HOME HEALTH REGULATORY ROUND UP

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Proposed HHPPS 2014

• Rebasing
  • Changes in the nature of the services provided during the 60 episode of care along with what it perceived to be “overpayments” for services
• Required by the ACA
• Phase in over 4 years
• Average cost compared to average payments
• Difference = - 13.63%
• Decrease rates by 3.5 % for the next four years
Proposed HHPPS -2014

- 2014 base rate
- Estimated average cost to average reimbursement for 2013
- Estimated Cost $2559.59 to estimated reimbursement - $2963.65
- -13.63%
  - Minus 3.5 % for rebasing
  - 2.4 market basket increase
  - Plus other factors
- Base rate in 2014 -$2860.20
- Base rate in 2013 – $2137.73

Proposed HHPPS -2014

- Case mix weights decreased by 26 %
  - Average weight should be 1
  - Average weight  1.3517 in 2012
  - Relative weight the same
- Base rate in 2014 -$2860.20
- Base rate in 2013 – $2137.73
  - HHRG = C1F1S1
  - 2013 -$ 2137.37  *.8186=$1749.65
  - 2014 -$2,860.20 *.6056 = $1723.14
- 1.5% decrease in base rate
- 2.0% Sequestration
Proposed HHPPS -2014

• LUPAS Rates
  • + 19.5%
  • 3.5% increase over the next four years
  • LUPA add on not a single rate but calculated depending on the discipline

• NRS
  • -9.2%
  • Reduce by 2.58% next four years
  • Conversion factor $53.84 for 2014
  • $53.97- 2013

Proposed HHPPS -2014

• 170 Diagnosis codes eliminated
  • Too acute
  • No increase in resource utilization

  • No change in the wage index
  • Labor portion and non labor portion remain the same
  • no change in outliers
Proposed HHPPS Rate Update

- **Quality Measures**
  - Two new claims based measures:
    - **Re-hospitalization during the first 30 days of HH**
      - Patient who had an acute care hospitalization 5 days prior to the SOC date and are admitted to an acute care hospital within 30 days.
    - **Emergency Department Use without hospital readmission during the first 30 days of HH**
      - Patients who had an acute care hospitalization 5 days prior to the SOC date and are and has an emergency room visits without a hospitalization within 30 days.
  - In addition to the claims based measures currently collected
  - Eliminate stratification of measures “all episodes” rather than short and long episodes from the CASPER reports. 18 reported process measures would be eliminated, no information to be lost.

Proposed HHPPS Rate Update

- **OASIS** data episodes between July 1, 2013 –June 30, 2013 for the full rate update for 2014

- **HHCAHPS.** The data collection period for the CY 2014 includes the second quarter 2012 through first quarter 2013 (the months of April 2012 through March 2013).

- Failure to collect and report will result in a 2% reduction in payments
Proposed HHPPS Rates -2014

• NAHC’s comments - Rebasing
  • It relies on proxies for payment and cost determinations while such are readily available from cost report data.
  • It fails to account for and address the wide range in revenue/cost per episode experience by disparately located HHAs serving a very diverse patient population. A single payment rate adjusted with available adjusters leads to significant payment inaccuracies requiring a rate “cushion” to maintain access to care.
  • It does not recognize all current costs, in particular new regulatory compliance costs and the use of clinical technologies and services permitted to be used in a home health episode of care.
  • It neglects to factor in the essential need for operating capital.
  • CMS calculated the rate change required for a four-year phase in at 3.6%, but applied the 3.5% annual allowable adjustment limit -- (13.63/4=3.4075).

Proposed HHPPS - 2014

NAHC’s comments Dx codes
• Elimination of ICD-9 codes for case mix points
  • GI ulcers and gastritis (531-535), diverticulitis/diverticulosis (562) and hemorrhage of GI tract (578.9)

  • 567.0-567.9, 572.0 and 577.0 (e.g. Peritonitis (567.21), Peritoneal Abscess (567.22), Liver Abscess (572.0))

  • Esophageal reflux (530.81) and Restless leg syndrome (333.94)
Face to Face

• Revisions 2013
  • Allow facility-based NPP to perform encounter
  • Require communication with the physician with whom collaborating (i.e. inpatient or community)
  • Allow the facility-based physician to complete the F2F and either certify or communicate findings to the certifying physician in the community

Documentation title and date
  • Allow any party to title and date F2F documentation

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)
F2F Documentation

- Face-to-face description should be a brief narrative describing the patient’s clinical condition and how the patient’s condition supports homebound status and the need for skilled services.
  - Standardized language prohibited (e.g. considerable and taxing effort)
  - Diagnosis alone is not sufficient to support skilled services
- CMS example
  - "The patient is temporarily homebound secondary to status post total knee replacement and currently walker dependent with painful ambulation. PT is needed to restore the ability to walk without support. Short-term skilled nursing is needed to monitor for signs of decomposition or adverse events from the new COPD medical regimen."

Inpatient F2F Encounter
No Certification

- Communication of clinical information from medical record to community physician (i.e. verbal, clinical notes, discharge summary, referral, etc.)
  - Information compilation may be by inpatient support staff
  - Community physician may obtain supplementary information via phone, email, if needed
- Community physician may "adopt" the document as his/her own encounter document but must sign and dates the documents(s)
  - CMS will allow the certifying physicians to “adopt” an allowed NPPs clinical notes
  - Community physician creates the F2F encounter document based on the facility physician’s encounter findings
    - Note: Inpatient physician or NPP signature not required
Inpatient F2F Encounter with certification

- Facility–based physician
- Completes the F2F encounter document based on his/her findings or the findings of an NPP
- Information compilation may be by inpatient support staff
- Signs and dates the document; “hands off” to community physician
- Signature not required by the physician who signs the POC

Requirements for Home Health Services Certification

- Certification
  - Physician certifies eligibility for home health services
    - The home health services are or were needed because the patient is or was confined to the home
    - The patient needs or needed skilled services
    - A plan of care has been established and is periodically reviewed by a physician; and
    - The services are or were furnished while the patient is or was under the care of a physician.
  - Includes F2F attestation
F2F Certification Statement(s)

• 42 CFR 424.11 General procedures.
  (a) Responsibility of the provider. The provider must—
  (1) Obtain the required certification and recertification statements;
  (2) Keep them on file for verification by the intermediary, if necessary; and
  (3) Certify, on the appropriate billing form, that the statements have been obtained and are on file.
  (b) Obtaining the certification and recertification statements. No specific procedures or forms are required for certification and recertification statements. The provider may adopt any method that permits verification. The certification and recertification statements may be entered on forms, notes, or records that the appropriate individual signs, or on a special separate form.
  (c) Required information. The succeeding sections of this subpart set forth specific information required for different types of services. If that information is contained in other provider records, such as physicians' progress notes, it need not be repeated. It will suffice for the statement to indicate where the information is to be found.

Other important considerations

• Checkboxes created by the physician are acceptable
• 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
  • Count back 30 days
  • Realignment of SOC: may use original OASIS, updated
  • Delete original OASIS
  • Realignment of SOC due to late F2F requires realignment of therapy
    13 and 19
**F2F**

- Sign-on letter
  - 75 representatives; sent to Marilyn Tavenner September 25
- Send F2F samples to mkc@nahc.org
- Law suit

**Medicaid F2F**

- Proposed rule July 2011
- Unified Agenda - October 2013
- Some States have a F2F requirement
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
  - In multi-discipline cases:
    - Each discipline must conduct a reassessment on therapy visit 11, 12, or 13
    - Each discipline must conduct the reassessment on therapy visit 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.

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

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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 deficiency
  - (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.
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

Alternative Sanctions

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

• Condition -Level deficiency w/IJ
  • 2 day notice
  • 23 days 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

### HIPAA: New Provisions

**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 evaluation more standardized
- Requires individual authorization for marketing
- PHI of Decedents
- 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
HIPAA Breaches

• Breach Notification requirements clarify when breaches of unsecured health information must be reported to HHS

• The significant risk portion “harm threshold” has been removed.

• Impermissible acquisition, access, use, or disclosure of unsecured protected health information is presumed to be a breach unless an exception applies; or

• the entity can demonstrates that there is a low probability that the PHI has been compromised

Breach Exceptions

• (i) Any unintentional acquisition, access, or use of protected health information by a workforce member or person acting under the authority of a covered entity or a business associate, if such acquisition, access, or use was made in good faith and within the scope of authority and does not result in further use or disclosure in a manner not permitted under subpart E of this part.

• (ii) Any inadvertent disclosure by a person who is authorized to access protected health information at a covered entity or business associate to another person authorized to access protected health information at the same covered entity or business associate, or organized health care arrangement in which the covered entity participates, and the information received as a result of such disclosure is not further used or disclosed in a manner not permitted under subpart E of this part.

• (iii) A disclosure of protected health information where a covered entity or business associate has a good faith belief that an unauthorized person to whom the disclosure was made would not reasonably have been able to retain such information.
HIPAA Breach

• If there is a suspected breach that does not meet one of the exceptions, the entity should conduct a risk assessment to determine the level of probability that the PHI has been compromised. The risk assessment must cover at least the following areas:
  • (i) The nature and extent of the protected health information involved, including the types of identifiers and the likelihood of re-identification;
  • (ii) The unauthorized person who used the protected health information or to whom the disclosure was made;
  • (iii) Whether the protected health information was actually acquired or viewed; and
  • (iv) The extent to which the risk to the protected health information has been mitigated.

HIPAA Breach

• Home Health and Hospice agencies are particularly vulnerable to breaches due to the nature of the business
  • Stolen and lost lap tops /records
HIPAA Breach

- The Secretary of Health and Human Services (HHS) is to be notified in situations where there is a breach of unsecured PHI, regardless of the number of individuals/residents. If over 500, the Secretary needs to be notified when the individuals are notified. If under 500, the entity is to maintain a log (or other documentation) of the breach and notify the Secretary not later than 60 days after the end of the calendar year in which the breach is discovered.

Notice of Privacy Practices (NPP)

Additional statements:

- a right to be notified following a breach of their unsecured PHI;
- They may be contacted to raise funds and have the right to opt out of receiving such communications;
- Most uses of and disclosures of PHI for marketing purposes and sales of PHI require the individual’s authorization;
- Entities that record or maintain psychotherapy notes also must state specifically that most uses or disclosures of such notes require the individual’s authorization;
- Uses and disclosures not described in the Privacy Notice will be made only with the authorization from the individual; and
- The right to restrict certain disclosures of PHI to a health plan when the individual pays for treatment at issue out of pocket in full.
- Distributed by September 23, 2013; post on web site
HIPAA Resources

- Model privacy notices and business associate agreements
  - [http://www.hhs.gov/ocr/privacy/hipaa/modelnotices.html](http://www.hhs.gov/ocr/privacy/hipaa/modelnotices.html)
- Final HIPAA Rule

OSHA- Revised Hazard Communication Standard

- New labeling and data sheets on chemicals according to the Globally Harmonized System (GHS)
- GHS is an international approach to hazard communication, providing agreed criteria for classification of chemical hazards, and a standardized approach to label elements and safety data sheets.
HCS Labels

- **Pictogram**: Each pictogram consists of a different symbol on a white background within a red square frame set on a point (i.e. a red diamond). There are nine pictograms under the GHS. However, only eight pictograms are required under the HCS.

- **Signal words**: a single word used to indicate the relative level of severity of hazard and alert the reader to a potential hazard on the label. The signal words used are "danger" and "warning." "Danger" is used for the more severe hazards, while "warning" is used for less severe hazards.

- **Hazard Statement**: a statement assigned to a hazard class and category that describes the nature of the hazard(s) of a chemical, including, where appropriate, the degree of hazard.

- **Precautionary Statement**: a phrase that describes recommended measures to be taken to minimize or prevent adverse effects resulting from exposure to a hazardous chemical, or improper storage or handling of a hazardous chemical.
Safety Data Sheet (SDS)

- Safety Data Sheet (SDS) under the revised Hazard Communication Standard
- The information required on the safety data sheet (SDS) will remain essentially the same as that in the current standard (HazCom 1994). The revised Hazard Communication Standard (HazCom 2012) requires that the information on the SDS be presented using specific headings in a specified sequence.

<table>
<thead>
<tr>
<th>Time Line</th>
<th>Effective Completion Date</th>
<th>Requirement(s)</th>
<th>Who</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>December 1, 2013</td>
<td>Train employees on the new label elements and safety data sheet (SDS) format.</td>
<td>Employers</td>
</tr>
<tr>
<td></td>
<td>June 1, 2015*</td>
<td>Compliance with all modified provisions of this final rule, except: The Distributor shall not ship containers labeled by the chemical manufacturer or importer unless it is a GHS label</td>
<td>Chemical manufacturers, importers, distributors and employers</td>
</tr>
<tr>
<td></td>
<td>December 1, 2015</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>June 1, 2016</td>
<td>Update alternative workplace labeling and hazard communication program as necessary, and provide additional employee training for newly identified physical or health hazards</td>
<td>Employers</td>
</tr>
<tr>
<td></td>
<td>Transition Period to the effective completion dates noted above</td>
<td>May comply with either 29 CFR 1910.1200 (the final standard), or the current standard, or both</td>
<td>Chemical manufacturers, importers, distributors, and employers</td>
</tr>
</tbody>
</table>
OSHA Resources

- [https://www.osha.gov/dsg/hazcom/](https://www.osha.gov/dsg/hazcom/)

- Final Rule
  - [https://www.osha.gov/dsg/hazcom/hazcom_2012_regulatory_text.pdf](https://www.osha.gov/dsg/hazcom/hazcom_2012_regulatory_text.pdf)

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
- Edit activation on hold – 60 day notice
PECOS

- 2 Change Requests:
  - 8441: Home Health Agency Reporting Requirements for the Certifying Physician and the Physician Who Signs the Plan of Care - Effective July 2014
  - 8356: Handling of Incomplete or Invalid Claims once the Phase 2 Ordering and Referring Edits are Implemented

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
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

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
  • Hospice related services billed with Condition code 07- Home Health: Automated
  • Non-Routine Medical Supplies and Home Health Consolidated billing: Automated
MAC

- Palmetto GBA
  - HIPPA codes 2CGK and 1BGP
- Cigna GBA
  - Home health claims for diagnosis 401.9 (Hypertension) and a length of stay greater than 120 days.
  - Start of care home health claims from among all HHAs billing to CGS.
  - Home health claims due to previous denials for selected beneficiary.
  - Utah provider
    - Average reimbursement per claim,
    - Average total visits, average total therapy visits, percent of claims with therapy services and percent of claims with 20+ therapy visits.
- National Government Services

All:

- F2F denial for insufficient documentation, etc.
- High percent of RAP auto cancels will result in RAP suppression - paid at 0
  - Providers are given the greater of 120 days after the start of the episode or 60 days after the paid date of the RAP to submit the final claim. If the final claim is not submitted within the specified time, the RAP will auto-cancel and the provider must resubmit the RAP before submitting the final claim.

HHABN

- 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
- Mandatory December 9, 2013
HIPPS Codes on MA plan claims

- Directive to the MA plans from CMS
- Plans are required to direct HHAS
- Plans are to be submitting with data effective July 1, 2013
- MA plan encounter data will be rejected beginning December 1, 2013

Confined to the Home

- Change Request 8444

- Clarifies that homebound must met both:
  - 1) The individual has a condition due to an illness or injury that restricts his or her ability to leave their place of residence except with the aid of supportive devices such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the assistance of another person; or if leaving home is medically contraindicated.
  - AND
  - 2), the condition of the patient should be such that there exists a normal inability to leave home and, consequently, and leaving home would require a considerable and taxing effort.
## Moratorium

- Home Health
- July 30, 2013 --- 6 months
  - Miami - Dade counties in Florida
  - Cook Counties in Illinois
- New providers
- Branches
- Approved status