td>6.0</td>
<td>7.4</td>
</tr>
<tr>
<td>Average episode payment</td>
<td>$2,773</td>
<td>$3,028</td>
</tr>
</tbody>
</table>

1 Per BKD study of 2012 Medicare freestanding cost report data of SHP Benchmark Leaders
2 Per BKD study of all Medicare freestanding cost reports with fiscal years ended in 2012

#### Expenses

<table>
<thead>
<tr>
<th>Metric</th>
<th>SHP/BKD</th>
<th>All Others</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Median</td>
<td>Best 25%</td>
</tr>
<tr>
<td>Cost per visit</td>
<td>$132</td>
<td>$109</td>
</tr>
<tr>
<td>Hours per visit</td>
<td>2.9</td>
<td>2.3</td>
</tr>
<tr>
<td>Visits per episode</td>
<td>15.0</td>
<td>13.4</td>
</tr>
<tr>
<td>Cost per episode</td>
<td>$2,064</td>
<td>$1,811</td>
</tr>
<tr>
<td>Labor percent of revenues</td>
<td>69.6%</td>
<td>62.2%</td>
</tr>
<tr>
<td>A&amp;G cost percent of revenues</td>
<td>33.1%</td>
<td>26.1%</td>
</tr>
<tr>
<td>A&amp;G hours per visit</td>
<td>1.0</td>
<td>0.7</td>
</tr>
</tbody>
</table>

1 Per BKD study of 2012 Medicare freestanding cost report data of SHP Benchmark Leaders
2 Per BKD study of all Medicare freestanding cost reports with fiscal years ended in 2012
### Revenue Cycle Performance

<table>
<thead>
<tr>
<th>Metric</th>
<th>Poor</th>
<th>Average</th>
<th>Best</th>
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</thead>
<tbody>
<tr>
<td>Medicare days in receivables</td>
<td>45 days or more</td>
<td>35 days</td>
<td>25 days or less</td>
</tr>
<tr>
<td>Non-Medicare days in receivables</td>
<td>75 days or more</td>
<td>60 to 75 days</td>
<td>60 days or less</td>
</tr>
<tr>
<td>Total days in receivables</td>
<td>60 days or more</td>
<td>50 days</td>
<td>40 days or less</td>
</tr>
<tr>
<td>Medicare receivables older than 120 days</td>
<td>10% or more</td>
<td>7%</td>
<td>3% or less</td>
</tr>
<tr>
<td>Total receivables older than 120 days</td>
<td>15% or more</td>
<td>10%</td>
<td>7% or less</td>
</tr>
<tr>
<td>Collections</td>
<td>Less than 100%</td>
<td>100%</td>
<td>More than 100%</td>
</tr>
<tr>
<td>Medicare write-offs</td>
<td>2% or more</td>
<td>1%</td>
<td>0%</td>
</tr>
<tr>
<td>Total write-offs</td>
<td>3% or more</td>
<td>2%</td>
<td>1% or less</td>
</tr>
<tr>
<td>Days to bill RAPs</td>
<td>More than 10 days</td>
<td>7 to 10 days</td>
<td>Less than 7 days</td>
</tr>
<tr>
<td>Days to bill claims</td>
<td>More than 10 days</td>
<td>7 to 10 days</td>
<td>Less than 7 days</td>
</tr>
</tbody>
</table>

### OTHER METRICS

**Strategic positioning**

**EBITDA**
- Net earnings before interest, taxes, depreciation, & amortization

**Cash conversion cycle**
- Days in receivables, vs.
- Days in payables

**KPIs**
- Quality, volume & compliance
- Revenues & expenses

1. Receivables balance ÷ average sales per day = days in receivables
2. Payables balance ÷ average cash expenses per day = days in payables
3. Days in receivables - days in payables = cash conversion cycle

<table>
<thead>
<tr>
<th>Metric</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
</tr>
</thead>
<tbody>
<tr>
<td>Days in receivables</td>
<td>27.7</td>
<td>28.5</td>
<td>32.9</td>
</tr>
<tr>
<td>Days in payables</td>
<td>23.9</td>
<td>11.2</td>
<td>8.7</td>
</tr>
<tr>
<td>Cash conversion cycle</td>
<td>3.8</td>
<td>17.3</td>
<td>24.2</td>
</tr>
<tr>
<td>Metric</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>------------------------------</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net revenues</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicare revenue percentage</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net margin</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EBITDA</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Days in receivables</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Days in payables</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash conversion cycle</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Case-mix weight</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Payment per episode</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Therapy visits per episode</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>LUPAs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Visits per episode</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cost per visit</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hours per visit</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cost per episode</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
MANAGING DATA

Identify
- key metrics

Gather
- performance data from available sources

Measure
- performance data

Compare
- performance results

Examine
- processes driving performance

Implement
- action & accountability plan

Data sources

Medicare cost reports

Medicaid cost reports

PS&Rs

OASIS

CAHPS

Vendors

Internal
- General ledger
- EMR
Any Questions?
AN OVERVIEW

NAHC Financial Management Conference & Exposition

Pre-Conference 2 - 701
Home Health Summer Camp 2014

Sunday, July 13, 2014

Nancy Boyd, BS
Senior Manager
Simione Healthcare Consultants

855A Requirements & Revalidation

MEDICARE ENROLLMENT APPLICATION
INSTITUTIONAL PROVIDERS

CMS-855A

SEE PAGE 1 TO DETERMINE IF YOU ARE COMPLETING THE CORRECT APPLICATION
SEE PAGE 2 FOR INFORMATION ON WHERE TO MAIL THIS APPLICATION
SEE PAGE 41 TO FIND A LIST OF THE SUPPORTING DOCUMENTATION THAT MUST BE SUBMITTED WITH THIS APPLICATION.
Requirements for Filing

- New Location
- New Business Name
- Change in ownership
- Acquisition/merger or stock transfer
- Additional Branch office
- Change of Address

Individual Updates / Changes

- If they have a 5 percent or greater direct or indirect ownership interest in the provider
- If the provider is a corporation (whether for-profit or non-profit), all officers and directors of the provider
Individual Updates / Changes

All individuals with a **partnership interest** in the provider, regardless of the percentage of ownership the partner has.

All **employees that have managing control** of the provider

Authorized and delegated **officials**

---

Timeline for Submission

- √ Change of ownership
- √ Acquisition/Merger
- √ Asset Sale
- √ Stock Transfer

**30 DAYS**
Timeline for Submission

✓ Updates to the provider – i.e.: change of information

90 DAYS

Revalidation Project

• If you enrolled in the Medicare Program before March 25, 2011 you will get a letter by March of 2015.

• Revalidation will be required every 5 years
Revalidation Project

• **DO NOT** respond until you get your letter.

• You have **60 days** from the date of your letter (**not two months**) to submit your 855A revalidation.

Revalidation Project

• Be watching for your letter. Many are not addressed to a specific person.
Revalidation Project

“The devil is in the details!”

You must submit a paid receipt with your revalidation letter and 855A

https://pecos.cms.hhs.gov/pecos/FeePaymentWelcome.do
Revalidation Project

- MACs are requesting your NPI email assigning your NPI – most went out in 2006. If you don’t have a copy of the email:
- Contact NPPES customer service at 800-465-3203 OR if you remember your user ID and password go to website and login, check that info is current and proceed to end and submit.
- You will get a new email in 24-36 hours.

https://nppes.cms.hhs.gov/NPPES/Welcome.do

Revalidation Project

- Make sure you submit your 855A on the current form.


This form was updated in July 2011.
(CMS 855A (07/11) will be on the bottom of the current form.)
Who Has Questions ???

SIMIONE.COM

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The way is in sight.
Pre-Conference 2
701. Home Health Summer Camp 2014
Program Integrity

M. Aaron Little, CPA
Managing Director
mlittle@bkd.com
Home health prospective payment system requirements

Billing and Payments. We will review compliance with various aspects of the home health prospective payment system (PPS), including the documentation required in support of the claims paid by Medicare. We will determine whether home health claims were in paid in accordance with Federal laws and regulations. Context—A prior OIG report found that one in four HHAs had questionable billing. Further, CMS designated newly enrolling HHAs as high-risk providers, citing their record of fraud, waste, and abuse. Since 2010, nearly $3 billion in improper Medicare payments and fraud has been identified relating to the home health benefit. Some beneficiaries who are confined to their homes are eligible to receive home health services. (Social Security Act, §§ 1835(a)(2)(A) and 1861(m).) Such services include part-time or intermittent skilled nursing care, as well as other skilled care services, such as physical, occupational, and speech therapy; medical social work; and home health aide services. (OAS; W-00-13-35501; W-00-14-35501; various reviews; expected issue date: FY 2014; work in progress and new start)

Source: 2014 OIG Work Plan
Medicare coverage & billing compliance

Know Program Integrity Contractors

Manage key risks

Know key risk areas
MACs

Medicare Administrative Contractors (MACs)

CMS authorized contractors responsible for claims processing & other administrative functions for designated HH & hospice jurisdictions

CGS Administrators, LLC (CGS)
National Government Services (NGS)
Palmetto GBA (PGBA)

Typically conduct program integrity activities through on-pre-payment medical review processes

Additional Development Requests (ADRs)

‘S B6001’ claim status location code

Providers have 30 days by which to respond to ADRs

Claims automatically deny if record not received by MAC by day 45

ADRs selected for various reasons

Automated edits
New provider/new benefit edits
Provider-specific probe edits
Provider-specific targeted review
Referral edits
Widespread probe edits
**New Home Health Denial Fact Sheets Quick Resource Tools**

CGS has developed home health denial fact sheets for each specific denial reason codes to assist home health clinical staff in avoiding medical review denials. The fact sheets are available on the “Home Health Quick Resource Tools” web page. In addition, they are accessible from the Home Health Denial Reason Codes web page on the CGS website. The fact sheets include:

- 5F/7F: Missing/Incomplete/Untraceable Face to Face Encounter
- 5F65: Homebound Status is Not Supported in the Record
- 5F/7G3: No OSAS Assessment in the Medical Record
- 5F/7G4: Missing/Incomplete/Antimicrobial Plan of Care and/or 5F/7G6: Missing/Incomplete/Untraceable Orders

Source: CGS

---

## HOME HEALTH WIDESPREAD EDITS

<table>
<thead>
<tr>
<th>Edit Number</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>5033T</td>
<td>This edit selects home health claims for diagnosis 401.5 (Hypertension) and a length of stay greater than 120 days.</td>
</tr>
<tr>
<td>52xT (xx)</td>
<td>This edit selects start of care home health claims from among all HHAs billing to CGS.</td>
</tr>
<tr>
<td>598Y9</td>
<td>This edit selects home health claims due to previous denials for selected beneficiary.</td>
</tr>
</tbody>
</table>

*Updated: 06.23.14*

Source: CGS
http://www.cgsmedicare.com/ hhh/medreview/med_review_edits.html

---

<table>
<thead>
<tr>
<th>Denial Code</th>
<th>Denial Description</th>
<th>No. of Claims</th>
<th>% Denied</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 5FF2F</td>
<td>Face to Face Encounter Requirements Not Met</td>
<td>1,812</td>
<td>54.2%</td>
</tr>
<tr>
<td>2 56900</td>
<td>Auto Deny - Requested Records not Submitted</td>
<td>757</td>
<td>22.6%</td>
</tr>
<tr>
<td>3 5CHG3</td>
<td>MR HIPPS Code Change Due to Partial Denial of Therapy</td>
<td>222</td>
<td>6.6%</td>
</tr>
<tr>
<td>4 5FNOA</td>
<td>Unable to Determine Med Nec of HIPPS Code Billed as App Oasis Not Submitted</td>
<td>134</td>
<td>4.0%</td>
</tr>
<tr>
<td>5 5F012</td>
<td>Physician’s Plan of Care and/or Certification Present - Signed but Not Dated</td>
<td>103</td>
<td>3.1%</td>
</tr>
<tr>
<td>6 5F041</td>
<td>Info Provided Does Not Support the M/N for This Service</td>
<td>72</td>
<td>2.2%</td>
</tr>
<tr>
<td>7 5F011</td>
<td>Physician’s Plan of Care and/or Certification Present - No Signature</td>
<td>69</td>
<td>2.1%</td>
</tr>
<tr>
<td>8 5A041</td>
<td>Info Provided Does Not Support the M/N for This Service</td>
<td>66</td>
<td>2.0%</td>
</tr>
<tr>
<td>9 5F023</td>
<td>No Plan of Care or Certification</td>
<td>65</td>
<td>1.9%</td>
</tr>
<tr>
<td>10 5FF2F</td>
<td>Face to Face Encounter Requirements Not Met</td>
<td>46</td>
<td>1.4%</td>
</tr>
</tbody>
</table>

Source: PGBA
http://www.palmettoggbb.com/palmetto/providers.nsf/DocsCat/Providers%3Fjurisdiction%3D2011%20Home%20Health%20and%20Hospice%20Medical%20Review%3FGeneral%3D93E756252?open&navmenu=Medical%20Review
CERTs

// Comprehensive Error Rate Testing (CERT) Program contractors

// Program established by Centers for Medicare & Medicare Services (CMS) to monitor accuracy of Medicare claim payment

  // Identify errors & assesses error rates
  // Evaluate performance of MACs

  // Randomly select statistical sample of paid claims to determine whether claims were paid properly

// Two CERT contractors

  // CERT Review Contractor
  // CERT Documentation Contractor
CERTs

CERT Documentation Contractor (CDC)

- Responsible for requesting & receiving medical record documentation
- Requests sent to providers via fax or mail
- Providers have up to 75 days to respond to CERT request

CERT Review Contractor (CRC)

- Responsible for reviewing selected claims & associated medical record documentation

CERTs

- CDC notifies provider claim is selected for review
- CRC performs review & notifies MAC of determination
- Claim adjustment is then made by MAC
- Claim is reprocessed & ending type of bill character is changed to “H”
- Example: “329” is changed to “32H”

Source: CGS
http://www.cgsmedicare.com/hhh/education/materials/CERT_Errors_Summary.html
CERTs

Medicare A/B Contractor CERT Task Force

Joint effort of Part A/B MACs to communicate national issues of concern regarding improper payments

- Includes all HH & hospice MACs
- Fully supported by CMS

Selects one to four national CERT ‘hot topics’ each year on which to publish targeted educational materials

RAs

Recovery Auditors (RAs)

- Contractors paid fee percent of amount recovered
  - Medicare RAs
    - Four contractors with fifth coming soon
  - Medicaid RAs
    - Each state Medicaid agency seeks its own contractor

- Responsible for reviewing claims on post-payment basis to identify improper payments
  - Look back period of three years from date claim paid
  - All ‘issues’ published & approved by CMS
  - 45 days to respond to record requests
  - Actual claim adjustment made by MAC or Medicaid
  - Automated vs. semi-automated vs. complex
RAs

// New Medicare contract procurement currently in process by CMS
// New RA activity currently paused
// New contract being created for specialized fifth RA dedicated to HH, hospice & durable medical equipment (DME)

ZPICs

// Zone Program Integrity Contractors (ZPICs)
// Identify cases of suspected fraud, investigate, & take action to ensure any inappropriate Medicare payments are recouped
// Fraud may include
// Billing for services not furnished
// Billing appearing to be deliberate for duplicate payment
// Altering claims or medical records to obtain higher payment
// Soliciting, offering, or receiving kickbacks or rebates for patient referrals
// Billing non-covered or non-chargeable services as covered
ZPICs

Actions may include

- Investigating potential fraud & abuse
- Interviews & onsite visits
- Performing medical review, typically on post-pay basis
- Performing data analysis
- Identifying need for administrative actions
- Payment suspensions
- Prepayment or auto-denial edits
- Referring cases to law enforcement for consideration & initiation of civil or criminal prosecution

ZPICs

<table>
<thead>
<tr>
<th>ZPIC</th>
<th>Zone</th>
<th>States in Zone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguard Services (SGS)</td>
<td>1</td>
<td>California, Hawaii, Nevada, American Samoa, Guam, and the Marian Islands</td>
</tr>
<tr>
<td>AdvanceMed</td>
<td>2</td>
<td>Washington, Oregon, Idaho, Utah, Arizona, Wyoming, Montana, North Dakota, South Dakota, Nebraska, Kansas, Iowa, Missouri, Alaska</td>
</tr>
<tr>
<td>Cahaba</td>
<td>3</td>
<td>Minnesota, Wisconsin, Illinois, Indiana, Michigan, Ohio, Kentucky</td>
</tr>
<tr>
<td>Health Integrity</td>
<td>4</td>
<td>Colorado, New Mexico, Texas, and Oklahoma</td>
</tr>
<tr>
<td>AdvanceMed</td>
<td>5</td>
<td>Arkansas, Louisiana, Mississippi, Tennessee, Alabama, Georgia, North Carolina, South Carolina, Virginia, West Virginia</td>
</tr>
<tr>
<td>Under Protest</td>
<td>6</td>
<td>Pennsylvania, New York, Delaware, Maryland, D.C., New Jersey, Massachusetts, New Hampshire, Vermont, Maine, Rhode Island, Connecticut</td>
</tr>
<tr>
<td>Safeguard Services (SGS)</td>
<td>7</td>
<td>Florida, Puerto Rico, Virgin Islands</td>
</tr>
</tbody>
</table>
SMRCs

// Specialty Medical Review Contractors (SMRCs)
// Contract awarded by CMS in October 2012 to StrategicHealthSolutions (SHS)
// Contract covers specialty review for nation
// Post-payment review determined based on data analysis
// Medicare Part A, Part B & DME
// SHS currently conducting review of Medicare HH compliance with physician face-to-face encounter documentation requirements
// Includes all Medicare certified HH agencies

MICs

// Medicaid Integrity Contractors (MICs)
// Entities with which CMS has contracted to conduct post-payment audits of Medicaid providers
// Goal is to identify overpayments & decrease inappropriate payments
MICs

// Three types of MICs

// Review MICs
// Analyze Medicaid claims data to identify high-risk areas & potential vulnerabilities
// Provide leads to audit MICs

// Audit MICs (Medicaid RAs)
// Conduct post-pay claim audits to identify potential overpayments
// http://w2.dehpg.net/RACSS/Map.aspx

// Education MICs
// Use findings from audit & review MICs to identify areas for provider education
// Develop training materials, awareness campaigns & conduct provider training

Audit MICs:
- Booz Allen Hamilton
- Fox & Associates
- IPRO
- Health Management Systems
- Health Integrity, LLC

Review MICs:
- AdvanceMed
- ACS Healthcare
- Thomson Reuters
- IMS Govt. Solutions

Education MICs:
- Information Experts
- Strategic Health Solutions

Source: CMS Fraud Prevention
http://cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Provider-Audits/Downloads/MIP-Contractors-Presentation.pdf
UPICs

Unified Program Integrity Contractor (UPIC)

New contractor...coming soon...that consolidates ZPIC & MIC activities

To predict, detect, prevent & deter fraud, waste & abuse in Medicare & Medicaid programs

By consolidating Medicare & Medicaid program integrity activities

Sharing & coordinating information among Medicare & Medicaid partners

Emphasizing timely administrative actions

Strengthening data matching across programs to expand view of provider billing patterns

CBRs

Comparative Billing Reports (CBRs) contractor

Data analysis reports that evaluate & compare individual provider billing trends

“...not intended to be punitive or sent as an indication of fraud. ...it is intended to be a proactive statement that will help the provider identify potential errors in their billing practice.”

Resulting in providers being selected for targeted pre-payment medical review
CBRs

As a Medicare Administrative Contractor (MAC), CGS Administrators, LLC is required by the Centers for Medicare and Medicaid Services (CMS) to analyze claims payment data in order to identify areas with the greatest risk of inappropriate program payment.

You have been selected for a prepayment review of 20 – 40 claims due to a high number of late episodes per beneficiary. Data analysis performed includes a comparison and evaluation of claims data. The analysis includes claim activity from October 1, 2012 through March 31, 2013. Please see the enclosed Comparative Billing Report. We have compared your billing to other providers during this time frame. The Comparative Billing Report depicts the average length of stay per beneficiary and percentage of beneficiaries with length of stay over 120 days as compared to all the providers claims processed during October 1, 2012 through March 31, 2013. The average length of stay of all CGS home health providers is included for comparison purposes. Your facility has been selected for review based on claims with length of stay greater than 180 days.

CBRs

<table>
<thead>
<tr>
<th></th>
<th>Claims</th>
<th>Length of Stay (Days)</th>
<th>Avg LOS / Claim</th>
<th>Benes LOS &gt; 120</th>
<th>% Benes LOS &gt; 120 Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>1780586</td>
<td>162</td>
<td>45,663</td>
<td>587.71</td>
<td>32</td>
<td>87.5%</td>
</tr>
<tr>
<td>CGS</td>
<td>135,198</td>
<td>13,064,245</td>
<td>112.85</td>
<td>348</td>
<td>10.0%</td>
</tr>
</tbody>
</table>

![Graph showing comparison of Average LOS per claim and % Benes LOS > 120 Days for 1780586 and CGS.]
Health Care Fraud Prevention & Enforcement Action Team (HEAT)

Created by Department of Health & Human Services (HHS) & Department of Justice (DOJ)

Mission

To gather resources across government to help prevent waste, fraud & abuse in Medicare & Medicaid programs

To crack down on people and organizations who abuse system

To reduce health care costs & improve quality of care

To highlight best practices by providers & organizations dedicated to ending waste, fraud & abuse in Medicare

To further build partnerships between HHS & DOJ
Expanding the Medicare fraud strike force

The joint DOJ-HHS Medicare Fraud Strike Force is a multi-agency team of federal, state, and local investigators designed to fight Medicare fraud. The Force uses Medicare data analysis techniques and an increased focus on community policing to combat fraud.

The Medicare Fraud Strike Force has recently expanded to include nine cities:
- Baton Rouge, Louisiana
- Brooklyn, New York
- Chicago, Illinois
- Dallas, Texas
- Detroit, Michigan
- Houston, Texas
- Los Angeles, California
- Miami-Dade, Florida
- Tampa Bay, Florida

Source: Stop Medicare Fraud
Develop culture of compliance
Identify current risk trends
Establish concurrent compliance monitoring processes
Maintain objective & accountable tracking systems
Periodically test compliance processes
Failure of process, personnel or software?

Non-compliant documentation received

Documentation logged into software system

Documentation filed in medical record

‘Compliance audit’ completed

Claim billed & paid

Pre-billing compliance audit completed

SUMMARY
Medicare coverage & billing compliance

Know Program Integrity Contractors

Manage key risks

Know key risk areas

QUESTIONS
Pre-Conference 2
701. Home Health Summer Camp 2014
Program Integrity

M. Aaron Little, CPA
Managing Director
mlittle@bkd.com
PreBilling Compliance

Melinda A. Gaboury - Healthcare Provider Solutions, Inc.

Billing Performance

- Job Descriptions:
  - Do they exist for all positions?
  - Do Employees have a copy?
  - Do Employees truly understand what they are responsible for?
  - Are positions over/under-staffed?

Develop measures to monitor staff performance

  - Review measures in team meetings
  - Set reasonable expectations/goals
  - Require staff to be accountable
  - Deal with low performance
  - Set limits for time allowed to perform at these levels
  - Reward high performance
Who Does What?

- **Billers - Collectors - Cash Posters - Managers/Supervisors**
  - Do you have separate designations or does one person wear all four hats?
  - Does each employee understand his/her responsibilities?
  - Who is the leader/manager/supervisor?
  - Is there required reporting in place to monitor progress?

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
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)

Prebilling Audit

- Face To Face Compliance
- Quick Review of 485
  - All Blanks Completed, Signed & Dated by Clinician
  - Signed & Dated by Physician
  - Supplies ordered on 485
- Supplemental Orders Signed & Dated by Physician
- Clinical Note for every visit
- Frequency & Duration Match Visits provided
- Therapy ReAssessment Visits
- Correct G code usage
- Supplies billed correctly
- OASIS transmitted to the state
Recommendations

- Recommend that Agencies do the following:
  - Send Billers/Collectors to Billing Workshops at least once per year
  - Join Listserves/Participate in Webinars/Teleconferences frequently
  - Have someone in agency closely monitor the Medicare MAC websites/newsletters
  - Update PreBilling Audit Tools as necessary
  - Have peers within agency randomly pull prebilling audits and double check the accuracy
  - Billing/Reimbursement Review by Third Party at least every two years

Current Billing Risks

- Identify common billing/payment errors
- Documentation controls are essential
- Implement compliance with billing
- Establish tracking of individual personnel & process compliance
Questions

Melinda A. Gaboury, COS-C
Chief Executive Officer
Healthcare Provider Solutions, Inc.
810 Royal Parkewy, Suite 200
Nashville, TN 37214
615-399-7499 Phone
615-399-7790 Fax
mgaboury@healthcareprovidersolutions.com

Nancy Boyd, BS
Senior Manager
50 Professional Center Drive, Suite 200
Rohnert Park, CA 94928
707.585.9317
nboyd@simione.com

Questions

Faculty Contact Info

Melinda A. Gaboury, COS-C
Chief Executive Officer
Healthcare Provider Solutions, Inc.
810 Royal Parkewy, Suite 200
Nashville, TN 37214
615-399-7499 Phone
615-399-7790 Fax
mgaboury@healthcareprovidersolutions.com

Nancy Boyd, BS
Senior Manager
50 Professional Center Drive, Suite 200
Rohnert Park, CA 94928
707.585.9317
nboyd@simione.com

The way is in sight.

Thomas E. Boyd, MBA, CFE
Vice President of Reimbursable Services
50 Professional Center Drive, Suite 200
Rohnert Park, CA 94928
707.585.9317
877.424.6527
thboyd@simione.com

M. Aaron Little
Managing Director
Health Care
910 E. St. Louis Street, Suite 200
P.O. Box 1190
Springfield, MO 65806-2523
mlittle@bkd.com

Nancy Boyd, BS
Senior Manager
50 Professional Center Drive, Suite 200
Rohnert Park, CA 94928
707.585.9317
877.424.6527
nboyd@simione.com

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