401. Efficiencies for Documentation Management –
RCD & TPE

FINANCIAL MANAGEMENT CONFERENCE & EXPO
Efficiencies for Documentation Management: RCD & TPE

Continuing Education

The planners and presenters of this activity disclose no relevant relationships with any commercial entity pertaining to the content.

• Nurse attendees may earn a maximum of 15.5 contact hours
• Accountant attendees can earn up to 18.9 CPEs

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Commercial Support provided by Brightree, Excel Health Group, Healthcare Provider Solutions, and Simione Healthcare Consultants.
Objectives For This Session

• Outline the documentation deficiencies surrounding the TPE & RCD
• Outline the documents required for submission of medical records under the Medicare benefit
• Detail best practices for optimizing documentation management processes that will assist in limiting compliance risks

Review Choice Demonstration

• RCD created as means to test process measures for investigation and prosecution of fraud
• Decreases need for appeals
• According to CMS, OIG, MedPAC, and GAO reports → Extensive fraud in home health
• Does not change documentation requirements
RCD: Focus of Review

Medicare beneficiary coverage requirements are met
- Medicare eligibility
- Reasonable and necessary care
- Medicare regulations are met

Documentation Deficiencies

- Denials continue:
  - Face to Face encounter requirements not met
  - No Plan of Care or Certification
  - No Physician’s Order for services or more than ordered
  - No documentation of services rendered
  - Information received does not support medical necessity for therapy services
RCD: Focus of Review

• Medicare home health benefit eligibility criteria
  1. Confined to the home
  2. Under the care of a physician
  3. Receiving care under plan of care established and periodically reviewed by a physician
  4. In need of skilled services
  5. Face to Face encounter
    ✓ 90 days prior or within 30 days of SOC
    ✓ Related to primary reason patient requires home health
    ✓ Approved provider type

Required Eligibility Documents

• Beneficiary information
• Certifying physician information
• Home health agency information
• Submitter information
• Benefit period requested
• Submission date
• From/Through date of 60-day episode
RCD Required Documents: PCR

- Initial or resubmission review request
- Number of episodes requested (if more than one)
- State of rendered service
- Documentation from medical record that supports beneficiary requirements are met to receive the home health benefit

RCD Required Documents: PCR

- Confined to home
- Under the care of a physician
- Plan of care established and periodically reviewed by physician
- In need of skilled services
- Face to Face encounter (as mandated by Affordable Care Act)
RCD Required Documents: Post-Payment

• ADR requested once claim is received and payment is processed
• ALL medical documentation
• Eligibility and Medical Necessity

RCD: Documentation Management Best Practices

• Begin collection of needed evidence at referral intake
  ✓ Who is certifying and signing plan of care orders?
  ✓ When did F2F encounter occur?
  ✓ Documentation of medical necessity*
  ✓ Documentation of confined to home*
  *agency documentation may be used to supplement this information, but must be signed, dated and incorporated into the physician’s medical records
RCD: Documentation Management Best Practices

• Continue collecting evidence of eligibility at assessments
  ✓ Clinician must assess for eligibility at initial assessment
  ✓ Must also assess for eligibility at comprehensive assessment
  ✓ Ensure assessing clinicians are documenting evidence
  ✓ Designate process for labeling documentation

RCD: Documentation Management Best Practices

• Use the Plan of Care as evidence
  ✓ Patient-specific, individualized
  ✓ Coordination with physician is well documented
  ✓ Software adds skilled need, medical necessity and confined to home criteria
  ✓ Signed and dated by physician
  ✓ Certification/recertification statement includes F2F date
  ✓ Be sure certifying physician is same as the physician signing plan of care
RCD: Documentation Management Best Practices

• Face to Face Documentation
  ✓ Approved provider type
  ✓ Clearly labeled
  ✓ Correct time period
  ✓ Related to primary reason patient needs home health care

RCD: Optimizing Documentation

- Train intake personnel
- Label and upload eligibility criteria
- Implement process for retrieval and storage
RCD: Documentation Management Best Practices

• Confined to Home Example:
  • Review of Face to Face encounter documentation received on referral shows that the provider documented only part of the criteria for confined to the home
  • This is communicated to the clinician who performs the initial assessment (PT Evaluation) and comprehensive assessment (RN OASIS follows)
RCD: Documentation Management Best Practices

• Confined to Home Example:
  • Designated personnel uploads F2F into patient chart, labels “Confined to home criteria 1”
  • Designated personnel uploads PT Eval into patient chart, labels “PT Confined to home criteria 2”
  • Designated personnel uploads applicable part of RN OASIS and/or Plan of Care documentation, labels “RN Confined to home criteria 2”

RCD: Documentation Management Best Practices

• Skilled services
  ✓ Planned and executed care meet eligibility criteria per Publication 100-2, Chapter 7
  ✓ Reasonable and necessary for diagnosis/treatment/illness/injury
  ✓ Ensure documentation is specific, individualized and clearly states skilled services and patient response (if doing post-review)
  ✓ If doing PCR, be sure this is clearly labeled and uploaded as evidence
RCD: In Closing

• Documentation of eligibility is tied to:
  ✓ Referral documentation
  ✓ Certification statement & Face to Face
  ✓ Initial/Comprehensive assessment
  ✓ Plan of Care
  ✓ Admission documents
  ✓ Visit notes
  ✓ Physician records
  ✓ Billing requirements

RCD: In Closing

• Remember, it is the agency’s responsibility to understand patient eligibility for the Medicare Home Health Benefit

• RCD is a process in which the agency uses collected evidence of this eligibility to prove payment is legally due them

• Agencies should know patient meets eligibility requirements are met BY ADMISSION
RCD: In Closing

As part of the Conditions of Participation, the agency must give the patient written information as to what he or she is required to pay for home health services.

This means the agency has to know by admission that the patient is eligible to receive the home health benefit or not.

Financial information in writing must reflect this decision.

Acronyms For This Session

- **CMS**: Center for Medicare and Medicaid Services
- **F2F**: Face to Face Encounter
- **GAO**: Government Accountability Office
- **MedPAC**: Medicare Payment Advisory Commission
- **OIG**: Office of Inspector General
- **POC**: Plan of Care
- **RCD**: Review Choice Demonstration
- **SOC**: Start of Care
- **TPE**: Targeted Probe and Educate
Resources For RCD Presentation

- Review Choice Demonstration FAQ’s
- RCD Operational Guide, May 9, 2019
- https://go.cms.gov/homehealthRCD
- MLN Matters SE1436
- MM 9119
- Publication 100-2, Chapter 7, Medicare Benefit Policy Manual
- Publication 100-8, Chapter 6, Program Integrity Manual

Resources For RCD Presentation

Review Decision Flowcharts:
- RCD Flowchart
- HHA and Physician Documentation
- PCR Decision Tool: Individual Education for Documentation Errors
- RCD Operational Appendix B through Appendix H
- CMS' RCD Info Page
Historical Perspective

- Back in 2010:
  - $19.5 billion paid to 11,203 HHAs for services provided to 3.4 million beneficiaries
  - $5 million paid in HH claims with 1 of 3 specific errors
  - Approximately 2 in every 4 HHA exceeded threshold that indicates unusually high billing for at least 1 of 6 measures of questionable billing
Historical Perspective

• Why look at Home Health in 2016?
  • $18.4 billion paid to more than 11,000 HHAs in CY 2015
  • Over $10 billion in improper payments estimated in FY 2015
  • Previous reports highlighting compliance and billing concerns
  • More than 350 criminal and civil actions and $975 million in investigative receivables in FYs 2011-2015

Historical Perspective


• The Medicare HH benefit is ill-defined
• HH payment should not be based on the number of therapy visits
  – Payments based on therapy thresholds creates financial incentives that distract agencies from focusing on patient characteristics when setting plans of care.
  – Trend of notable shifts away from non-therapy visits.
• HH payment should be determined by patient characteristics

• CMS PDGM Webinar
• Tuesday, February 12, 2019
The Bottom Line

• Data that looks like fraudulent, wasteful and abusive is more easily discoverable within a system that is more robust and sensitive
• Early identification is available through multiple channels to remediate behavior
• External scrutiny puts tremendous administrative and financial burden on HHAs

“Get it right the first time, that’s the main thing” – Billy Joel

Targeted Probe & Educate (TPE)

• Designed to help providers and suppliers reduce claim denials and appeals through 1-on-1 help.
• Purpose: “To help you quickly improve. MACs work with you, in person, to identify errors and help you correct them.”
• MACs use data analysis to ID:
  • Providers/suppliers with high claim error rates or unusual billing practices, and
  • Items/services that have high national error rates and are a financial risk to Medicare
Targeted Probe & Educate (TPE)

• Process:

Agency denial & billing practices

MAC notification by letter of TP&E selection

20-40 claims

Compliant?
Not Compliant?

Targeted Probe & Educate (TPE)

• Compliant
  • TPE on selected topic will be suspended for at least one year

• Not Compliant
  • Claim denials trigger MAC-provided education on how to identify and correct the errors
  • 45-day period to make changes and improve
  • MAC will again review 20-40 claims on topic
TPE: How It Works

- Problems that fail to improve after 3 rounds of TPE will be referred to CMS for next steps
- May include: 100% prepay review, extrapolation, referral to RAC, etc.
TPE: How It Works

• How is “improve” defined?
  • No published target
  • General consensus, through customer experience supports > 80% defensibility (at a minimum)

• Agency Mindset
  • Quality auditing of claims
  • Set minimum > 90%

TPE: Persistent Issues

• Common Claim Errors
  ➢ Signature of certifying physician not included
  ➢ Encounter notes did support all elements of eligibility
  ➢ Documentation does not meet medical necessity
  ➢ Missing or incomplete initial certification or recertification
TPE: Documentation Requirements

• TPE, like RCD, requires attention to the elements that establish eligibility for certification of the Medicare Home Health benefit.

- Confined to the home
- Physician-approved Plan of Care
- Under care of Physician
- Need for Skilled Care
- Physician Certification (F2F)

• Eligibility for recertification = establish the continuing need for service(s)

TPE: Documentation Requirements

• Elements of Eligibility: “Confined to Home”
  - Operationalize & individualize to the client
  - Clearly establish change from “normal” or “routine” PLOF

Criteria-One

- Have a condition such that leaving his or her home is medically contraindicated.
- (Because of illness or injury, need the aid of supportive devices such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the assistance of another person in order to leave their place of residence)

Criteria-Two

- There must exist a normal inability to leave home
- Leaving home must require a considerable and taxing effort

Criteria-One

- Need for Skilled Care
- Physician Certification (F2F)

Criteria-Two

- Confined to the home
- Physician-approved Plan of Care
- Under care of Physician
TPE: Documentation Requirements

• Answer the following question(s):
  • What functional deficits (i.e., gait distances, gait speed, balance, cognition, etc.) does patient currently exhibit that makes going into community for services unsafe?
  • What medical contraindications are present that make patient unable to receive care outside the home environment?
  • What risk does travel outside the home for care present to the patient? (*be specific!)

TPE: Documentation Requirements

• What does CMS Say?

• 30.1.1 – Patient Confined to the Home (Rev. 233, Issued: 02-24-17, Effective: 01-01-17, Implementation: 03-27-17)
  • “The aged person who does not often travel from home because of feebleness and insecurity brought on. By advanced age would not be considered confined to the home for purposes of receiving home health services unless they meet ..... conditions.”
### TPE: Documentation Requirements

#### Elements of Eligibility: ”Need for Skilled Care”
- Complexity such that safety and/or efficacy of intervention can only be achieved under the supervision of a skilled clinician
- Development, implementation, mgmt., evaluation of a care plan
- Periodic reevaluation of patient and plan

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<th>Skill</th>
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### TPE: Documentation Requirements

#### What does CMS Say?

**40.2 – Skilled Therapy Services** *(Rev. 179, Issued: 01-14-14, Effective: 01-07-14, Implementation: 01-07-14) A3-3118.2, HHA-205.2*

- “To be covered as skilled therapy, the services must require the skills of a qualified therapist and must be reasonable and necessary for the treatment of the patient’s illness or injury ..... Coverage does not turn on the presence or absence of an individual’s potential for improvement, but rather on the beneficiary’s need for skilled care.”
- “The service .....is a skilled therapy service if the inherent complexity of the service is such that it can be performed safely and/or effectively only by or under the general supervision of a skilled therapist.”
TPE: Documentation Requirements

• Medical Necessity:
  • Care that is related to illness, injury, or condition that is affecting patient.
  • Care that is consistent with acceptable standards of practice
  • Care that is integral to either maintain or improve patient status (i.e., function, knowledge, ability)

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The amount makes sense
The care is indispensable

TPE: Documentation Requirements

• What does CMS Say?

• 40.2.1 – General Principles Governing Reasonable and Necessary Physical Therapy, Speech-Language Pathology Services, and Occupational Therapy (Rev. 208, Issued: 04-22-15, Effective: 01-01-15, Implementation: 05-11-15)
  • “To be covered, assuming all other eligibility and coverage criteria have been met, the skilled services must also be reasonable and necessary to the treatment of the patient’s illness or injury or to the restoration or maintenance of function affected by the patient’s illness or injury.”
TPE: Quality Auditing of Documentation

• Quality auditing for documentation defensibility is not a “YES/NO” type of audit.
• Requires a detailed review of the unique presentation of each individual patient to ensure:
  • Eligibility elements met for this component of benefit
  • Reasonable and necessary established for each service providing/continuing care
  • Clear demonstration of skilled contribution of clinician on each completed visit
TPE: Quality Auditing of Documentation

• **Source:** www.palmettogba.gov J11 Medicare Administrative Contractor (MAC)

  “If it wasn’t documented – it wasn’t done”

  “Do it right the first time”

  “Would YOU pay for what was documented in the record?”

Resources For TPE Presentation

• Targeted Probe and Educate (TPE), Centers for Medicare & Medicaid Services. [https://www.cms.gov](https://www.cms.gov)


• JM Part A – Targeted Probe and Educate, Palmetto GBA. [https://palmettogba.com](https://palmettogba.com)

• Targeted Probe and Educate (TPE) Process, CGS Medicare. [https://cgsmedicare.com/hhh/medreview/tpe](https://cgsmedicare.com/hhh/medreview/tpe)